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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

PLAINTIFFS' RESPONSE TO ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION (ECF No. 3647)

Date: September 24, 2021
Time: 9:30 am
Crtrm.: 6, 2nd Floor
Judge: Hon. Jon S. Tigar

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

INTRODUCTION

Over the last eighteen months, a tragedy has played out behind state prison walls. The novel coronavirus found fertile breeding ground in the congested and poorly ventilated prisons. It has infected and replicated in the bodies of over 49,834 incarcerated people, and killed at least 238. Most patients who died were particularly vulnerable to the disease, including the elderly, medically fragile, and people with disabilities. Those who survived have endured blossoming outbreaks, severe lockdowns, and suspension of the most basic of prison programs, services, and activities, including mental health programs, rehabilitation, education, and visitation. They have worn masks, tried to physically distance, and washed their hands. But these measures have proved no match for the virus, which we now know spreads through the air and is evolving to become more transmissible.

At long last, safe and effective vaccines are widely available and can stanch the deadly flow of the virus into the prisons. But far too few staff have elected to receive them, notwithstanding priority access, convenient locations, and generous incentives. In fact, only 40% of custody staff statewide are fully vaccinated; at some prisons, the percentage is much lower. Only **16%** of custody staff at High Desert State Prison are fully vaccinated, **21%** at Pelican Bay State Prison, **25%** at the California Correctional Center, **28%** at the California Correctional Institution, and **29%** at Pleasant Valley State Prison.

In the meantime, staff infections are rising steeply, and the Plaintiff class continues to be infected, hospitalized, and killed by the virus. Just two weeks ago, an 81-year-old man in a wheelchair died from pneumonia, respiratory failure, and COVID-19.

Notwithstanding the substantial and proven risk of serious harm, this public health issue appears to have become a political one. On August 5, 2021, the State issued a vaccine mandate for workers in healthcare settings, on the basis that "statewide facility-directed measures are necessary to protect particularly vulnerable populations," but then exempted prisons. The rationale underlying the State's order, however, applies equally (if not more so) to prisons. There is no legitimate public health basis to exclude the almost 100,000 vulnerable and disenfranchised patients in prison, over whom the State has

complete control, from the order's protections. Almost 75% are Black or Latinx, and tens of thousands are highly vulnerable due to advanced age or underlying medical conditions.

On August 19, 2021, the State issued a watered-down version of the mandate for its prisons. That order applies only to a small subset of workers in certain healthcare settings. There is no public health basis for limiting mandatory vaccines to those workers. First, over 15,000 highly vulnerable patients are housed outside designated healthcare settings. Second, even in designated settings, the order covers only "regularly assigned" workers. That ignores operational constraints and realities in the day-to-day management of the California Department of Corrections and Rehabilitation, where staff often are reassigned to different posts, including in healthcare areas. Finally, the order fails entirely to address the core public health basis for the Receiver's recommendation—limiting the flow of the virus into the prisons as a whole. As such, the order evidences continued deliberate indifference to the health and safety of the Plaintiff class.

Put simply, we are not so far removed from when Judge Henderson found, fifteen years ago, "a lack of leadership and a prison culture that devalues the lives of its wards." *Plata v. Schwarzenegger*, No. C01-1351 TEH, 2005 WL 2932253, at *15 (N.D. Cal. Oct. 3, 2005). In the face of deliberate inaction, it falls to the Court to protect the constitutional rights and lives of the Plaintiff class. Plaintiffs agree with the public health conclusions in the Receiver's report, strongly support the vaccination mandate recommended by the Receiver, and ask that the Court order that the mandate be implemented without further delay. *See id.* at *29 (granting relief where "current leaders of the prison system have failed to take the bold measures necessary to protect the lives of prisoners").

STATEMENT OF THE ISSUES

I. Whether the Court should order that access by workers to CDCR institutions be limited to those workers who establish proof of vaccination (or have established a religious or medical exemption to vaccination) and that incarcerated persons who desire to work outside of the institution (e.g., fire camps) or to have in-person visitation must be vaccinated (or establish a religious or medical exemption).

II. Whether the rationale behind the California Department of Public Health Order of August 5, 2021, applies to some or all of CDCR's employees.

III. Whether there is any public health basis for limiting mandatory vaccines to all staff identified in Defendants' memorandum dated August 23, 2021, implementing the California Department of Public Health Order of August 19, 2021.

RELEVANT FACTS

I. The Plaintiff Class Is Particularly Vulnerable to COVID-19.

"The effects of COVID-19 are particularly significant for people over the age of 50, and those of any age with underlying health problems such as—but not limited to—cancer, obesity, weakened immune systems, serious heart conditions, chronic kidney disease, COPD, and diabetes." ECF No. 3638-3, Declaration of Dr. Tara Vijayan ("Vijayan Decl.") at 2 ¶ 5. State prisons hold tens of thousands of such patients—27,281 over the age of 50, and 17,860 with a COVID Weighted Risk Score of 3 or higher.[1] *See* Declaration of Sophie Hart, filed herewith ("Hart Decl."), at 1-4 ¶¶ 3, 5.

In addition, "African Americans, Latino/a Americans, and Native Americans suffer complications and death at much higher and disproportionate rates to their population." Vijayan Decl. at 2 ¶ 6. Those populations are significantly overrepresented in state prisons, where Black and Latinx people represent 29% and 45% of the incarcerated population, respectively. *See* Hart Decl., Ex. 16.

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[1] "The COVID Weighted Risk Score Factors and their weights in parentheses include: Age 65+ (4), Advanced Liver Disease (2), Persistent Asthma (1), High Risk Cancer (2), Chronic Kidney Disease (CKD) (1), Stage 5 CKD or receiving dialysis (1), Chronic Lung Disease (including Cystic Fibrosis, Pneumoconiosis, or Pulmonary Fibrosis) (1), COPD (2), Diabetes (1), High Risk Diabetes (1), Heart Disease (1), High Risk Heart Disease (1), Hemoglobin Disorder (1), HIV/AIDS (1), Poorly Controlled HIV/AIDS (1), Hypertension (1), Immunocompromised (2), Neurologic Conditions (1), Obesity (1), Other High Risk Chronic Conditions (1), and Pregnancy (1)." Hart Decl. at 3 ¶ 4.

II. Physical Distancing Is Impossible in State Prisons, Where Patients Are Exposed to a Higher Viral Inoculum.

Some of these vulnerable patients are housed in specialized healthcare locations. *See* Hart Decl. at 4 ¶ 6. The vast majority, however, are housed in cramped and poorly ventilated dorms and cellblocks. "It is not possible to consistently maintain physical distancing" in that environment. ECF No. 3638-1, Declaration of Dr. Joseph Bick at 5 ¶ 25 ("Bick Decl."). Most patients "are housed in dormitories that are too crowded to allow for social distancing," as can be seen in the photographs below of such housing during the pandemic. *See* ECF No. 3638-2, Declaration of Tammatha Foss ("Foss Decl.") at 2 ¶ 5; Declaration of Rita Lomio, filed herewith ("Lomio Decl."), Ex. F (SATF); Hart Decl., Ex. 26 (CIM, CVSP, NKSP, SVSP). "These accommodations typically have one hundred to two hundred bunk beds per room in close proximity to one another." Foss Decl. at 2 ¶ 5. The remainder of the Plaintiff class, who live in cells, often "have perforated doors or bars rather than solid doors." *Id.* at 2 ¶ 6. Patients frequently and unavoidably come in close contact with each other at communal toilets and showers, medication distribution, mental health programs, meals, and work assignments. *Id.* at 2-3 ¶¶ 7-11. They share a "large number of high-touch objects and surfaces." *Id.* at 3 ¶ 11. As a result, "incarcerated persons are much more likely to be exposed to the virus more frequently and for longer periods of time," Bick Decl. at 4 ¶ 22, increasing the risk of severe disease due to "exposure to a higher viral inoculum." Vijayan Decl. at 3 ¶ 8.

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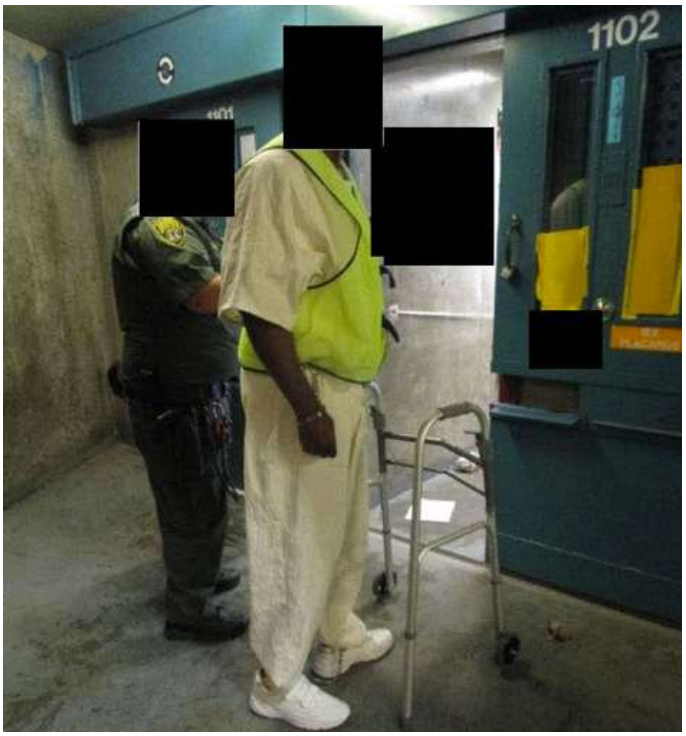
III. Staff Come Into Frequent, Close Contact with the Plaintiff Class.

"Healthcare staff have close contact with patients when providing treatment." Bick Decl. at 4 ¶ 21. Custody staff also "have frequent, daily, close contact with" patients. Foss Decl. at 1 ¶ 3. This includes during pat-down body searches prior to yard release; direct-contact escorts, including to medical appointments and transports; and, within housing units, delivery of meals and safety checks. *Id.* It simply "is not possible for corrections officers to perform their jobs with social distancing precautions." *Id.*



CALIFORNIA STATE PRISON, SACRAMENTO (JULY 2021)

See Lomio Decl., Ex. E.

Patients with developmental and physical disabilities are housed in every prison and largely depend on staff for disability-related help. *See* Lomio Decl. at 2-5 ¶¶ 5-16 (physical disabilities); Declaration of Sara Norman, filed herewith ("Norman Decl."), at 1-3 ¶¶ 2-7 (developmental disabilities). Among other things, staff must provide effective communication of announcements so D/deaf and hard-of-hearing people do not miss out on appointments and programs, which may involve speaking loudly and clearly while in close proximity to the patient. Lomio Decl. at 4 ¶ 13. Staff serve as sighted guides to blind

patients, must offer to provide a guided walk-through of a housing unit whenever a blind person is moved there for the first time, and must help with reading and writing. *Id.* at 4-5 ¶¶ 14-15 & Ex. C. Particularly in quarantine and isolation units, staff may be called on to perform a number of other support functions, including carrying food trays, pushing wheelchairs, and cleaning cell and bed areas. *Id.* at 5 ¶ 16 & Ex. D. Many of these tasks cannot be accomplished without extended periods of close contact. *Id.* at 4 ¶ 12.

Staff also provide support to patients with developmental disabilities, whose needs "range from activities of daily living (prompt people to shower, brush their teeth, attend appointments, and take medication) to behavior (monitor for isolation and acting out) to communication (simplify, deescalate, remind)." Norman Decl. at 2-3 ¶ 5. Patients "often need help understanding the rules and reading and writing forms like sick call slips and grievances. Many need to be monitored to protect them from theft or verbal or physical abuse." *Id.* This requires direct interaction, often of lengthy duration. *Id.* at 3 ¶ 6.

IV. Staff Are a Primary Vector for Transmission of COVID-19 Into the Prisons, and, Once Introduced, It Is Virtually Impossible to Stop the Spread.

"The data obtained from contact tracing and genomic sequencing confirm that CDCR staff are a primary vector for transmission of COVID-19 into CDCR institutions." Bick Decl. at 3 ¶¶ 16-17. This is unsurprising. "Because corrections officers and other staff go daily between the institutions in which they work and the communities in which they live, where they may be subject to community transmission of SARS-CoV2, there is a high risk of staff members unknowingly introducing SARS CoV2 to an institution." Vijayan Decl. at 6 ¶ 16. Indeed, two prisons with extremely low vaccination rates for custody and healthcare staff, High Desert State Prison (16% and 52%, respectively) and California Correctional Center (25% and 65%), are located in Lassen County, where only 20.4% of the community is fully vaccinated. *See* Bick Decl. at 14 (Ex. B); Hart Decl., Ex. 25 at 6.

"Because many staff members move throughout an institution in the course of performing their daily duties, a staff member infected with COVID-19 can come into contact with many inmates and staff, including inmates and staff from multiple housing

units and yards, potentially spreading SARS-CoV-2 throughout the institution." Bick Decl. at 4 ¶ 21. And "once introduced, it is extraordinarily difficult to prevent the spread of COVID-19, which could lead to large-scale outbreaks." *Id.* at 5-6 ¶ 32. To date, at least 49,834 patients have been infected, including 2,043 at High Desert State Prison and 1,405 at California Correctional Center, and 238 have died. *See* Hart Decl. at 12 ¶ 23 & Ex. 27.

V. COVID-19 Infections Impede Delivery of Medical Care Statewide.

"Frequent program modifications . . . have been necessary during the COVID-19 pandemic, either to slow the spread of the virus during an outbreak or in response to reduced staffing when high numbers of staff are quarantined for exposure." ECF No. 3652, Supplementary Declaration of Dr. Joseph Bick ("Bick Suppl. Decl.") at 4 ¶ 8. "These program modifications often prevent or limit routine, specialty, and screening appointments." *Id.*; *see also* Bick Decl. at 2 ¶ 7. For example, during the height of the pandemic, there were over 17,868 overdue specialty care appointments. Bick Suppl. Decl. at 5-6 ¶ 11 (noting importance in identifying cancer and alleviating pain). Just last month, as seen in the table below, there remained significant backlogs of PCP appointments, RN appointments, specialty care appointments, and laboratory orders—all steep increases from before the pandemic. *See* Hart Decl. at 9 ¶ 10; *see also id.* at 10 ¶ 12 (as of June 15, 2021, 544 PCP appointments were more than 90 days overdue). This includes overdue cancer screening ultrasounds for 876 patients with end-stage liver disease. *See id.* at 10 ¶ 13. And growing case rates likely will only increase these delays. Bick Suppl. Decl. at 5 ¶¶ 10-11.

TABLE 1: PENDING, OVERDUE MEDICAL APPOINTMENTS AND ORDERS

	January 2020	July 2021	+/-
PCP Appointments	2,749	4,814	+175%
RN Appointments	693	3,073	+443%
Specialty Care Appointments	3,674	7,950	+216%
Laboratory Orders	759	6,874	+905%

Outbreaks also have "created a significant impediment to the delivery of group therapy." Bick Decl. at 2 ¶ 9. And "patients who are on quarantine due to exposure to an infected staff member are unable to attend programming during the period of their quarantine." *Id.* On August 19, 2021, 2,412 patients were in quarantine due to exposure. Hart Decl. at 11 ¶ 16. Six prisons had more than 100 patients in exposure quarantine. *Id.*

TABLE 2: PATIENTS IN QUARANTINE DUE TO COVID-19 EXPOSURE (AS OF AUGUST 19, 2021)

CHCF	HDSP	SCC	CCWF	CCC	COR
811	270	263	242	186	104

More generally, "[t]he prolonged COVID pandemic has placed a great strain upon the CDCR and CCHCS workforce. Employees have seen an increased workload and more involuntary overtime." Bick Decl. at 2 ¶ 12. "Staff have been impacted emotionally by the constant stream of COVID-related illness and death in their patients, their coworkers, and family members. These factors have contributed to the challenge of maintaining sufficient staff to provide medical care to our patients." *Id.*

VI. Staff Vaccination Rates Remain Dangerously Low, While Staff Infection Rates Increase Steeply and the Novel Coronavirus Continues to Mutate.

"CDCR staff are vaccinated at far too low a rate to reduce the risk of mass outbreaks in CDCR institutions." Bick Decl. at 6 ¶ 37. Only 53% of staff statewide are partially or fully vaccinated. *Id.* at 14 (Ex. B). At many prisons, the vaccination rate for custody staff is much lower; at four prisons, it is between 17% and 29%, and at ten prisons it is between 30% and 39%. *Id.* at 14-15. "Institutions with low staff vaccination rates experience larger and more frequent COVID-19 outbreaks." Bick Suppl. Decl. at 4 ¶ 9.

The danger is ever increasing. "The Delta variant, now the most common variant in California, is 2-3 times more transmissible than the original wild-type SARS-CoV2." Vijayan Decl. at 5 ¶ 12; *see also* Bick Decl. at 5 ¶ 29 ("[A] patient infected with the Delta variant sheds 1,000 times more virus than an average patient with an earlier strain."). "In recent weeks, the number of people infected in California has grown at an extremely rapid

rate." Vijayan Decl. at 2 ¶ 3; *see also* Hart Decl., Ex. 20, Cal. Dep't of Public Health, Health Care Worker Vaccine Requirement at 1 (Aug. 5, 2021) ("California is currently experiencing the fastest increase in COVID-19 cases during the entire pandemic").

"Case rates have increased more than 500% among staff members in recent weeks, most of whom are infected with the Delta variant." Bick Decl. at 5 ¶ 30. In the last two months alone, "1,398 CDCR employees have been diagnosed with COVID-19." Bick Suppl. Decl. at 3 ¶ 2. To date, at least 19,359 staff have been infected, and at least 29 have died from COVID-19. *See* Hart Decl. at 12 ¶ 24. Unfortunately, "natural immunity from infection with an earlier strain of COVID-19 may be ineffective at preventing infection with the Delta variant." Vijayan Decl. at 5-6 ¶ 12; *see also* Bick Decl. at 5 ¶ 31. And although vaccines significantly reduce the risk of transmission, they do not provide complete protection. "Despite being fully vaccinated, to date 292 patients in CDCR custody have had a COVID-19 breakthrough infection," a quarter of whom "are at high risk of serious disease." Bick Suppl. Decl. at 3 ¶¶ 3-4. Two fully vaccinated patients already have died from the disease. *Id.* at 3 ¶ 4; *see also* Hart Decl. at 9 ¶ 9.

And there may be something worse than the Delta variant on the horizon. "The virus is likely to continue to mutate, potentially creating even more transmissible strains than Delta, as it has done repeatedly in the past. These strains may be even more difficult to constrain using basic public health precautions like masking, social distancing, and frequent cleaning of high touch surfaces." Bick Decl. at 6 ¶ 33. "Future variants may prove more resistant to the vaccine." *Id.* at 6 ¶ 35.

VII. The Receiver Concluded that COVID-19 Vaccination of Workers Who Travel Outside the Prisons Is Necessary to Protect the Plaintiff Class.

On August 4, 2021, Receiver J. Clark Kelso issued a report and recommendation "based on the advice of medical and public health professionals, including Dr. Joseph Bick," who has led the response to COVID-19 in California prisons for the last year. ECF No. 3638 at 3, 5 ("Receiver's Report"); Bick Decl. at 1 ¶ 1. The Receiver found that "[o]nce COVID-19 infection has been introduced into a prison, it is virtually impossible to

contain, and staff are indisputably a primary vector for introducing into the prison the infection now spreading rapidly in the larger community." Receiver's Report at 5. He concluded that "**mandatory COVID-19 vaccination for institutional staff is necessary to provide adequate health protection for incarcerated persons**." *Id.* (emphasis added). He later explained that "[e]ach week is critical" and, given urgency of the issue, the Court should not delay "decision of this matter until October." ECF No. 3645, Receiver's Proposed Briefing Schedule at 2.

Since the Receiver filed his report, "COVID infection rates have continued to increase nationwide, in California, and in CDCR institutions." Bick Suppl. Decl. at 3 ¶ 2. The Delta variant has "driven COVID cases within CDCR to their highest levels since March 2021." *Id.* at 3 ¶ 6. "As of August 16, 2021, there were 536 cases of active COVID among staff," and "an even greater percentage increase in cases of active COVID among patients." *Id.* at 3 ¶ 2. "Major outbreaks of COVID are occurring at four institutions," and "thirty-four facilities are currently on restricted operations due to a current or recent outbreak of COVID-19." *Id.* at 4 ¶ 6 (parenthetical omitted). "As of August 18, 2021, there were 2,345 incarcerated persons quarantined for exposure to someone with COVID-19." *Id.* And, "[i]n just the first 17 days of August, hundreds of staff members have been instructed to isolate after contracting COVID-19 and hundreds more to quarantine based upon contact with people infected with COVID-19." *Id.* at 4-5 ¶ 9.

ARGUMENT

I. The Court Should Order that the Receiver's Recommended Vaccination Mandate Be Implemented.

As the Three Judge Court in this action observed last year, "the Eighth Amendment requires Defendants to take adequate steps to curb the spread of disease within the prison system." *Coleman v. Newsom*, 455 F. Supp. 3d 926, 932 (E.D. Cal./N.D. Cal. 2020); *see also Helling v. McKinney*, 509 U.S. 25, 33 (1993) (recognizing that officials must not be "deliberately indifferent to the exposure of inmates to a serious, communicable disease"); *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996) ("[C]orrectional officials have an

affirmative obligation to protect inmates from infectious disease."). Defendants' failure to require that workers who enter CDCR institutions be vaccinated constitutes "'deliberate indifference' to a substantial risk of serious harm" to the Plaintiff class and therefore violates the Eighth Amendment. *See Farmer v. Brennan*, 511 U.S. 825, 828 (1994).

A. COVID-19 Presents a Substantial Risk of Serious Harm.

The first element of the Eighth Amendment analysis—the existence of a substantial risk of serious harm—already has been established. *See Plata v. Newsom*, 445 F. Supp. 3d 557, 562 (N.D. Cal. 2020) (noting that Defendants do not dispute "the risk of harm that COVID-19 poses to inmates" or "that those who are incarcerated may be at a higher risk for contracting COVID-19 given the circumstances of incarceration") (quotation marks and citation omitted); *Coleman*, 455 F. Supp. 3d at 933 ("Defendants themselves acknowledge that the virus presents a 'substantial risk of serious harm' and that the Eighth Amendment therefore requires them to take reasonable measures to abate that risk.").

"The effects of COVID-19 can be very severe, and can include severe respiratory illness, major organ damage, blood clots (in the lungs as well as strokes), multisystem inflammatory syndrome, and death." Vijayan Decl. at 2 ¶ 4; *see Plata v. Brown*, 427 F. Supp. 3d 1211, 1225 (N.D. Cal. 2013) (Henderson, J.) ("[I]t would be impossible to conclude that a disease that, in its severe form, could lead to death does not present a risk of serious harm."). This is true even for patients who are fully vaccinated. *See* Bick Suppl. Decl. at 3-4 ¶¶ 5-6 ("[T]he Delta variant presents a substantial risk of harm even to fully vaccinated patients . . . [and] is causing new infections, reinfections, breakthrough infections, illness, hospitalizations, and death"). "Patients who recover from COVID-19 often suffer lasting and serious complications, including long term effects on the central and peripheral nervous systems resulting in dizziness, dysautonomia, headaches and strokes." Vijayan Decl. at 2 ¶ 4; *see also* Bick Decl. at 1 ¶ 5; Bick Suppl. Decl. at 3 ¶ 4.

The Plaintiff class is particularly vulnerable. "Incarcerated persons experience worse health outcomes in part because they have risk factors for COVID-19 at a disproportionate rate compared to the general public." Receiver's Report at 17; *see* page 3,

above. They also are at higher risk because of the particular danger "of respiratory transmission in congregate environments, like prisons." *See* Vijayan Decl. at 5 ¶ 12; *see also id.* at 3 ¶ 8 (observing that an incarcerated person "is, by the nature of the living arrangements and density of people, exposed to these multiple modalities of transmission and high viral inoculum," and "[t]he risk of severe disease also increases with exposure to a higher viral inoculum"). "Incarcerated persons are five times as likely to be infected in outbreaks and nearly three times more likely to die." Receiver's Report at 6.

In addition, COVID-19 significantly disrupts medical care delivery in the prison system, as can be seen in the large backlogs in appointments, specialty care, and laboratory orders. *See* page 8, above. "[T]hese delays cannot continue indefinitely without negatively affecting patient care." Bick Suppl. Decl. at 4 ¶ 8. "Since the beginning of the pandemic, there have been hundreds of program modification orders at CDCR institutions, some of which lasted for months or even more than a year, and many of which are ongoing." *Id.* Frequent lockdowns "impede the effective delivery of care." *Brown v. Plata*, 563 U.S. 493, 521 (2011). "[S]taff must either escort prisoners to medical facilities or bring medical staff to the prisoners. Either procedure puts additional strain on already overburdened medical and custodial staff." *Id.*; *see* Health Care Dep't Operations Manual ("HCDOM") § 3.1.5(c)(3)(D)(2) (rev. Apr. 2019).

Infections among staff attributable to the Delta variant likely will result in continued and increasing staff shortages. *See* Bick Suppl. Decl. at 5 ¶ 9 ("The large number of staff in quarantine has contributed to delays in clinical care."); Bick Decl. at 5 ¶ 30. And it is not just shortages of healthcare staff that impede delivery of medical care. Custody staff also are essential to the delivery of medical care in prison. *See Plata*, 2005 WL 2932253 at *15. Custody staff provide security that permits medical care delivery in specialized units, including Correctional Treatment Centers, Outpatient Housing Units, Psychiatric Inpatient Programs, and Mental Health Crisis Beds, as well as the Transitional Care Unit and Skilled Nursing Facility at CCWF, and the hospice at CMF. Custody staff perform similar functions in housing units that house patients known or suspected to be infected by the

novel coronavirus. In addition, custody staff at all prisons are responsible for escort, transport, and delivering ducats (scheduling slips) for medical appointments. *See* HCDOM §§ 3.1.2(b)(3)(D)(3) (rev. Mar. 2017), 3.1.3(b)(3)(A)(14)-(15) (rev. Dec. 2020), 3.1.5(c)(3)(C) (rev. Apr. 2019), 3.1.11(b)(3)(A)(9) (rev. July 2020). They also supervise and facilitate medication administration, *see, e.g.*, *id.* § 3.2.4(c)(2)(C), (c)(3)(A), (c)(5)(A)(2)(e) (rev. Jan. 2016); inspect Durable Medical Equipment and medical supplies, *see id.* §§ 3.6.1(e)(9)(E) (rev. Sept. 2018), 3.1.9(c)(3)(E)(5) (rev. Apr. 2019); and provide life support during medical emergencies, *see id.* § 3.7.1(g)(2)(B)(1) (rev. July 2012).

B. The Mitigation Measures Taken To Date Are Inadequate Now That Safe and Effective Vaccines Are Available.

The second element of the Eighth Amendment analysis also is met here. By failing to require vaccination of all workers who travel into the prisons, Defendants have failed "to take reasonable measures" to abate the risk posed by COVID-19. *See Farmer*, 511 U.S. at 847. It is true that the Court sixteen months ago found Defendants' mitigation efforts to be reasonable. *See Plata*, 445 F. Supp. 3d at 568. But the analysis is different today in light of what we have learned about the transmission of the virus and now that safe and effective vaccines are widely available. *See id.* at 569 (noting that decision "does not preclude a finding of deliberate indifference at a later time"); *Plata*, 427 F. Supp. 3d at 1225 n.13 ("[T]he relevant question is not what Defendants have done in the past; only Defendants' 'current attitudes and conduct' are at issue.") (quoting *Farmer*, 511 U.S. at 845-46). Indeed, California has fallen far short of other jurisdictions, which already have mandated that all correctional workers be vaccinated. *See* Hart Decl. at 15-18 ¶ 34.

Put differently, although other mitigation strategies implemented by Defendants are "substantial efforts," they do not on their own satisfy constitutional requirements based on the tools available today. *See Jones v. City & County of San Francisco*, 976 F. Supp. 896, 908 (N.D. Cal. 1997) (although defendants had undertaken measures to improve fire safety, they "continued to abdicate their constitutional responsibility" by failing to implement two other measures); *see also Plata*, 427 F. Supp. 3d at 1227 (Defendants may

not "deal with this public health emergency by relying on measures which either have not worked in the past or which are unsubstantiated mitigating strategies") (internal quotation marks and citation omitted); *Coleman v. Wilson*, 912 F. Supp. 1282, 1319 (E.D. Cal. 1995) ("Given the nature and extent of the crisis and its duration, it is not possible to credit arguments that defendants entertain a good faith belief that such efforts were sufficient."); Bick Suppl. Decl. at 6 ¶ 12 ("Safe and effective vaccines are now widely available. COVID related outbreaks, the resulting lockdowns and quarantines, hospitalizations, and deaths are largely avoidable through very high levels of vaccination . . . .").

Existing measures have not stanched the flow of the virus into the prison system. "The Delta variant has already driven COVID cases within CDCR to their highest levels since March 2021." Bick Suppl. Decl. at 3 ¶ 6. Dr. Bick, who has led the COVID-19 response in the prisons, has concluded that, "in the absence of high rates of vaccination, routine public health measures such as physical distancing and environmental cleaning are insufficient to prevent spread of SARS-CoV-2." Bick Decl. at 1, 4 ¶¶ 1, 23. Dr. Vijayan also has concluded that "a very high vaccination rate, particularly among those with contact with the outside community who may introduce SARS-CoV2 into a CDCR institution, is the most effective means of preventing outbreaks in CDCR institutions." *Id.* at 7 ¶ 18; *see also id.* at 6-7 ¶ 17. Plaintiffs agree with those conclusions.

1. Physical Distancing Mandate

Defendants require "staff and all inmate-patients [to] adhere to . . . six-foot physical distancing." *See* Hart Decl., Ex. 17 at 2. But such distancing "cannot be effectively imposed in current present conditions," and, "even if it could, it is far less effective . . . than vaccination" in stopping the spread of infection. Receiver's Report at 22. First, "[a] majority of incarcerated persons in CDCR custody are housed in dormitories that are too crowded to allow for social distancing."[2] Foss Decl. at 2 ¶ 5.

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[2] We also now know that respiratory droplets containing the virus can build up over time and travel six to eight **meters** away. *See* Vijayan Decl. at 3-5 ¶¶ 8-11; Receiver's Report at 22 & n.107.

Second, "it is not possible for corrections officers to perform their jobs with social distancing precautions." *Id.* at 1 ¶ 3; *see also* Bick Decl. at 5 ¶ 25. Staff fulfill essential duties that require close contact. *See* Foss Decl. at 1-2 ¶¶ 3-4. Patients with developmental and/or physical disabilities in particular often require frequent, close interactions. For example, over 10,000 patients with documented physical disabilities are housed across all prisons, many of whom depend on staff to provide a wide range of disability-related help, including serving as a sighted guide and pushing wheelchairs to and from appointments. Lomio Decl. at 2-5 ¶¶ 6, 12-16. And the approximately 1,300 patients with documented developmental disabilities also come into frequent, close contact with staff to support activities of daily living, fill out sick call slips, and monitor them for verbal and physical abuse and theft, among other things. Norman Decl. at 2-3 ¶¶ 2, 4-5.

2. Face Covering Mandate

Defendants require "adherence to the universal use of face masks" by all staff and patients. Hart Decl., Ex. 17 at 2. But, as we have learned from experience, "[w]hile compliance with mask guidance helps slow the spread of COVID-19 in CDCR institutions, it alone cannot prevent transmission." Bick Decl. at 5 ¶ 26. "In addition, incarcerated persons cannot wear a mask while eating or sleeping, yet there is a very significant risk of transmission during those times." *Id.*; *see also* Receiver's Report at 13.

3. Testing Mandate

Defendants require COVID-19 testing by staff. But even if all 55,584 staff who work in the prisons were tested daily (which they are not), that would "not effectively prevent asymptomatic staff from introducing COVID-19 to CDCR institutions." Receiver's Report at 9; Hart Decl., Ex. 12 at 5. Indeed, "testing is universally recognized as a far imperfect substitute for vaccination." Receiver's Report at 8. Staff may be "asymptomatic but infectious, spreading COVID" in the institutions before receiving their test results and "learning they are infected." Bick Decl. at 3 ¶ 20; *see also* Receiver's Report at 8-9 ("Tests can detect a positive case only where a certain viral load is present, so a recently infected individual may not test positive for several days after exposure.").

4. Hand Hygiene Mandate

Defendants require "frequent hand hygiene" by all staff and patients. Hart Decl., Ex. 17 at 2. But "the predominant mode of transmission of SARS-CoV-2 is via respiratory droplets." Vijayan Decl. at 3 ¶ 8. And given the volume of "high-touch," communal objects and surfaces, *see* Foss Decl. at 3 ¶ 11, including telephones, stair handrails, sinks, tables, chairs, door handles, water fountains, and showers, it simply is unreasonable to think that hand hygiene alone will prevent all or most infections.

5. Voluntary Vaccination Program

"Voluntary efforts [to encourage staff vaccination] have not produced acceptable results, and continuation with a voluntary approach that yields such results must be acknowledged for what it has proven to be—an unacceptable half-way measure." Receiver's Report at 23; *see also id.* at 24 (noting "widely advertised vaccine clinics for all staff during all shifts, at all facilities in May; offers of up to 80 hours of supplemental paid sick leave; and peer education through the COVID Mitigation Action Program"). "Voluntary efforts to increase the rate of vaccination have made very little progress over the four weeks between June 30, 2021 and July 29, 2021. In that period, the total number of full vaccinated and partially vaccinated staff each increased by just 1%." Bick Decl. at 6-7 ¶ 37. Assuming that rate remains constant and applies equally to all prisons, which is unlikely, it would take around **seven years** for all custody staff at High Desert State Prison to be fully vaccinated. *See id.* at 14. (This also assumes that staff voluntarily and timely take any necessary additional vaccine doses or booster shots.) That simply is too long. "Delaying a mandatory vaccination policy until the next wave is upon us will not produce results until it is too late and the worst of the wave is over." Receiver's Report at 26.

C. The Proposed Vaccination Mandate Meets the Requirements of the Prison Litigation Reform Act.

The Receiver's proposed mandate satisfies the needs-narrowness-intrusiveness requirements of the Prison Litigation Reform Act. *See* 18 U.S.C. § 3626(a)(1)(A). The proposed mandate is narrowly drawn—it extends only to those who travel between the

outside community and a prison (or who have similar close contact with the community through in-person visitation), the group known to be "a primary vector for transmission of COVID-19 into CDCR institutions." Bick Decl. at 3 ¶ 16. It focuses on the need "to limit the introduction of COVID into CDCR institutions because, once introduced, it is extraordinarily difficult to prevent the spread of COVID-19, which could lead to large-scale outbreaks." *Id.* at 5-6 ¶ 32; Vijayan Decl. at 6 ¶ 16.

"There is no other equally effective method." Receiver's Report at 10; *see also id.* at 5 ("[T]he only method to ensure adequate protection and care for incarcerated persons is vaccination of all persons who can bring infections into the prison."). As explained above, no other measures—alone or in combination—will correct the constitutional violation.[3] *Cf. Plata*, 2005 WL 2932253, at *24 ("[T]he Court is not required to restrict its powers to those means that have proven inadequate, or that show no promise of being fruitful.").

II. The Rationale Behind the Department of Public Health Order of August 5, 2021, Applies to All CDCR Employees Who Enter the Prisons.

The rationale behind the California Department of Public Health Order of August 5, 2021, applies to all CDCR employees who enter the prisons. *See* Hart Decl., Ex. 20 ("August 5, 2021 CDPH Order").

First, state prisons "are particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations including hospitalization, severe illness, and death." *See* August 5, 2021 CDPH Order at 1. There has been a "staggeringly high incidence of COVID-19" in the state prisons "because of the design of facilities, the manner in which they must be operated, population density, and the transmission characteristics of the virus." Receiver's Report at 10-11.

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[3] There are, of course, **more** intrusive measures. Staff could "tak[e] up residence in the prisons and never travel[] beyond the walls for the duration of the pandemic." Receiver's Report at 7. Or Defendants could dramatically reduce the prison population, something they steadfastly have refused to do. *See, e.g.*, *id.* at 16 ("[M]edical and public health experts . . . visited [SATF] and concluded that, in order to minimize COVID-19 risk, dorms with a capacity of fifty people should house only three people, and that small dorms with a capacity of six people and cells with capacity of two people should both house only a single person.").

Second, "patients are at high risk of severe COVID-19 disease due to underlying health conditions, advanced age, or both." *See* August 5, 2021 CDPH Order at 1. There are 27,281 patients over 50 years of age in the state prisons, and 17,860 patients with a COVID Weighted Risk Score of 3 or higher, who suffer from high-risk chronic conditions like advanced liver disease, cancer, COPD, heart disease, HIV/AIDS, and obesity. *See* Hart Decl. at 1-4 ¶¶ 3-5. In fact, 95% of those who died from COVID-19 while in Defendants' custody were in one or both of those categories. *See* Bick Suppl. Decl. at 3, 21-25 (Ex. B).

Third, "[t]here is frequent exposure to staff and highly vulnerable patients, including elderly, chronically ill, critically ill, medically fragile, and disabled patients." *See* August 5, 2021 CDPH Order at 1. That is the very definition of a prison system, where tens of thousands of patients depend entirely on others to support their ability to care for themselves and keep them safe. *See Plata*, 563 U.S. at 510 ("To incarcerate, society takes from prisoners the means to provide for their own needs."). This includes not only patients in hospice care or other specialized units, but also the many chronically ill patients housed throughout the prison system and the thousands of patients with developmental and physical disabilities who depend on staff for basic supports every day. *See* Norman Decl. at 1-3 ¶¶ 2, 4-6 (developmental); Lomio Decl. at 2-3, 4-5 ¶¶ 6, 12-16 (physical). It simply is not possible for staff to perform their essential duties in the prison system without frequent, sustained contact with high-risk patients. *See, e.g.*, Foss Decl. at 1 ¶ 3.

The reasoning and plain language of the August 5, 2021 order, then, applies to state prisons. And it extends to all CDCR employees who enter the prisons. This is because each prison has a healthcare clinic, and any employee may be assigned there or to other areas accessible to patients. *See* August 5, 2021 CDPH Order at 3 (order applies to "individuals who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose," including where the worker provides security); Cal. Code Regs. tit. 15, § 3397 ("in an emergency any employee must perform any service, including custodial functions, if so directed by the warden, regional administrator or his or her delegate."). This is explained in more detail in Section III.B, below.

III. There Is No Public Health Basis for Limiting Mandatory Vaccines to Staff "Regularly Assigned" to Certain Healthcare Settings Based on the Department of Public Health's August 19, 2021 Order.

The California Department of Public Health's order dated August 19, 2021, and Defendants' implementation of it, represents an ineffective half-measure that fails to adequately protect the Plaintiff class and fails to address the urgent public health basis for the Receiver's recommendation—limiting the introduction of the virus into the prisons.

A. High-Risk Patients Are Housed Throughout the Prison System.

The August 19, 2021 order applies only to certain healthcare settings within the prisons. *See* Hart Decl., Ex. 22 at 1-2 ("August 19, 2021 CDPH Order"). But the vast majority of patients at higher risk of severe illness or death from COVID-19 are housed outside of those areas. *Id.* at 4-8 ¶ 6.

TABLE 3: HOUSING OF PATIENTS WITH COVID RISK SCORE OF 3 OR HIGHER (AS OF AUGUST 26, 2021)

Prison	Total	Covered by CDPH Order	Not Covered by CDPH Order	Prison	Total	Covered by CDPH Order	Not Covered by CDPH Order
ASP	165	3	**162**	HDSP	239	10	**229**
CAC	108	0	**108**	ISP	163	0	**163**
CAL	94	9	**85**	KVSP	299	4	**295**
CCC	83	1	**82**	LAC	741	4	**737**
CCI	278	3	**275**	MCSP	1,646	2	**1,644**
CCWF	447	22	**425**	NKSP	213	3	**210**
CEN	152	6	**146**	PBSP	212	0	**212**
CHCF	1,419	1,419	**0**	PVSP	53	0	**53**
CIM	1,134	43	**1,091**	RJD	1,261	15	**1,246**
CIW	275	11	**264**	SAC	344	3	**341**
CMC	926	29	**897**	SATF	800	14	**786**
CMF	900	900	**0**	SCC	167	0	**167**
COR	515	38	**477**	SOL	911	6	**905**
CRC	253	4	**249**	SQ	1,047	15	**1,032**
CTF	950	8	**942**	SVSP	455	57	**398**
CVSP	300	2	**298**	VSP	698	14	**684**
FSP	421	0	**421**	WSP	191	2	**189**
TOTAL	17,860	2,647	**15,213**				

Patients are not housed in the covered settings **because** they have underlying chronic conditions or disabilities that make them particularly vulnerable to COVID-19, but rather may be housed there for other reasons, including the stress of imprisonment and

disruption of coping abilities or because they require palliative care. *See* Hart Decl., Ex. 24 at 3; HCDOM § 1.2.14, App. 1(a). And sometimes people who should be housed in such settings cannot be immediately moved there. *See* Hart Decl., Ex. 15 at 1.

The current vaccination policy makes unprincipled distinctions. Patients, including those with disabilities, may be protected from unvaccinated staff for the relatively brief time they are in a clinic, but not when interacting with staff in their unit every day. Patients who require dialysis may be protected from unvaccinated staff while receiving dialysis, but not in their housing units and program areas. *See* Hart Decl. at 8 ¶ 8. And Defendants' decision not to require that staff in quarantine and isolation units be vaccinated is particularly perplexing. Those workers are more likely to be exposed to the virus, and may spread it throughout the prison. *See* Lomio Decl. at 5 ¶ 16 & Ex. D; Bick Decl. at 4 ¶ 21.

This does not appear to have been the original intention of the Department of Public Health. A previous, published version of the August 19 order also applied to staff in areas "'*to which inmate patients have access for any purpose*,'" mirroring language in the August 5 order that applies to non-prison settings. *See* ECF No. 3653, Order Modifying Schedule at 2 n.1 (emphasis by Court). The *post hoc* deletion of that provision has no legitimate public health basis, leads to dangerous risks and absurd results, and seems to evidence nothing more than continued discrimination against incarcerated patients.

B. The August 19, 2021 Order Covers Only a Small Fraction of Workers Who Travel Daily Between the Community and Prisons.

The August 19, 2021 order also limits its application to people "regularly assigned" to work in healthcare facilities. *See* Hart Decl., Ex. 22 at 2. That limitation is entirely inappropriate. First, those workers represent only a small fraction of the hundreds and thousands of workers who travel into each prison daily, and thus the order fails to address the public health basis of the Receiver's recommendation—the need to reduce opportunities for workers to "introduc[e] into the prison the infection now spreading rapidly in the larger community" because once a "COVID-19 infection has been introduced into a prison, it is virtually impossible to contain." *See* Receiver's Report at 5.

Second, the order does not take reasonable measures to mitigate risk even in limited healthcare settings. In particular, it ignores the day-to-day operational realities of managing a large and complex prison system. As Director Foss explained, "[o]fficers working their ordinary shifts are often reassigned to cover high-need vacant positions. For example, a gym officer may be reassigned for the day to guard a clinic in order to keep the clinic operating. . . . Corrections officers also frequently work overtime in housing units and yards to which they are not ordinarily assigned, based on availability and need of the institution."[4] Foss Decl. at 1-2 ¶ 4. In fact, Defendants already have informed the Court that they can**not** make staff assignments "permanent and completely static because the prisons need to have the flexibility to send custody staff to locations where they are needed, which can change from day to day due to staff illness, leave, emergencies, changes in programming, staffing shortages, promotions, and transfers, among other reasons."[5] *See* ECF No. 3314, Defendants' Response to the Court's April 29, 2020 Questions Concerning Dorms at 5-6 (May 1, 2020) (characterizing flexibility as "essential" during the pandemic).

Defendants' own directive implementing the August 19, 2021 order lists the many

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[4] Such movement, of course, may spread the virus throughout a prison. *See* Hart Decl., Ex. 23, Amend & Berkeley Public Health, Urgent Memo, COVID-19 Outbreak: San Quentin Prison, at 7 (June 13, 2020) ("At present work shift plans are inadequate from a public health perspective. For example, we learned about staff who were working in the Medical Isolation Unit (Adjustment Center) during the shift and were scheduled to work the next shift in the dorms. This is an enormous risk for the spread of COVID-19 between housing units.").

[5] *See also Hastings v. Dep't of Corrections*, 2 Cal. Rptr. 3d 329, 331 (Ct. App. 2003) ("The correctional officer is expected to have the ability to work 24 hours at any post or any particular assignment or watch. . . . [A]ny correctional officer may be called upon to respond immediately to any emergency situation, at any time, in the correctional facilities."); *Furtado v. State Personnel Bd.*, 151 Cal. Rptr. 3d 292, 299, 310 (Ct. App. 2013) ("a correctional lieutenant assigned to one post may be required to report to another area because there is a greater need in the other area," including because of modified programming or lockdowns, and may need to escort patients to "medical offices" or be "involved in the transportation" of patients to "outside medical care") (internal quotation marks omitted); CDCR Department Operations Manual § 51040.5.1 (rev. Jan. 1, 2021) ("'All peace officers have the responsibility to take appropriate action during an emergency and to work assignments as necessitated.'") (parenthetical omitted).

people who may work in healthcare settings but will **not** be required to be vaccinated, including "relief staff, voluntary overtime, mandatory overtime, swaps, . . . staff making pick-ups or deliveries, conducting maintenance repairs, conducting tours, etc.," as well as "staff responding to emergencies."[6] ECF No. 3657-1 at 6. These exceptions create a substantial risk of serious harm to incarcerated people and are unacceptable. Custody staff perform direct-contact care for patients in healthcare settings. For example, custodial personnel in Correctional Treatment Centers are responsible for serving meals, "[a]mbulating (exercising) independent, ambulatory inmate-patients," "[h]olding or immobilizing a patient during a treatment or diagnostic procedure," and providing "[c]ardiopulmonary resuscitation and first aid." Cal. Code Regs. tit. 22, § 79813.

Staff shortages during the pandemic already have resulted in significant disruption to "regular" staff assignments. For example, at the end of last year, a 28% staff vacancy rate at the Correctional Training Facility necessitated major assignment modifications:

> CTF had been using its staff contingency plan as of [December 29, 2020,] and continues to do so. CTF had also instituted a rolling blackout to try and cover a temporary spike in vacant posts. This temporary spike is a result of twenty-one (21) patients being sent to hospitals in the area, requiring 126 posts, twenty-nine (29) of CTF's own staff being quarantined/ isolated (Monterey County has been very high rate of infection, 25 percent infection rate being reported) and the numerous alternate housing areas requiring housing staff and fire watch. **CTF is also using sergeants and lieutenants to cover officer posts, however, the high volume of vacancies within those ranks meant there were no volunteers. CCs are now being offered the overtime to cover office[r]s posts** and that is helping but during the time period being discussed, that had not been authorized and was pending. **All means to fully staff the prison were used and continue to be used**.

See Hart Decl., Ex. 13 at 7 (emphasis added).

In July 2021, Richard J. Donovan Correctional Facility "experienced abnormally high staff vacancies," which "resulted in extreme program closures" that affected "all

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[6] Defendants' exclusion of people who conduct maintenance repairs appears at odds with the August 19, 2021 order, which expressly includes "facilities maintenance staff." *See* Hart Decl., Ex. 22 at 2.

areas," including "the Enhanced Out Patient programming areas." *Id.*, Ex. 14 at 3. And just this month, there were 73.2 vacant custody officer positions at California State Prison, Sacramento, including nineteen officers out due to a positive COVID test, one officer out due to COVID-19 exposure, and two officers on long-term medical due to COVID-19. *Id.*, Ex. 28 at 1. There also were 46 healthcare staff vacancies. *Id.* at 2. To "cover vacant posts," the prison "is utilizing services of Registry/Contractors through Management solutions" and the "VOR [Voluntary Overtime Roster] process to cover vacancies **on a daily basis**." *Id.* (emphasis added). And at least 50 officers from other prisons were reassigned to the prison. *See id.*, Ex. 10 at 7.

C. Workers Who Are Unvaccinated Due to Religious Beliefs Should Not Be Allowed Entry Into the Prisons.

Finally, the August 19, 2021 order has a carve-out for any worker who signs a form stating that they are "declining vaccination based on religious beliefs." Hart Decl., Ex. 22 at 2. Those workers may continue to work in healthcare settings but must be tested regularly. *Id.* Such a sweeping exemption has no basis in state or federal law, which require only that employees with sincerely held religious beliefs be provided reasonable accommodations if they do not impose an undue hardship. *See* Cal. Gov't Code § 12940(l); 42 U.S.C. § 2000e(j); *Cook v. Lindsay Olive Growers*, 911 F.2d 233, 241 (9th Cir. 1990). The "undue hardship" standard is not a high bar; it is met "whenever that accommodation results in 'more than a *de minimis* cost' to the employer." *Soldinger v. Nw. Airlines, Inc.*, 58 Cal. Rptr. 2d 747, 762 (Ct. App. 1996) (quoting *Ansonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 67 (1986)). Defendants' implementing directive properly limits eligibility to those with sincerely held religious beliefs, but does not explain how requests will be evaluated. *See* ECF No. 3657-1 at 6.

Even assuming that a worker has such a belief, any blanket "accommodation" that involves continued entry into the prisons almost certainly would be unreasonable in light

of the serious threat posed to the worker, their colleagues, and the Plaintiff class.[7] *See Robinson v. Children's Hospital Boston*, No. 14-10263 DJC, 2016 WL 1337255, at *9 (D. Mass. Apr. 5, 2016) (holding that exemption of nurse from mandatory flu vaccine policy "would have been an undue hardship because it would have increased the risk of transmitting influenza to its already vulnerable patient population"); *Bhatia v. Chevron U.S.A., Inc.*, 734 F.2d 1382, 1383, 1384 (9th Cir. 1984) (undue hardship where machinist would not shave his facial hair and thus could not achieve a gas-tight face seal when wearing a respirator); *Kalsi v. N.Y. City Transit Auth.*, 62 F. Supp. 2d 745, 760 (E.D.N.Y. 1998), *aff'd*, 189 F.3d 461 (2d Cir. 1999) (undue hardship where inspector refused to wear a hard hat). For example, nurses in Correctional Treatment Centers are responsible for, among other things, "[c]hanging position of bedfast and chairfast patients," "[m]aintaining proper body alignment and joint movement to prevent contractures and deformities," and "[p]roviding care to maintain clean, dry skin free from feces and urine." Cal. Code Regs. tit. 22, § 79637. The CDPH's accommodation requires at most twice-a-week testing of nurses performing those duties, which the Receiver explained "does not effectively prevent asymptomatic staff from introducing COVID-19 to CDCR institutions" and does not adequately protect vulnerable patients from infected staff. *See* Receiver's Report at 9.

CONCLUSION

The Court should order that the Receiver's recommendation be implemented without further delay.

DATED: August 30, 2021

PRISON LAW OFFICE

By: /s/ Rita Lomio
Rita Lomio

Attorneys for Plaintiffs

[7] It is well settled that "certain anti-vaccination beliefs are not religious." *Fallon v. Mercy Cath. Med. Ctr. of Se. Pennsylvania*, 877 F.3d 487, 492 (3d Cir. 2017) (employee was not entitled to exemption from flu vaccination); *see also Friedman v. S. Cal. Permanente Med. Grp.*, 125 Cal. Rptr. 2d 663 (Ct. App. 2002) (employee was not entitled to exemption from mumps vaccination due to veganism).

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF SOPHIE HART IN SUPPORT OF PLAINTIFFS' RESPONSE TO ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION (ECF No. 3647)

I, Sophie Hart, declare:

1. I am an attorney licensed to practice before the courts of the State of California and admitted in the Northern District of California. I am a staff attorney at the Prison Law Office, counsel of record for Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify.

2. On August 27, 2021, I downloaded the California Correctional Healthcare Services (CCHCS) Healthcare Services Dashboard – Statewide Comparison for July 2021. I used CCHCS's interactive Dashboard, which I have access to as counsel for Plaintiffs in this action, and set the parameters to Institutions: All Institutions; Dashboard Release: July 2021; Report Range: Current Month. True and correct copies of excerpts of this Dashboard report are attached hereto as **Exhibit 1**.

3. The July 2021 Dashboard (Ex. 1) shows that **28% (27,281)** of all patients in CDCR were 50 years of age or older. The Dashboard also reports this measure for each prison. While only the percentages are seen in the PDF version of the Dashboard, when using the Dashboard in real time, the total number of patients appears when I hover my cursor over the reported percentage. Using that function, I determined there were in July 2021 the following number of patients aged 50 or older at each prison:

Prison	Patients aged 50 +
Avenal State Prison (ASP)	1,012
California City Correctional Facility (CAC)	228
Calipatria State Prison (CAL)	237
California Correctional Center (CCC)	222
California Correctional Institution (CCI)	646

Central California Women's Facility (CCWF)	469
California State Prison, Centinela (CEN)	330
California Health Care Facility, Stockton (CHCF)	1,583
California Institution for Men (CIM)	1,313
California Institution for Women (CIW)	310
California Men's Colony (CMC)	1,333
California Medical Facility (CMF)	1,043
California State Prison, Corcoran (COR)	819
California Rehabilitation Center (CRC)	515
Correctional Training Facility (CTF)	2,206
Chuckawalla Valley State Prison (CVSP)	763
Deuel Vocational Institution (DVI)[1]	4
Folsom State Prison (FSP)	802
High Desert State Prison (HDSP)	356
Ironwood State Prison (ISP)	388

[1] DVI was in the process of being closed. *See* ECF No. 3460 at 22. The July 2021 Dashboard reported only 22 patients incarcerated at that prison.

Kern Valley State Prison (KVSP)	484
California State Prison, Los Angeles County (LAC)	832
Mule Creek State Prison (MCSP)	1,772
North Kern State Prison (NKSP)	435
Pelican Bay State Prison (PBSP)	360
Pleasant Valley State Prison (PVSP)	212
Richard J. Donovan Correctional Facility (RJD)	1,427
California State Prison, Sacramento (SAC)	322
Substance Abuse Treatment Facility and State Prison, Corcoran (SATF)	1,454
Sierra Conservation Center (SCC)	489
California State Prison, Solano (SOL)	1,168
San Quentin State Prison (SQ)	1,512
Salinas Valley State Prison (SVSP)	562
Valley State Prison (VSP)	1,330
Wasco State Prison (WSP)	343

4. As counsel for Plaintiffs in this action, I also have access to CCHCS's COVID-19 Patient Vaccination Registry, which, among other things, reports a "COVID-19 Weighted Risk Score" for each patient in CDCR custody. Attached hereto as **Exhibit 2** is a true and correct copy of the COVID-19 Patient Vaccination Registry Report Definitions, which I downloaded from the Patient Vaccination Registry on August 18, 2021. As that document explains, "[t]he COVID Weighted Risk Score Factors and their weights in parentheses include: Age 65+ (4), Advanced Liver Disease (2), Persistent Asthma (1), High Risk Cancer (2), Chronic Kidney Disease (CKD) (1), Stage 5 CKD or receiving dialysis (1), Chronic Lung Disease (including Cystic Fibrosis, Pneumoconiosis, or Pulmonary Fibrosis) (1), COPD (2), Diabetes (1), High Risk Diabetes (1), Heart Disease (1), High Risk Heart Disease (1), Hemoglobin Disorder (1), HIV/AIDS (1), Poorly Controlled HIV/AIDS (1), Hypertension (1), Immunocompromised (2), Neurologic Conditions (1), Obesity (1), Other High Risk Chronic Conditions (1), and Pregnancy (1)."

5. According to the CCHCS COVID-19 Patient Vaccination Registry, as of August 26, 2021, there were **17,860** patients in CDCR custody with a COVID-19 weighted risk score of 3 or higher. I determined this by running a report on August 26, 2021 in the Registry with the following parameters: Institutions: All; Facility: All; Building: All; Care Team: All; Vaccine Status: All; Patient Filters: COVID Risk Score 3+; COVID Filters: All; Job Category: All; Health Care Beds: All.

6. To determine the number of patients with a COVID-19 weighted risk score of 3 or higher who are incarcerated in a housing facility covered by the August 19 California Department of Public Health (CDPH) Order (¶ 27 & Ex. 22) and August 23 CDCR/CCHCS implementing directive (ECF No. 3657-1 at 5-8), I first ran the same report described in Paragraph 5 for each prison, to determine the total number of patients with a COVID-19 weighted risk score of 3 or higher at each prison. Then, for every

prison except California Health Care Facility, Stockton (CHCF) and California Medical Facility (CMF), I ran that same report, but set the filter "Health Care Beds" to include only those patients housed in a Correctional Treatment Center (CTC), Outpatient Housing Unit (OHU), Mental Health Crisis Bed (MHCB), or Psychiatric Inpatient Program (PIP). I did this because the August 23 CDCR/CCHCS Memorandum (ECF No. 3657-1 at 5-8) requires staff to be vaccinated if they work at CHCF, at CMF, or in the Skilled Nursing Facility (SNF) at Central California Women's Facility (CCWF), or are "regularly assigned to work in" CTCs, PIP housing, MHCB housing, OHUs, hospice units, and dialysis units.[2] I did not separately investigate how many patients were housed in hospice or dialysis units, because I understand the only hospice unit in CDCR is at CMF, (*see* Ex. 15, attach. A), and the only dialysis unit is at CHCF, so both are already covered by the requirement that staff at those prisons be vaccinated. Finally, I believe the Vaccine Registry's filter for CTC housing includes those in CCWF's SNF (*see* Ex. 15, attach. A), so I used the same function described above to determine the total number of patients housed in units covered by the current vaccine requirement at CCWF. The following table displays my results:

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[2] I did not include patients housed in CDCR's Enhanced Outpatient Program (EOP) beds, because the August 23 CDCR/CCHCS implementing directive (ECF No. 3657-1 at 5-8) does not state that the August 19 CDPH Order (¶ 27 & Ex. 22) will be applied to these units. During a meeting on August 27, 2021, we asked counsel for the Receiver whether EOP units will be included, but they did not have an immediate answer.

Prison	Total Patients with a COVID-19 Risk Score of 3 or Higher	Patients in Units **Covered** by CDPH Order and CDCR/CCHCS Memo	Patients in Units **Not Covered** by CDPH Order and CDCR/CCHCS Memo
Avenal State Prison (ASP)	165	3	162
California City Correctional Facility (CAC)	108	0	108
Calipatria State Prison (CAL)	94	9	85
California Correctional Center (CCC)	83	1	82
California Correctional Institution (CCI)	278	3	275
Central California Women's Facility (CCWF)	447	22	425
California State Prison, Centinela (CEN)	152	6	146
California Health Care Facility (CHCF), Stockton	1,419	1,419	0
California Institution for Men (CIM)	1,134	43	1,091
California Institution for Women (CIW)	275	11	264
California Men's Colony (CMC)	926	29	897
California Medical Facility (CMF)	900	900	0
California State Prison, Corcoran (COR)	515	38	477

California Rehabilitation Center (CRC)	253	4	249
Correctional Training Facility (CTF)	950	8	942
Chuckawalla Valley State Prison (CVSP)	300	2	298
Folsom State Prison (FSP)	421	0	421
High Desert State Prison (HDSP)	239	10	229
Ironwood State Prison (ISP)	163	0	163
Kern Valley State Prison (KVSP)	299	4	295
California State Prison, Los Angeles County (LAC)	741	4	737
Mule Creek State Prison (MCSP)	1,646	2	1644
North Kern State Prison (NKSP)	213	3	210
Pelican Bay State Prison (PBSP)	212	0	212
Pleasant Valley State Prison (PVSP)	53	0	53
Richard J. Donovan Correctional Facility (RJD)	1,261	15	1246
California State Prison, Sacramento (SAC)	344	3	341
Substance Abuse Treatment Facility and State Prison, Corcoran (SATF)	800	14	786

Sierra Conservation Center (SCC)	167	0	167
California State Prison, Solano (SOL)	911	6	905
San Quentin State Prison (SQ)	1,047	15	1,032
Salinas Valley State Prison (SVSP)	455	57	398
Valley State Prison (VSP)	698	14	684
Wasco State Prison (WSP)	191	2	189
TOTAL	17,860	2,647	15,213

7. Attached hereto as **Exhibit 3** is a true and correct copy of the CDCR Institutional Bed Audit, dated August 25, 2021, and emailed to me by counsel for Defendants on August 26, 2021.

8. On August 26, 2021, my colleague, Rita Lomio, emailed me a list of all patients in CDCR with a "DKD" designation as of August 9, 2021, meaning they are on dialysis. *See* Declaration of Rita Lomio ¶¶ 6, 10; Health Care Department Operations Manual ("HCDOM") § 2.1.2(e)(3)(C)(9) (rev. March 2018). Attached hereto as **Exhibit 4** is a true and correct copy of this document, which I redacted to protect patient confidentiality. According to this document, there are **136** patients currently on dialysis in CDCR. Of those, **32** are housed in units that are not covered by the August 19 CDPH Order (¶ 27) and August 23 CDCR/CCHCS implementing directive (ECF No. 3657-1 at 5-8). I determined this by excluding all patients housed at CHCF and CMF, and then looking up the housing location for each remaining patient in the Bed Audit (¶ 7 & Ex. 3), to determine if the patient was housed in a CTC, OHU, PIP, MHCB, or SNF.

Although the August 23 CDCR/CCHCS implementing directive references "dialysis units," we understand that, other than at CHCF, dialysis occurs off-site.

9. As counsel for Plaintiffs in this action, I also have access to electronic health records for all patients in CDCR. I recently reviewed the medical records of a fully vaccinated CDCR patient who died on August 18, 2021, after testing positive for COVID-19 on August 7, 2021. I saw in his electronic health record that he was 81 years old and a fulltime wheelchair user. He received his second dose of the COVID-19 vaccine on April 27, 2021. On August 6, 2021, he was sent to the emergency room. He tested positive for COVID-19 within hours of arriving in the emergency room, and was admitted to the hospital, where he remained until his death. The provisional cause of death noted in his medical records is "[p]neumonia, respiratory failure, Covid infection."

10. From January 2020 to July 2021, the number of pending, overdue medical appointments in CDCR has grown **from 2,749 to 4,814** for Primary Care Provider (PCP) appointments; **693 to 3,073** for Registered Nurse (RN) appointments; **3,674 to 7,950** for specialty care appointments; and **759 to 6,874** for laboratory orders. I retrieved these numbers from the CCHCS Healthcare Services Dashboards for July 2021 (¶ 2 & Ex. 1) and January 2020. Attached hereto as **Exhibit 5** are true and correct copies of excerpted portions of the CCHCS Healthcare Services Dashboard – Statewide Comparison for January 2020. I generated this Dashboard report on August 27, 2021, by setting the parameters in the Dashboard application to Institutions: All Institutions; Dashboard Release: January 2020; Report Range: Current Month.

11. Attached hereto as **Exhibit 6** are excerpts from the CCHCS Healthcare Services Dashboard Glossary, which I received via email from CCHCS on August 19, 2021, defining "Laboratory Backlog," "PCP Backlog," "RN Backlog," "Specialty Backlog," and "Inmates 50 Years of Age or Older." As that document explains, the Dashboard reports backlogs as a rate per 1000 patients. When reviewing the Dashboard

in real time, the total number of overdue appointments for each measure appears when I hover my cursor over the reported rate.

12. Each month, as a part of a regular document production in this case, CCHCS provides Plaintiffs' counsel with a report titled "PCP Staffing and Backlog Report" via a Secure File Transfer Protocol (SFTP) server. My colleague Steven Fama downloaded a copy of this report from the server, covering June 1, 2021 to June 15, 2021, and emailed it to me on August 4, 2021. A true and correct copy of the report is attached hereto as **Exhibit 7**. The report states that as of June 15, there were **5,287** overdue PCP appointments in CDCR. Of those, 2,075 were more than 30 days overdue, and 544 were more than 90 days overdue.

13. On July 26, 2021, CCHCS emailed Plaintiffs' counsel a memorandum, with the subject line "PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO SPECIALTY SERVICES," dated July 26, 2021. A true and correct copy of that memorandum is attached hereto as **Exhibit 8**. The memorandum reports that, as of July 15, 2021, **876** patients in CDCR were overdue for cancer screening ultrasounds for end stage liver disease.

14. At least weekly, staff at each prison completes and uploads an "Outbreak Management Tool" (OMT) to a server accessible by Plaintiffs' counsel. Among other things, the OMTs report how many patients are currently on quarantine at each prison. Recent OMTs continue to report hundreds of patients on quarantine due to exposure to COVID-19. For example, the August 3, August 10, and August 17, 2021 OMTs for CHCF report 350-700 patients on quarantine each week due to exposure to COVID-19 positive staff members. True and correct copies of the August 3, August 10, and August 17, 2021 OMTs for CHCF are attached hereto as **Exhibit 9**.

15. A true and correct copy of the August 10, 2021 OMT for California State Prison, Sacramento (SAC) is attached hereto as **Exhibit 10**.

16. As counsel for Plaintiffs, I receive regular updates from CCHCS regarding the number of patients on quarantine statewide in CDCR. Most recently, on August 19, 2021, Tammy Foss, Director of Corrections Services at CCHCS, emailed Plaintiffs' counsel a table of patients placed on quarantine due to COVID-19. A true and correct copy of this table is attached hereto as **Exhibit 11**. As of that date, **2,412** patients were on quarantine to due exposure to COVID-19, and six prisons had more than 100 patients on quarantine due to exposure: 811 patients were on quarantine due to exposure at CHCF, 270 at High Desert State Prison (HDSP), 263 at Sierra Conservation Center (SCC), 242 at Central California Women's Facility (CCWF), 186 at California Correctional Center (CCC), and 104 at California State Prison, Corcoran (COR).

17. As counsel for Plaintiffs, I also receive weekly emails from CCHCS, reporting, among other things, the total number of staff working in CDCR prisons and the rates of vaccination for staff. I last received this update on August 27, 2021. A true and correct copy of this email is attached hereto as **Exhibit 12**. As of that date, CCHCS reported there were 55,584 staff members working in CDCR prisons. Of those, 29,942 (54%) had been administered at least one dose of vaccine.

18. On December 30, 2020, I emailed a document titled "Plata Plaintiffs' Urgent Concerns Regarding Current COVID-19 Outbreaks" to CDCR/CCHCS, which included questions and concerns about COVID-19 protocols at several prisons, including the Correctional Training Facility (CTF). On January 12, 2021, CDCR/CCHCS emailed me a document responding to these questions. A true and correct copy of this document is attached hereto as **Exhibit 13**.

19. On July 15, 2021, my colleague, Rana Anabtawi, emailed a document titled "Prison Law Office Prison-specific COVID-19 questions for week of July 12, 2021" to CDCR/CCHCS, which included questions and concerns about COVID-19 protocols at several prisons, including the Richard J. Donovan Correctional Facility

(RJD). I was copied on that email. On July 21, 2021, counsel for CDCR emailed Ms. Anabtawi a document responding to these questions. I was also copied on this email. A true and correct copy of this document is attached hereto as **Exhibit 14**, which I redacted to protect patient confidentiality.

20. On July 23, 2021, CCHCS emailed Plaintiffs' counsel a memorandum, with the subject line "PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO OUTPATIENT HOUSING UNIT BED AVAILABILITY," dated July 23, 2021. Attached hereto as **Exhibit 15** is a true and correct copy of this memorandum and accompanying attachment.

21. On July 12, 2021, Mr. Fama emailed CCHCS a request for data regarding vaccination efforts in CDCR. I was copied on that email. Attached hereto as **Exhibit 16** is a true and correct copy of an excerpted page from the document CCHCS emailed to Plaintiffs' counsel on July 19, 2021, in response to Mr. Fama's request.

22. Attached hereto as **Exhibit 17** is a true and correct copy of a CDCR/CCHCS memorandum titled "RECOMMENDED COVID-19 PERSONAL PROTECTIVE EQUIPMENT AND PHYSICAL DISTANCING REQUIREMENTS FOR STAFF AND INMATE-PATIENTS UPDATE," and dated May 10, 2021. I received this memorandum from Defendants' counsel via email on May 21, 2021.

23. Attached hereto as **Exhibit 18** is screenshot of CCHCS/CDCR's COVID-19 Tracker, downloaded on August 27, 2021, from https://www.cdcr.ca.gov/covid19/population-status-tracking. According to that tracker, as of August 27, 2021, 49,834 incarcerated patients in CDCR had been infected with COVID-19 and 238 had died.

24. Attached hereto as **Exhibit 19** is a true and correct copy of CCHCS/CDCR's COVID-19 Employee Status website, downloaded on August 27, 2021, from https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status. According to

this report, as of August 27, 2021, 19,359 staff have been infected and at least 29 have died from COVID-19.

25. Attached hereto as **Exhibit 20** is a true and correct copy of a memorandum from the CDPH regarding the Health Care Worker Vaccine Requirement, dated August 5, 2021, and available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx.

26. Attached hereto as **Exhibit 21** is a true and correct copy of the CDPH's "Q&A" regarding the August 5 Order, titled "Public Health Order Questions & Answers: Health Care Worker Vaccine Requirement," dated August 20, 2021, and available at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/FAQ-Health-Care-Worker-Vaccine-Requirement.aspx.

27. Attached hereto as **Exhibit 22** is a true and correct copy of a memorandum from the CDPH regarding the State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement, dated August 19, 2021, and available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx.

28. Attached hereto as **Exhibit 23** is a true and correct copy of a memorandum authored by AMEND at University of California San Francisco and The University of California, Berkeley School of Public Health, titled "Urgent Memo: COVID-19 Outbreak: San Quentin Prison," dated June 15, 2020, and available at https://amend.us/wp-content/uploads/2020/06/COVID19-Outbreak-SQ-Prison-6.15.2020.pdf.

29. Attached hereto as **Exhibit 24** is a true and correct copy of Chapter 5 ("Mental Health Crisis Bed") of the California Department of Corrections and

Rehabilitation Mental Health Services Delivery System Program Guide, filed by the Special Master in the case *Coleman v. Newsom*, No. 2:90-cv-00520-KJM-DB (E.D. Cal.), on July 30, 2018, at ECF No. 5864-1.

30. Attached hereto as **Exhibit 25** is a true and correct copy of a Los Angeles Times website titled "Tracking coronavirus vaccinations in California," updated August 28, 2021, and available at: https://www.latimes.com/projects/california-coronavirus-cases-tracking-outbreak/covid-19-vaccines-distribution.

31. Attached hereto as **Exhibit 26** are true and correct copies of redacted photographs of CDCR dormitory housing units. Counsel for Defendants emailed the photos of the dormitory housing units at California Institution for Women (CIW), California Medical Facility (CMF), and Salinas Valley State Prison (SVSP) to Plaintiffs' counsel on May 7, 2020, to demonstrate compliance with the Receiver's April 10, 2020 directive to create 8-person cohorts in the dormitories. *See* ECF No. 3276-6 at 2; ECF No. 3322 at 12. Counsel for Defendants emailed the photos of the dormitory housing units at Correctional Training Facility (CTF), Chuckawalla Valley State Prison (CVSP), and North Kern State Prison (NKSP) to Plaintiffs' counsel on May 14, 2020, for the same purpose. *See* ECF No. 3328 at 18-19. Counsel for Defendants emailed the photo of the California Institution for Men (CIM) dormitory to Plaintiffs' counsel on May 26, 2020. That photo was taken at the request of Plaintiffs' counsel during a virtual tour of that prison, which I attended via a remote videoconferencing service.

32. Attached hereto as **Exhibit 27** are screenshots of CCHCS/CDCR's COVID-19 Tracker, of the "Institution View" for High Desert State Prison (HDSP) and California Correctional Center (CCC), which I downloaded on August 28, 2021, from https://www.cdcr.ca.gov/covid19/population-status-tracking.

33. On August 12, 2021, my colleague, Ms. Anabtawi, emailed a document titled "Prison Law Office Prison-specific COVID-19 questions for week of August 9,

2021" to CDCR/CCHCS, which included questions and concerns about COVID-19 protocols at several prisons, including the California State Prison, Sacramento (SAC). I was copied on that email. On August 18, 2021, CCHCS emailed Ms. Anabtawi a document responding to these questions. I was also copied on this email. A true and correct copy of this document is attached hereto as **Exhibit 28**.

34. Multiple public entities have mandated the COVID-19 vaccine as a condition of employment for government employees, including those working in correctional agencies:

a. **Colorado Department of Corrections**: Attached hereto as **Exhibit 29** is a true and correct copy of a Press Release from the Colorado Department of Corrections (CDOC), the Colorado Department of Human Services (CDHS), and the Colorado Department of Public Health and Environment (CDPHE), which I downloaded on August 19, 2021, and is available at https://cdoc.colorado.gov/news-article/state-agencies-with-24/7-facilities-to-require-covid-19-vaccinations-for-staff-members.

b. **Illinois Department of Corrections**: Attached hereto as **Exhibit 30** is a true and correct copy of an article titled "Read Gov. Pritzker's Full Remarks on New COVID Mitigations for Illinois," dated August 4, 2021, and available at https://www.nbcchicago.com/news/coronavirus/read-gov-pritzkers-full-remarks-on-new-covid-mitigations-for-illinois/2580482.

c. **Massachusetts Department of Corrections:** Attached hereto as **Exhibit 31** is a true and correct copy of an Executive Order from Governor Charles D. Baker, dated August 19, 2021, and available at

https://www.mass.gov/doc/august-19-2021-executive-department-employee-vaccination-order/download.

d. **Oregon Department of Corrections**: Attached hereto as **Exhibit 32** is a true and correct copy of a News Release from Governor Kate Brown's office, dated August 10, 2021, and available at https://www.oregon.gov/newsroom/pages/NewsDetail.aspx?newsid=64241.

e. **Washington Department of Corrections**: Attached hereto as **Exhibit 33** is a true and correct copy of a Proclamation by Governor Jay Inslee, dated August 9, 2021, and available at https://www.governor.wa.gov/sites/default/files/proclamations/21-14%20-%20COVID-19%20Vax%20Washington%20%28tmp%29.pdf.

f. **Contra Costa County, CA Jails:** Attached hereto as **Exhibit 34** is a true and correct copy of a letter from Monica Nino, County Administrator, dated August 27, 2021, and available at: https://ca-contracostacounty2.civicplus.com/DocumentCenter/View/72143/20210827--Memo-to-Employees.

g. **Los Angeles County, CA Jails:** Attached hereto as **Exhibit 35** are true and correct copies of an Executive Order from Hilda Solis, Chair, Los Angeles County Board of Supervisors, dated August 4, 2021, and available at: https://hildalsolis.org/wp-content/uploads/2021/08/Executive-Order-COVID-19-Vaccines-for-LACo-Employees.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term and a Press Release from Chair

Solis, available at: https://hildalsolis.org/chair-hilda-l-solis-statement-issuing-executive-order-require-all-la-county-employees-to-be-vaccinated-against-covid-19.

h. **San Francisco County, CA Jails**: Attached hereto as **Exhibit 36** is a true and correct copy of an Order from the San Francisco Department of Public Health, titled "ENCOURAGING COVID-19 VACCINE COVERAGE AND REDUCING DISEASE RISKS (Safer Return Together)," updated on August 24, 2021, and available at https://www.sfdph.org/dph/alerts/files/C19-07-Safer-Return-Together-Health-Order.pdf.

i. **Santa Clara County, CA Jails**: Attached hereto as **Exhibit 37** is a true and correct copy of a memorandum from Jeffrey V. Smith, County Executive and James R. Williams, County Counsel, regarding the "COVID-19 Vaccination Requirement for County Personnel," and dated August 5, 2021. The Prison Law Office is counsel for Plaintiffs in *Chavez v. County of Santa Clara*, Case No. 15-cv-05277-RMI (N.D. Cal.), and received a copy of this memorandum from county counsel in that case via email on August 5, 2021.

j. **Bucks County, PA Jails**: Attached hereto as **Exhibit 38** is a true and correct copy of an article, titled "Bucks County orders jail staff to get COVID vaccine or be terminated," dated August 24, 2021, and available at: https://www.buckscountycouriertimes.com/story/news/2021/08/25/bucks-county-covid-19-vaccine-deadline-corrections-employee-mandate-montgomery-prison-health/8249988002.

k. **King County, WA Jails**: Attached hereto as **Exhibit 39** is a true and correct copy of a King County News Release, titled "King County, State of Washington and City of Seattle announce vaccination requirement for most employees, private health care and long-term care workers," dated August 9, 2021, and available at https://kingcounty.gov/elected/executive/constantine/news/release/2021/August/09-employee-vaccine.aspx.

35. Multiple healthcare entities, both public and private, have likewise mandated their employees be vaccinated for COVID-19, including:

a. **Atrium and Novant**: Attached hereto as **Exhibit 40** is a true and correct copy of an article titled "Novant, Atrium, health departments requiring all employees to get COVID-19 vaccine," dated August 30, 2021, and available at https://www.wsoctv.com/news/local/novant-atrium-require-all-employees-get-covid-19-vaccine-by-fall/7JQG3SPDDREMJIQXDPGJ64QBQI.

b. **Banner Health**: Attached hereto as **Exhibit 41** is a true and correct copy of a Press Release from Banner Health, titled "Banner Health expands its COVID-19 employee vaccination program," dated July 20, 2021, and available at https://www.bannerhealth.com/newsroom/press-releases/banner-health-expands-its-covid19-employee-vaccination-program.

c. **Houston Methodist Hospital**: Attached hereto as **Exhibit 42** is a true and correct copy of a Houston Methodist policy, dated August 9, 2021, and available at

https://hrportal.ehr.com/LinkClick.aspx?fileticket=WbwcMj8SRPg%3d&portalid=78.

d. **Kaiser Permanente**: Attached hereto as **Exhibit 43** is a true and correct copy of a Press Release from Kaiser Permanente, titled "Protecting health and safety through vaccination," dated August 2, 2021, and available at https://about.kaiserpermanente.org/our-story/news/announcements/protecting-health-and-safety-through-vaccination.

e. **New York State**: Attached hereto as **Exhibit 44** is a true and correct copy of a webpage titled "Governor Cuomo Announces COVID-19 Vaccination Mandate for Healthcare Workers," dated August 16, 2021, and available at https://www.governor.ny.gov/news/governor-cuomo-announces-covid-19-vaccination-mandate-healthcare-workers.

f. **Trinity Health**: Attached hereto as **Exhibit 45** is a true and correct copy of a Press Release from Trinity Health, titled "Trinity Health Announces COVID-19 Vaccine Requirement for All Colleagues," dated July 8, 2021, and available at https://www.trinity-health.org/news/trinity-health-announces-covid-19-vaccine-requirement-for-all-colleagues.

g. **Veterans Health Administration**: Attached hereto as **Exhibit 46** is a true and correct copy of a News Release from the U.S. Department of Veterans Affairs, dated July 16, 2021, and available at https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=5696.

h. **Hundreds of other hospitals and health systems, both public and private**: Attached hereto as **Exhibit 47** is a true and correct copy of an article titled "Hospitals, health systems mandating vaccines for workers," updated August 27, 2021, and available at https://www.beckershospitalreview.com/workforce/hospitals-health-systems-mandating-vaccines-for-workersjune17.html.

36. Multiple public entities have also mandated COVID-19 vaccines for school faculty and staff, including for those working in:

a. **California State University**: Attached hereto as **Exhibit 48** is a true and correct copy of a California State University policy titled "COVID-19 Vaccination Interim Policy," dated July 30, 2021, and available at https://calstate.policystat.com/policy/9779821/latest.

b. **Indiana University**: Attached hereto as **Exhibit 49** is a true and correct copy of an Indiana University webpage titled "COVID-19 Vaccine," which I downloaded on August 30, 2021, and is available at https://www.iu.edu/covid/prevention/covid-19-vaccine.html.

c. **Los Angeles Unified School District**: Attached hereto as **Exhibit 50** is a true and correct copy of the Los Angeles Unified School District's website, titled "Safe Steps to Safe Schools: Frequently Asked Questions," which I downloaded on August 30, 2021, and is available at https://achieve.lausd.net/covidfaq.

d. **New York City public schools**: Attached hereto as **Exhibit 51** is a true and correct copy of an article titled "NYC mandates vaccinations for public school teachers, staff," dated August 23, 2021, and available at https://apnews.com/article/health-education-coronavirus-pandemic-676f2a2c63b4136360f8ea3682f48287.

e. **Ohio State University**: Attached hereto as **Exhibit 52** is a true and correct copy of an Ohio State University webpage titled "Ohio State announces vaccination requirement," which I downloaded on August 30, 2021, and is available at https://news.osu.edu/ohio-state-announces-vaccination-requirement.

f. **School District of Philadelphia**: Attached hereto as **Exhibit 53** is a true and correct copy of a School District of Philadelphia Press Release titled "The Board of Education Approves a Vaccine Mandate for all School District Employees," dated August 26, 2021, and available at https://www.philasd.org/schoolboard/2021/08/26/the-board-of-education-approves-a-vaccine-mandate-for-all-school-district-employees.

g. **University of California**: Attached hereto as **Exhibit 54** is a true and correct copy of a University of California policy titled "SARS-CoV-2 (COVID-19) Vaccination Program," updated July 15, 2021, and available at https://policy.ucop.edu/doc/5000695/SARS-CoV-2_Covid-19.

h. **Washington State**: Attached hereto as **Exhibit 55** is a true and correct copy of a Washington Office of Superintendent of Public Instruction document titled "COVID-19 Vaccination Requirement for K–12 School Employees: Frequently Asked Question," updated August 23, 2021, and available at https://www.k12.wa.us/sites/default/files/public/communications/2021docs/FAQ-COVID-19-Vaccine-Requirement-for-K-12-School-Employees.pdf.

i. **Hundreds of other colleges and universities, both public and private**: Attached hereto as **Exhibit 56** is a true and correct copy of an article titled "State-by-state look at colleges requiring COVID-19 vaccines," updated August 28, 2021, and available at https://universitybusiness.com/state-by-state-look-at-colleges-requiring-vaccines/.

37. Attached hereto as **Exhibit 57** is a Centers for Medicare & Medicaid Services (CMS) Press Release, announcing the development of an emergency regulation requiring staff vaccinations within all Medicare and Medicaid-participating nursing homes, titled "Biden-Harris Administration Takes Additional Action to Protect America's Nursing Home Residents from COVID-19," dated August 18, 2021, and available at https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-additional-action-protect-americas-nursing-home-residents-covid-19. Many companies operating senior living/nursing homes have already mandated the COVID-19 vaccine as a condition of employment, including:

a. **Brookdale Senior Living**: Attached hereto as **Exhibit 58** is a true and correct copy of an article titled "Brookdale Senior Living to require Covid vaccine for staff, CEO says," dated August 6, 2021, and available at https://www.cnbc.com/2021/08/06/covid-nursing-home-chain-brookdale-senior-living-mandates-vaccine-for-staff.html.

b. **Genesis Healthcare**: Attached hereto as **Exhibit 59** is a true and correct copy of a Genesis Healthcare webpage, titled "Coronavirus Updates," which I downloaded on August 30, 2021, and is available at: https://www.genesishcc.com/coronavirus-updates.

c. **Good Samaritan**: Attached hereto as **Exhibit 60** is a true and correct copy of an article titled "As breakthrough covid infections rise, nursing home chains require that staffers be vaccinated," dated August 5, 2021, and available at https://www.washingtonpost.com/business/2021/08/05/vaccine-mandate-nursing-home-staff.

d. **Sunrise Senior Living**: Attached hereto as **Exhibit 61** is a true and correct copy of a Sunrise Senior Living blogpost, titled "Welcoming Brighter Days at Sunrise," dated March 23, 2021, and available at https://www.sunriseseniorliving.com/blog/march-2021/welcoming-brighter-days-at-sunrise.aspx.

38. Other large private companies have also announced COVID-19 vaccine mandates for staff (either for all staff, or all in-office staff) including:

a. **Fifty/50 Restaurant Group**: Attached hereto as **Exhibit 62** is a true and correct copy of a Fifty/50 Restaurant Group webpage, which I downloaded on August 20, 2021, and is available at https://www.thefifty50group.com/covidvaccines/.

b. **Cisco**: Attached hereto as **Exhibit 63** is a true and correct copy of a Cisco webpage, which I downloaded August 29, 2021, and is available at https://www.cisco.com/c/en/us/about/supplier-information/access-non-manufacturing-supplier-connection/return-to-office.html.

c. **Norwegian Cruise Line**: Attached hereto as **Exhibit 64** is a true and correct copy of a Norwegian Cruise Line webpage, titled "Sail Safe," which I downloaded on August 30, 2021, and is available at https://www.ncl.com/sail-safe.

d. **Tyson Foods**: Attached hereto as **Exhibit 65** is a true and correct copy of a Tyson Foods blogpost, titled "Our Next Step in the Fight Against the Pandemic," dated August 3, 2021, and available at: https://thefeed.blog/2021/08/03/our-next-step-in-the-fight-against-the-pandemic.

e. **Union Square Hospitality Group**: Attached hereto as **Exhibit 66** is a true and correct copy of an article, titled "Danny Meyer Restaurant Group Will Require Vaccines To Dine And Work In Major Shift For Fine Dining," dated July 29, 2021, and available at https://www.forbes.com/sites/carlieporterfield/2021/07/29/danny-meyers-restaurants-are-the-first-major-group-to-require-proof-of-coronavirus-vaccination/?sh=685b30c71b11.

f. **United and Frontier Airlines**: Attached hereto as **Exhibit 67** is a true and correct copy of an article, titled "United Airlines will require vaccination, and Amazon revives mask mandates," updated August 9, 2021, and available at https://www.nytimes.com/2021/08/06/business/united-airlines-vaccines.html.

g. **Anthem, BlackRock, Citigroup, CVS (patient-facing staff and corporate employees), Deloitte, Facebook, Goldman Sachs, Google, Lyft, Microsoft, NBCUniversal, the New York Times, the Washington Post, Salesforce, Twitter, Uber, the Walt Disney Company, Walmart**: Attached hereto as **Exhibit 68** is a true and correct copy of an article, titled "Here are the companies mandating vaccines for all or some employees," updated August 25, 2021, and available at: https://www.nbcnews.com/business/business-

news/here-are-companies-mandating-vaccines-all-or-some-employees-n1275808.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at Contra Costa County, California this 30 day of August, 2021.

DATED: August 30, 2021

/s/ Sophie Hart
Sophie Hart

INDEX OF EXHIBITS

TO DECLARATION OF SOPHIE HART

Exhibit Number	Description
1	Excerpts of CCHCS Healthcare Services Dashboard – Statewide Comparison (July 2021)
2	CCHCS COVID-19 Patient Vaccination Registry Report Definitions (downloaded August 18, 2021)
3	CDCR Institutional Bed Audit (dated August 25, 2021)
4	List of all patients in CDCR with a "DKD" designation (redacted) (as of August 9, 2021)
5	Excerpts of CCHCS Healthcare Services Dashboard – Statewide Comparison (January 2020)
6	Excerpts of CCHCS Healthcare Services Dashboard Glossary (received August 19, 2021)
7	CCHCS PCP Staffing and Backlog Report (June 1-15, 2021)
8	CCHCS Memorandum titled "PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO SPECIALTY SERVICES" (dated July 26, 2021)
9	Outbreak Management Tools (OMTs) for California Health Care Facility (CHCF) (dated August 3, August 10, and August 17, 2021)
10	OMT for California State Prison, Sacramento (SAC) (dated August 10, 2021)
11	Quarantine data emailed from Tammy Foss, Director of Corrections Services at CCHCS (received August 19, 2021)
12	Email from CCHCS reporting rates of staff vaccination (August 27, 2021)

13	CDCR/CCHCS response to *Plata* Plaintiffs' Urgent Concerns Regarding Current COVID-19 Outbreaks (received January 12, 2021)
14	CDCR response to Prison Law Office Prison-specific COVID-19 questions for week of July 12, 2021 (redacted) (received July 21, 2021)
15	CCHCS memorandum titled "PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO OUTPATIENT HOUSING UNIT BED AVAILABILITY" (dated July 23, 2021)
16	Excerpt of vaccine data CCHCS emailed to Plaintiffs' counsel (received July 19, 2021)
17	CDCR/CCHCS memorandum titled "RECOMMENDED COVID-19 PERSONAL PROTECTIVE EQUIPMENT AND PHYSICAL DISTANCING REQUIREMENTS FOR STAFF AND INMATE-PATIENTS UPDATE" (dated May 10, 2021)
18	Screenshot of CCHCS/CDCR's COVID-19 Tracker (downloaded August 27, 2021)
19	CCHCS/CDCR's COVID-19 Employee Status website (last updated August 27, 2021)
20	CDPH memorandum regarding the Health Care Worker Vaccine Requirement (dated August 5, 2021)
21	CDPH "Q&A" regarding the August 5 Order (dated August 20, 2021)
22	CDPH memorandum regarding the State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement (August 19, 2021)
23	AMEND at University of California San Francisco and The University of California, Berkeley School of Public Health memorandum titled "Urgent Memo: COVID-19 Outbreak: San Quentin Prison" (dated June 15, 2020)

24	Chapter 5 ("Mental Health Crisis Bed") of the California Department of Corrections and Rehabilitation Mental Health Services Delivery System Program Guide (filed in *Coleman v. Newsom*, No. 2:90-cv-00520-KJM-DB (E.D. Cal.) at ECF No. 5864-1 on July 30, 2018)
25	Los Angeles Times website titled "Tracking coronavirus vaccinations in California" (updated August 28, 2021)
26	Redacted photographs of CDCR dormitory housing units (received on May 7, 14, and 26, 2020)
27	Screenshot of CCHCS/CDCR's COVID-19 Tracker, of the "Institution View" for High Desert State Prison (HDSP) and California Correctional Center (CCC) (downloaded August 28, 2021)
28	CCHCS response to Prison Law Office Prison-specific COVID-19 questions for week of August 9, 2021 (received August 18, 2021)
29	Press Release from the Colorado Department of Corrections (CDOC), the Colorado Department of Human Services (CDHS), and the Colorado Department of Public Health and Environment (CDPHE) (downloaded August 19, 2021)
30	Article titled "Read Gov. Pritzker's Full Remarks on New COVID Mitigations for Illinois" (dated August 4, 2021)
31	Executive Order from Massachusetts Governor Charles D. Baker (dated August 19, 2021)
32	News Release from Oregon Governor Kate Brown (dated August 10, 2021)
33	Proclamation by Washington Governor Jay Inslee (dated August 9, 2021)
34	Letter from Monica Nino, County Administrator, Contra Costa County (dated August 27, 2021)

35	Executive Order and Press Release from Hilda Solis, Chair, Los Angeles County Board of Supervisors (dated August 4, 2021)
36	Order from the San Francisco Department of Public Health, titled "ENCOURAGING COVID-19 VACCINE COVERAGE AND REDUCING DISEASE RISKS (Safer Return Together)" (updated August 24, 2021)
37	Memorandum from Jeffrey V. Smith, County Executive and James R. Williams, County Counsel, regarding the "COVID-19 Vaccination Requirement for County Personnel" (dated August 5, 2021)
38	Article, titled "Bucks County orders jail staff to get COVID vaccine or be terminated" (dated August 24, 2021)
39	King County News Release, titled "King County, State of Washington and City of Seattle announce vaccination requirement for most employees, private health care and long-term care workers" (dated August 9, 2021)
40	Article titled "Novant, Atrium, health departments requiring all employees to get COVID-19 vaccine" (dated August 30, 2021)
41	Press Release from Banner Health, titled "Banner Health expands its COVID-19 employee vaccination program" (dated July 20, 2021)
42	Houston Methodist policy (dated August 9, 2021)
43	Press Release from Kaiser Permanente, titled "Protecting health and safety through vaccination" (dated August 2, 2021)
44	Webpage titled "Governor Cuomo Announces COVID-19 Vaccination Mandate for Healthcare Workers" (dated August 16, 2021)
45	Press Release from Trinity Health, titled "Trinity Health Announces COVID-19 Vaccine Requirement for All Colleagues" (dated July 8, 2021)

46	News Release from the U.S. Department of Veterans Affairs (dated July 16, 2021)
47	Article titled "Hospitals, health systems mandating vaccines for workers" (updated August 27, 2021)
48	California State University policy titled "COVID-19 Vaccination Interim Policy" (dated July 30, 2021)
49	Indiana University webpage titled "COVID-19 Vaccine" (downloaded August 30, 2021)
50	Los Angeles Unified School District's website titled "Safe Steps to Safe Schools: Frequently Asked Questions" (downloaded August 30, 2021)
51	Article titled "NYC mandates vaccinations for public school teachers, staff" (dated August 23, 2021)
52	Ohio State University webpage titled "Ohio State announces vaccination requirement" (downloaded August 30, 2021)
53	School District of Philadelphia webpage titled "The Board of Education Approves a Vaccine Mandate for all School District Employees" (dated August 26, 2021)
54	University of California policy titled "SARS-CoV-2 (COVID-19) Vaccination Program" (updated July 15, 2021)
55	Washington Office of Superintendent of Public Instruction document titled "COVID-19 Vaccination Requirement for K–12 School Employees: Frequently Asked Question" (updated August 23, 2021)
56	Article titled "State-by-state look at colleges requiring COVID-19 vaccines" (updated August 28, 2021)
57	Centers for Medicare & Medicaid Services (CMS) Press Release, titled "Biden-Harris Administration Takes Additional Action to Protect America's Nursing Home Residents from COVID-19" (dated August 18, 2021)

58	Article titled "Brookdale Senior Living to require Covid vaccine for staff, CEO says" (dated August 6, 2021)
59	Genesis Healthcare webpage, titled "Coronavirus Updates" (downloaded August 30, 2021)
60	Article titled "As breakthrough covid infections rise, nursing home chains require that staffers be vaccinated" (dated August 5, 2021)
61	Sunrise Senior Living blogpost, titled "Welcoming Brighter Days at Sunrise" (dated March 23, 2021)
62	Fifty/50 Restaurant Group webpage (downloaded August 20, 2021)
63	Cisco webpage (downloaded August 29, 2021)
64	Norwegian Cruise Line webpage, titled "Sail Safe" (downloaded August 20, 2021)
65	Tyson Foods blogpost, titled "Our Next Step in the Fight Against the Pandemic" (dated August 3, 2021)
66	Article titled "Danny Meyer Restaurant Group Will Require Vaccines To Dine And Work In Major Shift For Fine Dining" (dated July 29, 2021)
67	Article titled "United Airlines will require vaccination, and Amazon revives mask mandates" (updated August 9, 2021)
68	Article titled "Here are the companies mandating vaccines for all or some employees" (updated August 25, 2021)

EXHIBIT 1

DASHBOARD STATEWIDE COMPARISON

All Institutions

July 2021

Report Range:	*Current Month Selected*
Selected Domain(s):	*All*

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Scheduling & Access to Care	SW	ASP	CAC	CAL	CCC	CCI	CCWF	CEN	CHCF	CIM	CIW	CMC	CMF	COR	CRC
Patient Requested Exam 90 Days	38%	16%	44%	72%	70%	75%	27%	7%	54%	81%	35%	28%	21%	27%	43%
Notice of Exam	97%	99%	99%	100%	100%	99%	95%	100%	100%	96%	98%	99%	99%	99%	99%
Appts Cancelled due to Custody- Medical	**0.4%**	**0.0%**	**0.0%**	**0.0%**	**0.2%**	**0.1%**	**1.2%**	**0.1%**	**0.3%**	**0.0%**	**0.2%**	**0.5%**	**0.3%**	**0.2%**	**0.2%**
Seen as Scheduled- Medical	**85%**	**91%**	**92%**	**89%**	**86%**	**89%**	**83%**	**91%**	**79%**	**88%**	**85%**	**87%**	**77%**	**85%**	**88%**
Effective Communication Provided	**98%**	**100%**	**100%**	**99%**	**100%**	**99%**	**99%**	**100%**	**98%**	**99%**	**98%**	**99%**	**97%**	**93%**	**100%**
Medical Services	98%	100%	100%	99%	100%	99%	99%	100%	98%	99%	98%	99%	97%	93%	100%
Dental Services	96%	98%	96%	95%	96%	93%	94%	100%	98%	96%	95%	92%	97%	96%	97%
Sign Language Interpreter (SLI) Provided	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Backlog*	**244.4**	**56.7**	**83.8**	**66.6**	**194.8**	**174.7**	**213.6**	**209.0**	**866.4**	**60.8**	**263.5**	**363.8**	**282.3**	**166.0**	**80.4**
Allied Health Backlog*	1.3	0.0	0.0	1.4	1.3	0.0	0.0	2.1	1.2	0.0	0.0	0.0	9.4	4.9	0.8
Laboratory Backlog*	69.3	8.5	16.4	21.6	95.4	160.4	13.8	155.6	355.7	24.7	6.0	33.2	83.4	70.4	46.8
LVN Backlog*	8.8	5.6	13.0	5.1	24.4	0.3	0.4	9.9	0.4	0.4	3.0	4.6	6.4	1.5	0.4
PCP Backlog*	48.5	16.7	1.9	4.7	11.5	3.5	47.1	2.1	114.7	0.8	111.8	78.1	57.3	53.3	8.3
Radiology Backlog*	5.4	2.6	0.0	0.0	0.0	0.3	5.8	0.3	24.2	4.9	9.0	1.6	28.6	5.2	0.4
RN Backlog*	31.0	7.3	32.3	0.3	0.9	0.3	7.1	2.4	1.2	4.5	12.0	10.5	7.9	10.7	7.9
Specialty Backlog*	80.1	16.1	20.2	33.4	61.2	9.8	139.3	36.7	369.0	25.5	121.8	235.7	89.3	19.9	15.7

Population Health Management	SW	ASP	CAC	CAL	CCC	CCI	CCWF	CEN	CHCF	CIM	CIW	CMC	CMF	COR	CRC
Adult Immunizations	**57%**	**50%**	**35%**	**66%**	**85%**	**46%**	**71%**	**66%**	**76%**	**63%**	**75%**	**48%**	**56%**	**53%**	**60%**
Tdap/Td	76%	71%	47%	75%	96%	53%	85%	85%	88%	88%	89%	70%	81%	74%	82%
Hepatitis B	45%	47%	23%	63%	69%	48%	59%	52%	67%	44%	65%	40%	45%	42%	27%
Pneumococcal	74%	100%	100%	100%	100%	77%	78%	33%	81%	82%	75%	55%	77%	80%	75%

** Rate Per 1,000 Inmates*

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DASHBOARD STATEWIDE COMPARISON

All Institutions

July 2021

Report Range:	*Current Month Selected*
Selected Domain(s):	*All*

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Scheduling & Access to Care	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP	RJD	SAC	SATF
Patient Requested Exam 90 Days	7%	46%	100%	24%	10%	49%	71%	66%	25%	76%	15%	36%	26%	24%	14%
Notice of Exam	100%	99%	98%	99%	99%	85%	88%	100%	99%	68%	99%	99%	97%	100%	94%
Appts Cancelled due to Custody- Medical	**0.1%**	**0.0%**	**1.1%**	**0.1%**	**0.1%**	**0.1%**	**0.1%**	**0.2%**	**0.2%**	**0.2%**	**0.1%**	**0.5%**	**2.7%**	**0.9%**	**0.4%**
Seen as Scheduled- Medical	**83%**	**86%**	**89%**	**93%**	**82%**	**88%**	**86%**	**81%**	**87%**	**77%**	**90%**	**88%**	**81%**	**86%**	**84%**
Effective Communication Provided	**99%**	**99%**	**99%**	**100%**	**99%**	**99%**	**99%**	**98%**	**100%**	**98%**	**99%**	**100%**	**99%**	**98%**	**97%**
Medical Services	99%	100%	100%	100%	99%	100%	99%	98%	100%	98%	100%	100%	100%	99%	97%
Dental Services	88%	93%	50%	92%	94%	92%	99%	98%	98%	98%	86%	97%	95%	96%	95%
Sign Language Interpreter (SLI) Provided	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Backlog*	**39.9**	**195.5**	**-**	**25.2**	**518.4**	**50.0**	**284.8**	**624.0**	**232.0**	**210.3**	**225.6**	**29.2**	**439.1**	**157.0**	**292.7**
Allied Health Backlog*	0.9	1.8	-	0.0	0.9	0.0	0.0	1.1	0.5	0.0	1.9	0.0	0.0	0.0	6.3
Laboratory Backlog*	15.1	28.3	-	4.7	186.5	10.6	199.2	89.1	43.3	0.0	13.5	12.7	100.3	107.4	21.7
LVN Backlog*	0.4	7.7	-	0.0	21.5	12.6	4.3	3.6	4.4	1.6	7.9	2.2	2.7	0.5	31.7
PCP Backlog*	4.3	26.0	-	0.8	26.1	0.4	56.1	460.8	28.2	194.8	0.0	0.7	112.5	18.9	94.1
Radiology Backlog*	1.3	1.8	-	3.5	1.2	1.6	1.1	0.4	2.0	0.3	0.0	0.0	4.5	1.4	6.5
RN Backlog*	1.7	6.4	-	2.4	26.7	1.6	6.3	16.2	15.4	5.4	189.7	2.2	4.2	2.4	93.5
Specialty Backlog*	16.2	123.5	-	13.8	255.4	23.2	17.7	52.7	138.3	8.3	12.6	11.2	214.9	26.5	39.1

Population Health Management	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP	RJD	SAC	SATF
Adult Immunizations	**46%**	**47%**	**51%**	**48%**	**59%**	**55%**	**56%**	**53%**	**63%**	**52%**	**73%**	**73%**	**68%**	**53%**	**60%**
Tdap/Td	70%	67%	67%	66%	75%	69%	78%	72%	86%	69%	90%	82%	88%	67%	82%
Hepatitis B	44%	41%	44%	37%	43%	46%	49%	39%	43%	33%	56%	63%	54%	53%	45%
Pneumococcal	74%	73%	-	50%	56%	88%	47%	62%	82%	100%	58%	-	82%	75%	80%

** Rate Per 1,000 Inmates*

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DASHBOARD STATEWIDE COMPARISON

All Institutions

July 2021

Report Range:	*Current Month Selected*
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Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Scheduling & Access to Care	SCC	SOL	SQ	SVSP	VSP	WSP
Patient Requested Exam 90 Days	23%	20%	37%	25%	46%	44%
Notice of Exam	100%	100%	99%	99%	100%	83%
Appts Cancelled due to Custody- Medical	**0.1%**	**0.0%**	**0.5%**	**0.0%**	**0.0%**	**0.0%**
Seen as Scheduled- Medical	**80%**	**83%**	**74%**	**82%**	**88%**	**91%**
Effective Communication Provided	**98%**	**99%**	**100%**	**97%**	**99%**	**100%**
Medical Services	98%	100%	100%	97%	99%	100%
Dental Services	97%	91%	99%	94%	94%	98%
Sign Language Interpreter (SLI) Provided	-	-	-	-	-	-
Medical Backlog*	**193.1**	**371.7**	**379.0**	**143.4**	**169.4**	**541.4**
Allied Health Backlog*	0.9	0.0	3.5	0.7	0.0	1.8
Laboratory Backlog*	28.8	99.9	106.5	45.1	38.1	117.3
LVN Backlog*	51.3	1.5	13.5	1.3	1.0	27.9
PCP Backlog*	4.2	0.6	25.9	2.6	36.4	10.0
Radiology Backlog*	0.9	48.0	26.2	7.9	0.7	0.5
RN Backlog*	40.5	0.6	35.5	3.9	0.7	369.6
Specialty Backlog*	66.6	221.1	167.9	81.9	92.6	14.2
Population Health Management	**SCC**	**SOL**	**SQ**	**SVSP**	**VSP**	**WSP**
Adult Immunizations	**50%**	**63%**	**52%**	**51%**	**68%**	**30%**
Tdap/Td	67%	78%	78%	73%	91%	37%
Hepatitis B	33%	45%	34%	41%	52%	25%
Pneumococcal	77%	74%	68%	78%	76%	75%

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Institution & Population Characteristics	SW	ASP	CAC	CAL	CCC	CCI	CCWF	CEN	CHCF	CIM	CIW	CMC	CMF	COR	CRC
High Risk Priority 1	7.1%	0.1%	0.1%	0.3%	0.4%	0.9%	6.8%	0.7%	49.8%	18.4%	13.6%	9.2%	29.4%	5.2%	1.1%
High Risk Priority 2	9.4%	1.3%	0.7%	1.1%	1.2%	5.0%	9.1%	1.4%	18.8%	29.4%	15.7%	17.7%	24.6%	7.5%	4.2%
Medium Risk	35%	36%	15%	15%	9%	44%	55%	16%	24%	34%	43%	39%	34%	45%	47%
Low Risk	48%	62%	84%	83%	89%	50%	29%	82%	7%	19%	28%	34%	12%	42%	48%
Mental Health EOP	6.3%	0.0%	0.0%	0.0%	0.0%	0.1%	3.5%	0.0%	17.8%	0.2%	4.9%	17.6%	22.9%	6.4%	0.1%
Patients with Disability	10.4%	3.0%	1.7%	1.6%	1.0%	2.8%	9.5%	1.7%	50.8%	19.4%	13.2%	10.6%	37.6%	8.6%	2.5%
Inmates 50 Years or Older	28%	30%	11%	8%	10%	23%	20%	11%	64%	53%	31%	44%	51%	25%	21%
Men and Women Institutions	-	M	M	M	M	M	W	M	M	M	W	M	M	M	M
Specialized Health Care Beds	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Institution Population	99,215	3,421	2,076	2,960	2,254	2,867	2,397	2,918	2,477	2,466	1,002	3,046	2,026	3,266	2,413

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July 2021

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Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Institution & Population Characteristics	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP	RJD	SAC	SATF
High Risk Priority 1	3.4%	1.6%	0.0%	2.6%	1.4%	0.5%	2.5%	12.0%	22.4%	1.0%	1.0%	0.0%	19.3%	5.4%	4.9%
High Risk Priority 2	9.2%	5.4%	9.1%	8.9%	3.2%	2.6%	5.5%	16.9%	23.2%	3.1%	5.0%	0.3%	21.1%	14.3%	7.5%
Medium Risk	39%	20%	27%	34%	40%	14%	42%	44%	40%	34%	25%	29%	44%	50%	52%
Low Risk	49%	73%	64%	55%	55%	83%	50%	27%	14%	62%	69%	71%	16%	31%	36%
Mental Health EOP	0.0%	0.0%	4.6%	0.2%	0.2%	0.0%	3.3%	19.9%	17.8%	2.5%	0.2%	0.0%	23.4%	39.4%	9.2%
Patients with Disability	9.5%	5.9%	0.0%	3.3%	5.7%	2.5%	5.5%	15.3%	23.3%	2.7%	3.4%	2.4%	28.1%	5.3%	15.4%
Inmates 50 Years or Older	47%	35%	18%	32%	11%	16%	14%	30%	45%	11%	17%	8%	43%	15%	28%
Men and Women Institutions	M	M	M	M/W	M	M	M	M	M	M	M	M	M	M	M
Specialized Health Care Beds	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Institution Population	4,689	2,194	22	2,543	3,254	2,462	3,494	2,771	3,905	3,866	2,145	2,673	3,350	2,114	5,114

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DASHBOARD STATEWIDE COMPARISON

All Institutions

July 2021

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Selected Domain(s):	*All*

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Institution & Population Characteristics	SCC	SOL	SQ	SVSP	VSP	WSP
High Risk Priority 1	0.6%	10.6%	15.9%	5.7%	6.9%	1.2%
High Risk Priority 2	1.7%	15.3%	23.1%	10.1%	10.6%	3.7%
Medium Risk	19%	24%	34%	50%	48%	38%
Low Risk	79%	50%	27%	35%	35%	57%
Mental Health EOP	0.0%	0.1%	7.4%	10.6%	9.3%	2.8%
Patients with Disability	2.4%	14.3%	12.1%	11.5%	21.2%	2.9%
Inmates 50 Years or Older	15%	35%	58%	18%	45%	9%
Men and Women Institutions	M	M	M	M	M	M
Specialized Health Care Beds	-	-	-	-	-	-
Institution Population	3,335	3,293	2,591	3,041	2,969	3,801

** Rate Per 1,000 Inmates*

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EXHIBIT 2

COVID PATIENT VACCINATION REGISTRY

Report Definitions

Description: *The COVID Patient Vaccination Registry displays one row per patient. It can be used to monitor patients at an institution who are unvaccinated ,**vaccinated** , refused Dose 1 or Dose 2,received Dose 1 and are yet to receive Dose 2, Dose 1 Administered Date, Dose 2 Administered Date, Last Refusal Date, Dose 2 Due Dates by Brand for COVID along with the patient's COVID details like COVID Risk Score, Housing type, COVID Status, Days Since First Positive and First Postive Test Date.*

	FIELD NAME	FULL NAME	DESCRIPTION	ALERT FLAG DEFINITION	ADDITIONAL FUNCTIONALITY		DATA SOURCE
Patient Identification	Inst	Institution	Patient's currently endorsed CDCR institution.	-	Sort	Sort arrows sort patients alpha-numerically by current Institution abbreviation.	SOMS
	CDCR #	CDCR Number	Patient's CDCR Number.	-	Sort	Sort ordered by CDCR number alpha-numerically.	SOMS
					Click	Click on the CDCR number to bring up Patient Summary in a new window.	
	First Name	First Name	Patient's First Name.	-	Sort	Sort arrows will sort by patient's last name, alphabetically.	SOMS
					Hover	Hover over will give patient's full name (Last, First).	
	Last Name	Last Name	Patient's Last Name.	-	Sort	Sort arrows will sort by patient's last name, alphabetically.	SOMS
					Hover	Hover over will give patient's full name (Last, First).	
Patient Demographics & Housing	Age	Age	Patient's age.	-	Sort	Sort arrows will sort patients by birthdate - oldest to youngest.	SOMS
					Hover	Hover will show the patient's date of birth.	
	Ethnicity	Ethnicity	Patient's ethnicity.	-	Sort	Sort arrows will sort based on ethnicity, alphabetically.	SOMS
	Building	Building	The Building where patient is housed	-	Sort	Sort arrows will sort patients by their building alpha-numerically.	SOMS
	Facility	Facility	The Facility where patient is housed	-	Sort	Sort arrows will sort patients by their facility alpha-numerically.	SOMS
	Cell Bed	Cell Bed Number	Field will display the patient's Cell bed number.	-	Sort	Sort arrows will sort patients by their cell bed alpha-numerically.	SOMS
	Bed Type	Bed Type	Field will display the patient's Bed Type.	-	Sort	Sort arrows will sort patients alphabetically.	SOMS
	Care Team	Assigned Care Team or Yard	Patient's currently assigned care team or yard.	-	Sort	Sort arrows will order patients by Care Team, alpha-numerically.	SOMS
	Housing Type	Housed in Dorm or Cell	Housing type-Dorm or Cell	-	Sort	Sort arrows will sort alphabetically by Housing Type.	SOMS
	MH LOC	Mental Health Level of Care	Patient's Level of Care (LOC) in the Mental Health (MH) program.	-	Sort	Sort arrows will sort by MH LOC bringing those within the MH program to the top.	EHRS
	Job Category	Job Category	Field will display Job Category/Categories of the patient	-	Sort	Sort arrows will sort alphabetically by Job Category.	SOMS
					Hover	Hover over Job Category to see Job Title/Tiltes of the patient.	
Release	Release Date	Estimated Release Date	The patient's Estimated Parole Release Date (EPRD), Minimum Eligible Parole Date (MEPD), or Projected Revocation Release Date (PRRD).	Yellow = Patient's estimated release date is within 30 days(MEPD and EPRD) or past 30 days(only EPRD)	Sort	Sort arrows will sort patients by their estimated release date with the earliest dates to the top.	SOMS
	Release Type	Release Type	The release type: Estimated Parole Release Date (EPRD), Minimum Eligible Parole Date (MEPD), or Projected Revocation Release Date (PRRD).	-	Sort	Sort arrows will sort alphabetically by release type.	SOMS

COVID PATIENT VACCINATION REGISTRY

Report Definitions

Description: *The COVID Patient Vaccination Registry displays one row per patient. It can be used to monitor patients at an institution who are unvaccinated ,**vaccinated** , refused Dose 1 or Dose 2,received Dose 1 and are yet to receive Dose 2, Dose 1 Administered Date, Dose 2 Administered Date, Last Refusal Date, Dose 2 Due Dates by Brand for COVID along with the patient's COVID details like COVID Risk Score, Housing type, COVID Status, Days Since First Positive and First Postive Test Date.*

	FIELD NAME	FULL NAME	DESCRIPTION	ALERT FLAG DEFINITION	ADDITIONAL FUNCTIONALITY		DATA SOURCE
COVID Details	COVID Risk	COVID Weighted Risk Score	The COVID Weighted Risk Score Factors and their weights in parentheses include: Age 65+ (4), Advanced Liver Disease (2), Persistent Asthma (1), High Risk Cancer (2), Chronic Kidney Disease (CKD) (1), Stage 5 CKD or receiving dialysis (1), Chronic Lung Disease (including Cystic Fibrosis, Pneumoconiosis, or Pulmonary Fibrosis) (1), COPD (2), Diabetes (1), High Risk Diabetes (1), Heart Disease (1), High Risk Heart Disease (1), Hemoglobin Disorder (1), HIV/AIDS (1), Poorly Controlled HIV/AIDS (1), Hypertension (1), Immunocompromised (2), Neurologic Conditions (1), Obesity (1), Other High Risk Chronic Conditions (1), and Pregnancy (1).	-	Sort	Sort arrows will sort patients by their COVID Weighted Risk Score, highest to lowest.	EHRS
					Hover	Hover over a patient's COVID Weighted Risk Score to see the risk factors that make up their score.	
	COVID Susceptible	COVID Susceptible	This column will display a check mark ("v") if the patient is considered "susceptible" to COVID. This includes all patients who have never tested positive for COVID, patients who tested positive for COVID, but 84 or more days have past since the first positive test, and patients who received a false positive test, as recorded in the CCHCS Public Health surveillance system.	-	Sort	Sort arrows will bring patients who are considered susceptible to the top.	EHRS, Quest, Public Health
	COVID Status	COVID Status	The status of the patient's COVID disease: "Confirmed Active" - the patient has ever had a positive result for COVID within the EHRS or directly reported to CCHCS Public Health surveillance system and has not been released, resolved, or died; "Resolved" - the patient was Confirmed Active for COVID and has now (1) had their Public Health case closed with reason of "recovered" or "resolved," (2) the Public Health case surveillance system confirmed and documented the patient was released from isolation in the past, and (3) date the case was closed is in the past.	-	Sort	Sort arrows will sort "Confirmed Active" to the top, followed by "Resolved" and then "Naive"	EHRS, Quest, Public Health
	Days Since First Positive COVID Test	Days Since First Positive COVID Test	The number of days since the patient first tested positive for COVID.	-	Sort	Sort arrows will bring the patients with the shortest number of days since a positive test for COVID to the top.	EHRS, Quest, Public Health
	First Positive Test	First Postive Test Date	Date when patient was first tested positive for COVID	-	Sort	Sort arrows will sort patients who had most recently tested positive for COVID by date on top	EHRS, Quest, Public Health
	Past/Current Hosp. with COVID	Past/Current Hosp. with COVID	A checkmark "√" Indicates that the patient has had a COVID related Hospitalization	-	Sort	Sort arrows will sort patients who had a COVID related Hospitalization on the top.	EHRS, Quest, Public Health
	MCAb Administration Date	MCAb Administration Date	Date the monoclonal antibody treatment was performed. Patient onsite is anyone who has a completed medication administration. Patient offsite is anyone who has a completed referral to monoclonal antibodies and does not have a completed medication administration.	-	Sort	Sort arrows will sort patients by MCAb Administration Date, showing more recent on the top.	EHRS

COVID PATIENT VACCINATION REGISTRY

Report Definitions

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	FIELD NAME	FULL NAME	DESCRIPTION	ALERT FLAG DEFINITION	ADDITIONAL FUNCTIONALITY		DATA SOURCE
Vaccine Details	Dose 1 Administered Date	Dose 1 Administered Date	Date on which Dose 1 was administered	-	Sort	Sort arrows will sort by Dose 1 Administered Date, bringing patients with most recent date on top	EHRS
	Dose 2 Administered Date	Dose 2 Administered Date	Date on which Dose 2 was administered	-	Sort	Sort arrows will sort by Dose 2 Administered Date, bringing patients with most recent date on top	EHRS
	Vaccine Allergy	Vaccine Allergy	A checkmark "√" Indicates the patient has COVID Vaccine		Sort	Sort arrows will sort patients with allergy on top	EHRS
					Hover	Hover over to see the vaccine brand for which the patient has a documented allergy	
	Dose 2 Due Date	Dose 2 Due Date	Date on which Dose 2 is due as per Vaccine Brand(Pfizer-21 days, Moderna-28 days)	**Red** = Current Date is past Due Date. **Yellow =** Due Date is within the next 3 days	Sort	Sort arrows will sort patients by Dose 2 Due Date, with overdue on top, followed by dose 2 due dates approaching within the next three days.	EHRS
					Hover	Hover over the Dose 2 Due Date to see when Dose 2 is due or if it is overdue	
	Last Refusal Date	Last Refusal Date	Most recent date on which the patient refused the vaccine.	-	Sort	Sort arrows will sort patients by Last Refused Date, bringing patients with most recent date on top	EHRS
	Vaccine Brand	Vaccine Brand	Patient's Dose 1 Vaccination Brand from EHRS	-	Sort	Sort arrows will sort by Vaccine Brand,alphabetically.	EHRS
	Medical Hold	Medical Hold	A checkmark "√" Indicates the patient has a medical hold.	**Red** = Patient received Dose 1 of Pfizer and does not have a medical hold.	Sort	Sort arrows will sort by missing medical hold on top.	SOMS
					Hover	Hover over the medical Hold column to see the reason for the alert flag	
	Vaccination Status	Vaccination Status	The status of the patient's vaccination: Vaccinated = Both Dose 1 and Dose 2 have been administered(Moderna or Pfizer) or one Dose of Janssen Vaccine Unvaccinated=Patient has not received Dose 1 . Partially Vaccinated= Dose 1 has been administered , Dose 2 is yet to be administered(Pfizer or Moderna)	-	Sort	Sort arrows will sort patients by Vaccination status alphabetically.	EHRS
Order Details	Active Order	Active Order	A checkmark "√" Indicates the patient has an active Vaccine Order	-	Sort	Sort arrows will sort patients who have an active order for the vaccine at the top	EHRS
	Dose 1 Lot Number	Dose 1 Lot Number	Pharamacy Dose 1 Lot Number	-	Sort	Sort arrows will sort patients by Dose 1 Lot Number alpha-numerically.	EHRS
	Dose 2 Lot Number	Dose 2 Lot Number	Pharamacy Dose 2 Lot Number	-	Sort	Sort arrows will sort patients by Dose 2 Lot Number alpha-numerically.	EHRS

COVID PATIENT VACCINATION REGISTRY

Report Definitions

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FIELD NAME	FULL NAME	DESCRIPTION	ALERT FLAG DEFINITION	ADDITIONAL FUNCTIONALITY	DATA SOURCE

FILTER	FILTER OPTION	FILTER DSECRIPTION
Institution	*[All Institutions]*	List of all institutions. Multi-select and select all available.
Housing Facility	*[Institution Housing Facilities]*	List of all institution housing facilities. Multi-select and select all available.
Building	*[Building or first 6 characters of cell bed]*	List of all institution housing facilities at finer detail than housing facility filter. Uses the first 6 characters of the patient's cell bed. Multi-select available. Must choose a housing facility to get list of buildings.
Care Team	*[Institution Care Team(s)]*	List of all institution care teams. Multi-select and select all available.
COVID Filters	*All*	Shows all patients at the chosen institution(s) today.
	COVID Resolved	Shows all patients who were "Confirmed Active" for COVID and are now "Resolved."
	COVID Naïve	Shows all patients who are "naïve" for COVID (i.e., have never tested positive for COVID).
	COVID Confirmed Active	Shows all patients that have tested positive and currently have active COVID.
	COVID Susceptible	Shows all patients who are considered susceptible to COVID infection.
	COVID Resolved 6+ Months	Shows all Patients with COVID Resolved 6+ months
	COVID Resolved 3-6 Months	Shows all Patients with COVID Resolved 3-6 months
	COVID Resolved < 3 Months	Shows all Patients with COVID Resolved < 3 months
Vaccine status	*All*	Shows all patients at the institution(s).
	Vaccine Not Offered	Shows [Unvaccinated patients]-[Patients who Refused Dose 1 or Dose 2]
	Unvaccinated	Shows all patients which are yet to receive Dose 1.
	Partially Vaccinated	Shows all patients who received Dose 1 and are yet to receive Dose 2
	Dose 1 Refused	Shows all patients who refused Dose 1
	Dose 2 Refused	Shows all patients who refused Dose 2
	Vaccinated	Shows all patients which are Vaccinated(Dose 1 and Dose 2 have been administered).
Patient Filters	*All*	Shows all patients at the chosen institution(s) today.
	COVID Risk Score 6+	Shows all patients with a COVID Risk Score ≥6
	COVID Risk Score 3+	Shows all patients with a COVID Risk Score ≥3
	Age 65+	Shows all patients with age ≥65
	Age < 65	Shows all patients with age less than 65
	COVID Risk Score < 3	Shows all patients with a COVID Risk Score less than 3
	Past Hospitalization with COVID	Shows all patients with a Hospitalization with COVID
	Armstrong Class Members	Shows all patients who are Armstrong class members
	Clark Class Members	Shows all patients who are Clark Class members.
	Coleman Class Members	Shows all patients who are Coleman Class members.
Job Category	*All*	Shows all patients at the institution(s).
	ADA/Peer Support	Shows all patients that have aleast 1 Job in this Job Category.
	Clerk	Shows all patients that have aleast 1 Job in this Job Category.
	Culinary	Shows all patients that have aleast 1 Job in this Job Category.
	Firefighter/Trainee	Shows all patients that have aleast 1 Job in this Job Category.
	HealthCare	Shows all patients that have aleast 1 Job in this Job Category.
	Inmate Labor	Shows all patients that have aleast 1 Job in this Job Category.
	PIA	Shows all patients that have aleast 1 Job in this Job Category.
	Plant Operations	Shows all patients that have aleast 1 Job in this Job Category.
	Porter/Janitor	Shows all patients that have aleast 1 Job in this Job Category.
	Yard Worker	Shows all patients that have aleast 1 Job in this Job Category.
	Other	Shows all patients that have aleast 1 Job in this Job Category.
	No Job	Shows all patients that do not have a job.

COVID PATIENT VACCINATION REGISTRY

Report Definitions

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FIELD NAME	FULL NAME	DESCRIPTION	ALERT FLAG DEFINITION	ADDITIONAL FUNCTIONALITY	DATA SOURCE
FILTER			FILTER OPTION	FILTER DSECRIPTION	
Health Care Beds		*All*	Shows all patients at the chosen institution(s) today.		
		CTC	Shows all patients with a bed type "CTC" or "HSP".		
		DSH	Shows all patients with MH LOC "DMH".		
		MHCB	Shows all patients with bed type "MCB" or MH LOC "MHCB".		
		OHU	Shows all patients with bed type "OHU".		
		PIP	Shows all patients with bed type "PIP"/"ICF"/"ACU" or MH LOC "Acute"/'ICF"		

EXHIBIT 3

Generated by :
JERRY.GOLD

Institution Bed Audit

Time run: 8/25/2021 2:48:35 PM

ASP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
ASP-Central Service	FIR	S FIR 1	Dorm	10	0	0	10	I	FH	10	9	0	0	90%
	INF	S INF 1	Cell	11	0	2	13	NA	OHU	11	6	7	0	55%
			Dorm	0	0	15	15	NA	OHU	0	5	10	0	
ASP-Central Service Total				**21**	**0**	**17**	**38**			**21**	**20**	**17**	**0**	**95%**
ASP-Facility A	110	A 110 1	270 Dorm	68	68	0	136	II	PF	102	92	43	0	135%
		A 110 2	270 Dorm	62	62	0	124	II	PF	93	91	33	0	147%
	120	A 120 1	270 Dorm	68	68	0	136	II	PF	102	93	43	0	137%
		A 120 2	270 Dorm	62	62	0	124	II	PF	93	93	31	0	150%
	130	A 130 1	Dorm	100	100	0	200	II	PF	150	111	89	0	111%
	140	A 140 1	270 Cell	50	50	0	100	II	VAR	75	46	54	0	92%
		A 140 2	270 Cell	50	50	0	100	II	VAR	75	0	100	0	0%
ASP-Facility A Total				**460**	**460**	**0**	**920**			**690**	**526**	**393**	**0**	**114%**
ASP-Facility B	210	B 210 1	270 Dorm	68	68	0	136	II	PF	102	106	30	0	156%
		B 210 2	270 Dorm	62	62	0	124	II	PF	93	88	36	0	142%
	220	B 220 1	Dorm	100	100	0	200	II	PF	150	107	93	0	107%
	230	B 230 1	270 Dorm	68	68	0	136	II	PF	102	89	47	0	131%
		B 230 2	270 Dorm	62	62	0	124	II	PF	93	80	44	0	129%
	250	B 250 1	270 Dorm	68	68	0	136	II	PF	102	89	47	0	131%
		B 250 2	270 Dorm	62	62	0	124	II	PF	93	72	52	0	116%
ASP-Facility B Total				**490**	**490**	**0**	**980**			**735**	**631**	**349**	**0**	**129%**
ASP-Facility C	310	C 310 1	270 Dorm	68	68	0	136	II	PF	102	92	44	0	135%
		C 310 2	270 Dorm	62	62	0	124	II	PF	93	77	47	0	124%
	320	C 320 1	Dorm	100	100	0	200	II	PF	150	117	83	0	117%
	330	C 330 1	270 Dorm	68	68	0	136	II	VAR	102	0	136	0	0%
		C 330 2	270 Dorm	62	62	0	124	II	VAR	93	0	124	0	0%
	350	C 350 1	270 Dorm	68	68	0	136	II	PF	102	89	47	0	131%
		C 350 2	270 Dorm	62	62	0	124	II	PF	93	84	40	0	135%
ASP-Facility C Total				**490**	**490**	**0**	**980**			**735**	**459**	**521**	**0**	**94%**
ASP-Facility D	410	D 410 1	270 Dorm	68	68	0	136	II	PF	102	90	46	0	132%
		D 410 2	270 Dorm	62	62	0	124	II	PF	93	86	38	0	139%
	420	D 420 1	Dorm	100	100	0	200	II	PF	150	108	92	0	108%
	430	D 430 1	270 Dorm	68	68	0	136	II	PF	102	89	47	0	131%
		D 430 2	270 Dorm	62	62	0	124	II	PF	93	82	41	0	132%
	450	D 450 1	270 Dorm	68	68	0	136	II	PF	102	87	49	0	128%
		D 450 2	270 Dorm	62	62	0	124	II	PF	93	79	44	0	127%
ASP-Facility D Total				**490**	**490**	**0**	**980**			**735**	**621**	**357**	**0**	**127%**
ASP-Facility E	510	E 510 1	270 Dorm	68	68	0	136	II	PF	102	91	45	0	134%
		E 510 2	270 Dorm	62	62	0	124	II	PF	93	86	38	0	139%
	520	E 520 1	Dorm	100	100	0	200	II	PF	150	103	97	0	103%
	530	E 530 1	270 Dorm	68	68	0	136	II	PF	102	91	45	0	134%
		E 530 2	270 Dorm	62	62	0	124	II	PF	93	87	37	0	140%
	550	E 550 1	270 Dorm	62	62	0	124	II	PF	93	84	40	0	135%
		E 550 2	270 Dorm	62	62	0	124	II	PF	93	84	40	0	135%
ASP-Facility E Total				**484**	**484**	**0**	**968**			**726**	**626**	**342**	**0**	**129%**
ASP-Facility F	610	F 610 1	270 Dorm	64	64	0	128	II	PF	96	83	45	0	130%
		F 610 2	270 Dorm	61	61	0	122	II	PF	92	77	45	0	126%
	630	F 630 1	270 Dorm	68	68	0	136	II	PF	102	92	43	0	135%
		F 630 2	270 Dorm	62	62	0	124	II	PF	93	84	40	0	135%
	640	F 640 1	Dorm	100	100	0	200	II	PF	150	115	85	0	115%
	650	F 650 1	270 Dorm	68	68	0	136	II	PF	102	91	45	0	134%
		F 650 2	270 Dorm	62	62	0	124	II	PF	93	81	43	0	131%
ASP-Facility F Total				**485**	**485**	**0**	**970**			**728**	**623**	**346**	**0**	**128%**
Grand Total				**2920**	**2899**	**17**	**5836**			**4370**	**3506**	**2325**	**0**	**120%**

Generated by :
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CAC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CAC-Facility A	001	A 001A1	Cell	0	0	0	0	II	GP	0	33	11	0	
		A 001A2	Cell	0	0	0	0	II	GP	0	37	7	0	
		A 001B1	Cell	0	0	0	0	II	GP	0	26	14	0	
		A 001B2	Cell	0	0	0	0	II	GP	0	24	16	0	
		A 001C1	Cell	0	0	0	0	NA	ASU	0	19	8	6	
		A 001C2	Cell	0	0	0	0	NA	ASU	0	12	30	2	
	002	A 002A1	Cell	0	0	0	0	II	VAR	0	0	44	0	
		A 002A2	Cell	0	0	0	0	II	VAR	0	0	44	0	
		A 002B1	Cell	0	0	0	0	II	VAR	0	1	39	0	
		A 002B2	Cell	0	0	0	0	II	VAR	0	0	40	0	
		A 002C1	Cell	0	0	0	0	II	GP	0	4	36	4	
		A 002C2	Cell	0	0	0	0	II	GP	0	0	44	0	
CAC-Facility A Total				**0**	**0**	**0**	**0**			**0**	**156**	**333**	**12**	
CAC-Facility B	001	B 001A1	Cell	0	0	0	0	II	GP	0	42	1	0	
		B 001A2	Cell	0	0	0	0	II	GP	0	43	1	0	
		B 001B1	Cell	0	0	0	0	II	GP	0	37	1	2	
		B 001B2	Cell	0	0	0	0	II	GP	0	38	2	0	
		B 001C1	Cell	0	0	0	0	II	GP	0	41	2	1	
		B 001C2	Cell	0	0	0	0	II	GP	0	43	1	0	
	002	B 002A1	Cell	0	0	0	0	II	GP	0	41	3	0	
		B 002A2	Cell	0	0	0	0	II	GP	0	43	1	0	
		B 002B1	Cell	0	0	0	0	II	GP	0	38	1	1	
		B 002B2	Cell	0	0	0	0	II	GP	0	37	3	0	
		B 002C1	Cell	0	0	0	0	II	GP	0	39	5	0	
		B 002C2	Cell	0	0	0	0	II	GP	0	41	3	0	
		B 003A1	Cell	0	0	0	0	II	GP	0	43	1	0	
	003	B 003A2	Cell	0	0	0	0	II	GP	0	41	3	0	
		B 003B1	Cell	0	0	0	0	II	GP	0	35	5	0	
		B 003B2	Cell	0	0	0	0	II	GP	0	38	2	0	
		B 003C1	Cell	0	0	0	0	II	GP	0	44	0	0	
		B 003C2	Cell	0	0	0	0	II	GP	0	43	1	0	
	004	B 004A1	Cell	0	0	0	0	II	GP	0	42	2	0	
		B 004A2	Cell	0	0	0	0	II	GP	0	44	0	0	
		B 004B1	Cell	0	0	0	0	II	GP	0	37	3	0	
		B 004B2	Cell	0	0	0	0	II	GP	0	40	0	0	
		B 004C1	Cell	0	0	0	0	II	GP	0	39	5	0	
		B 004C2	Cell	0	0	0	0	II	GP	0	42	2	0	
CAC-Facility B Total				**0**	**0**	**0**	**0**			**0**	**971**	**48**	**4**	
CAC-Facility C	001	C 001A1	Cell	0	0	0	0	II	GP	0	40	4	0	
		C 001A2	Cell	0	0	0	0	II	GP	0	41	3	0	
		C 001B1	Cell	0	0	0	0	II	GP	0	39	0	0	
		C 001B2	Cell	0	0	0	0	II	GP	0	38	2	0	
		C 001C1	Cell	0	0	0	0	II	GP	0	43	1	0	
		C 001C2	Cell	0	0	0	0	II	GP	0	42	2	0	
	002	C 002A1	Cell	0	0	0	0	II	GP	0	42	2	0	
		C 002A2	Cell	0	0	0	0	II	GP	0	44	0	0	
		C 002B1	Cell	0	0	0	0	II	GP	0	37	3	0	
		C 002B2	Cell	0	0	0	0	II	GP	0	36	3	0	
		C 002C1	Cell	0	0	0	0	II	GP	0	40	2	2	
		C 002C2	Cell	0	0	0	0	II	GP	0	42	2	0	
	003	C 003A1	Cell	0	0	0	0	II	GP	0	38	5	1	
		C 003A2	Cell	0	0	0	0	II	GP	0	43	1	0	
		C 003B1	Cell	0	0	0	0	II	GP	0	40	0	0	
		C 003B2	Cell	0	0	0	0	II	GP	0	39	1	0	
		C 003C1	Cell	0	0	0	0	II	GP	0	42	2	0	
		C 003C2	Cell	0	0	0	0	II	GP	0	39	4	1	
	004	C 004A1	Cell	0	0	0	0	II	GP	0	44	0	0	
		C 004A2	Cell	0	0	0	0	II	GP	0	42	1	1	
		C 004B1	Cell	0	0	0	0	II	GP	0	37	3	0	
		C 004B2	Cell	0	0	0	0	II	GP	0	35	3	2	
		C 004C1	Cell	0	0	0	0	II	GP	0	43	1	0	
		C 004C2	Cell	0	0	0	0	II	GP	0	44	0	0	
CAC-Facility C Total				**0**	**0**	**0**	**0**			**0**	**970**	**45**	**7**	
Grand Total				**0**	**0**	**0**	**0**			**0**	**2097**	**426**	**23**	

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JERRY.GOLD

CAL Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CAL-AD SEG	001	Z 001 1	Cell	100	100	0	200	NA	ASU	125	52	132	12	52%
CAL-AD SEG Total				**100**	**100**	**0**	**200**			**125**	**52**	**132**	**12**	**52%**
CAL-Central Service	INF	S INF 1	Cell	0	0	18	18	NA	OHU	0	16	2	0	
CAL-Central Service Total				**0**	**0**	**18**	**18**			**0**	**16**	**2**	**0**	
CAL-Facility A	001	A 001 1	270 Cell	50	50	0	100	IV	GP	75	75	22	3	150%
		A 001 2	270 Cell	50	50	0	100	IV	GP	75	90	10	0	180%
	002	A 002 1	270 Cell	50	50	0	100	IV	GP	75	75	25	0	150%
		A 002 2	270 Cell	50	50	0	100	IV	GP	75	79	20	1	158%
	003	A 003 1	270 Cell	50	50	0	100	IV	GP	75	68	28	2	136%
		A 003 2	270 Cell	50	50	0	100	IV	GP	75	86	14	0	172%
	004	A 004 1	270 Cell	50	50	0	100	IV	GP	75	73	27	0	146%
		A 004 2	270 Cell	50	50	0	100	IV	GP	75	79	19	2	158%
	005	A 005 1	270 Cell	50	50	0	100	IV	VAR	75	0	100	0	0%
		A 005 2	270 Cell	50	50	0	100	IV	VAR	75	0	100	0	0%
CAL-Facility A Total				**500**	**500**	**0**	**1000**			**750**	**625**	**365**	**8**	**125%**
CAL-Facility B	001	B 001 1	270 Cell	50	50	0	100	IV	GP	75	71	25	3	142%
		B 001 2	270 Cell	50	50	0	100	IV	GP	75	84	13	1	168%
	002	B 002 1	270 Cell	50	50	0	100	IV	GP	75	78	21	1	156%
		B 002 2	270 Cell	50	50	0	100	IV	GP	75	78	21	0	156%
	003	B 003 1	270 Cell	50	50	0	100	IV	GP	75	77	21	0	154%
		B 003 2	270 Cell	50	50	0	100	IV	GP	75	76	21	1	152%
	004	B 004 1	270 Cell	50	50	0	100	IV	GP	75	80	19	1	160%
		B 004 2	270 Cell	50	50	0	100	IV	GP	75	81	18	1	162%
	005	B 005 1	270 Cell	50	50	0	100	IV	VAR	75	9	83	0	18%
		B 005 2	270 Cell	50	50	0	100	IV	VAR	75	7	87	0	14%
CAL-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**641**	**329**	**8**	**128%**
CAL-Facility C	001	C 001 1	270 Cell	50	50	0	100	III	GP	75	82	18	0	164%
		C 001 2	270 Cell	50	50	0	100	III	GP	75	79	19	2	158%
	002	C 002 1	270 Cell	50	50	0	100	III	GP	75	88	10	2	176%
		C 002 2	270 Cell	50	50	0	100	III	GP	75	86	14	0	172%
	003	C 003 1	270 Cell	50	50	0	100	III	GP	75	94	6	0	188%
		C 003 2	270 Cell	50	50	0	100	III	GP	75	90	10	0	180%
	004	C 004 1	270 Cell	50	50	0	100	III	GP	75	93	7	0	186%
		C 004 2	270 Cell	50	50	0	100	III	GP	75	87	13	0	174%
	005	C 005 1	270 Cell	50	50	0	100	III	GP	75	91	8	1	182%
		C 005 2	270 Cell	50	50	0	100	III	GP	75	89	10	1	178%
CAL-Facility C Total				**500**	**500**	**0**	**1000**			**750**	**879**	**115**	**6**	**176%**
CAL-Facility D	001	D 001 1	270 Cell	50	50	0	100	IV	SNY	75	71	28	1	142%
		D 001 2	270 Cell	50	50	0	100	IV	SNY	75	63	33	4	126%
	002	D 002 1	270 Cell	50	50	0	100	IV	SNY	75	70	29	1	140%
		D 002 2	270 Cell	50	50	0	100	IV	SNY	75	73	23	4	146%
	003	D 003 1	270 Cell	50	50	0	100	IV	SNY	75	69	27	4	138%
		D 003 2	270 Cell	50	50	0	100	IV	SNY	75	63	36	1	126%
	004	D 004 1	270 Cell	50	50	0	100	IV	SNY	75	70	29	1	140%
		D 004 2	270 Cell	50	50	0	100	IV	SNY	75	77	23	0	154%
	005	D 005 1	270 Cell	50	50	0	100	IV	SNY	75	9	89	1	18%
		D 005 2	270 Cell	50	50	0	100	IV	SNY	75	16	83	1	32%
CAL-Facility D Total				**500**	**500**	**0**	**1000**			**750**	**581**	**400**	**18**	**116%**
CAL-MSF	001	M 001 1	Dorm	100	50	0	150	I	WC	150	30	120	0	30%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	23	177	0	23%
	FIR	M FIR 1	Dorm	8	0	0	8	I	FH	8	5	3	0	63%
CAL-MSF Total				**208**	**150**	**0**	**358**			**308**	**58**	**300**	**0**	**28%**
Grand Total				**2308**	**2250**	**18**	**4576**			**3433**	**2852**	**1643**	**52**	**124%**

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CCC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CCC-CAMPS	Alder	X20001 1	Dorm	100	10	0	110	I	CMP	100	44	66	0	44%
	Antelope	X25001 1	Dorm	120	20	0	140	I	CMP	120	64	76	0	53%
	Ben Lomond	X45001 1	Dorm	100	10	0	110	I	CMP	100	45	65	0	45%
	Deadwood	X23001 1	Dorm	80	8	0	88	I	CMP	80	47	41	0	59%
	Delta	X08001 1	Dorm	119	13	0	132	I	CMP	119	53	79	0	45%
	Eel River	X31001 1	Dorm	120	12	0	132	I	CMP	120	57	75	0	48%
	Intermountain	X22001 1	Dorm	80	8	0	88	I	CMP	80	60	28	0	75%
	Ishi	X18001 1	Dorm	100	10	0	110	I	CMP	100	58	52	0	58%
	Konocti	X27001 1	Dorm	100	10	0	110	I	CMP	100	54	56	0	54%
	Parlin Fork	X06001 1	Dorm	100	10	0	110	I	CMP	100	54	56	0	54%
	Salt Creek	X07001 1	Dorm	120	12	0	132	I	CMP	120	68	64	0	57%
	Sugar Pine	X09001 1	Dorm	120	12	0	132	I	CMP	120	52	80	0	43%
	Trinity	X03001 1	Dorm	120	12	0	132	I	CMP	120	64	68	0	53%
	Washington Ridge	X44001 1	Dorm	100	10	0	110	I	CMP	100	59	51	0	59%
CCC-CAMPS Total				**1479**	**157**	**0**	**1636**			**1479**	**779**	**857**	**0**	**53%**
CCC-Central Service	INF	S INF 1	Cell	14	0	0	14	NA	OHU	14	5	8	0	36%
			Dorm	5	0	0	5	NA	OHU	5	1	3	0	20%
CCC-Central Service Total				**19**	**0**	**0**	**19**			**19**	**6**	**11**	**0**	**32%**
CCC-Facility B	001	B 001D1	Dorm	112	112	0	224	II	PF	168	154	70	0	138%
		B 001D2	Dorm	113	112	0	225	II	PF	170	151	74	0	134%
		B 001E1	Dorm	112	112	0	224	II	PF	168	131	93	0	117%
		B 001E2	Dorm	112	112	0	224	II	PF	168	133	91	0	119%
		B 001F1	Dorm	133	21	0	154	II	PF	200	69	85	0	52%
		B 001F2	Dorm	80	80	0	160	II	PF	120	74	86	0	93%
CCC-Facility B Total				**662**	**549**	**0**	**1211**			**993**	**712**	**499**	**0**	**108%**
CCC-Facility C	001	C 001 1	270 Cell	50	50	0	100	III	GP	75	79	21	0	158%
		C 001 2	270 Cell	50	50	0	100	III	GP	75	83	17	0	166%
	002	C 002 1	270 Cell	50	50	0	100	III	GP	75	76	23	1	152%
		C 002 2	270 Cell	50	50	0	100	III	GP	75	80	20	0	160%
	003	C 003 1	270 Cell	50	50	0	100	III	VAR	75	10	90	0	20%
		C 003 2	270 Cell	50	50	0	100	III	VAR	75	22	78	0	44%
	004	C 004 1	270 Cell	50	50	0	100	NA	ASU	63	57	28	15	114%
		C 004 2	270 Cell	50	50	0	100	NA	ASU	63	43	43	14	86%
	005	C 005 1	270 Cell	50	50	0	100	III	GP	75	33	67	0	66%
		C 005 2	270 Cell	50	50	0	100	III	GP	75	38	62	0	76%
CCC-Facility C Total				**500**	**500**	**0**	**1000**			**725**	**521**	**449**	**30**	**104%**
CCC-MSF	077	M 077 1	Dorm	19	19	0	38	I	PF	29	22	16	0	116%
	078	M 078 1	Dorm	19	19	0	38	I	PF	29	18	20	0	95%
	079	M 079 1	Dorm	19	19	0	38	I	PF	29	15	23	0	79%
	081	M 081 1	Dorm	19	19	0	38	I	PF	29	16	22	0	84%
	082	M 082 1	Dorm	19	19	0	38	I	PF	29	20	18	0	105%
	083	M 083 1	Dorm	19	19	0	38	I	PF	29	0	38	0	0%
	084	M 084 1	Dorm	19	19	0	38	I	PF	29	0	38	0	0%
	085	M 085 1	Dorm	19	19	0	38	I	PF	29	0	38	0	0%
	086	M 086 1	Dorm	19	19	0	38	I	PF	29	0	38	0	0%
	FIR	M FIR 1	Dorm	13	4	0	17	I	FH	13	15	2	0	115%
CCC-MSF Total				**184**	**175**	**0**	**359**			**270**	**106**	**253**	**0**	**58%**
Grand Total				**2844**	**1381**	**0**	**4225**			**3486**	**2124**	**2069**	**30**	**75%**

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CCI Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CCI-Central Service	FIR	S FIR 1	Dorm	8	0	0	8	I	FH	8	4	2	0	50%
CCI-Central Service Total				**8**	**0**	**0**	**8**			**8**	**4**	**2**	**0**	**50%**
CCI-Facility A	001	A 001A1	180 Cell	10	10	0	20	IV	SNY	15	15	3	2	150%
		A 001A2	180 Cell	10	10	0	20	IV	SNY	15	13	6	1	130%
		A 001B1	180 Cell	10	10	0	20	IV	SNY	15	15	4	1	150%
		A 001B2	180 Cell	10	10	0	20	IV	SNY	15	17	3	0	170%
		A 001C1	180 Cell	12	10	0	22	IV	SNY	18	11	9	2	92%
		A 001C2	180 Cell	11	11	0	22	IV	SNY	17	13	9	0	118%
	002	A 002A1	180 Cell	11	11	0	22	IV	SNY	17	14	7	1	127%
		A 002A2	180 Cell	11	11	0	22	IV	SNY	17	14	5	3	127%
		A 002B1	180 Cell	10	10	0	20	IV	SNY	15	15	4	1	150%
		A 002B2	180 Cell	10	10	0	20	IV	SNY	15	14	3	3	140%
		A 002C1	180 Cell	11	9	0	20	IV	SNY	17	12	7	1	109%
		A 002C2	180 Cell	10	10	0	20	IV	SNY	15	13	7	0	130%
	003	A 003A1	180 Cell	10	10	0	20	IV	SNY	15	14	5	1	140%
		A 003A2	180 Cell	10	10	0	20	IV	SNY	15	15	4	1	150%
		A 003B1	180 Cell	10	10	0	20	IV	SNY	15	11	8	1	110%
		A 003B2	180 Cell	10	10	0	20	IV	SNY	15	14	3	3	140%
		A 003C1	180 Cell	11	11	0	22	IV	SNY	17	14	7	1	127%
		A 003C2	180 Cell	11	11	0	22	IV	SNY	17	19	3	0	173%
	004	A 004A1	180 Cell	11	11	0	22	IV	SNY	17	15	4	3	136%
		A 004A2	180 Cell	12	10	0	22	IV	SNY	18	14	7	1	117%
		A 004B1	180 Cell	11	9	0	20	IV	SNY	17	11	6	1	100%
		A 004B2	180 Cell	10	10	0	20	IV	SNY	15	14	4	2	140%
		A 004C1	180 Cell	13	7	0	20	IV	SNY	20	11	6	1	85%
		A 004C2	180 Cell	10	10	0	20	IV	SNY	15	13	7	0	130%
	005	A 005A1	180 Cell	10	10	0	20	IV	SNY	15	12	8	0	120%
		A 005A2	180 Cell	10	10	0	20	IV	SNY	15	13	6	1	130%
		A 005B1	180 Cell	10	10	0	20	IV	SNY	15	12	4	4	120%
		A 005B2	180 Cell	10	10	0	20	IV	SNY	15	11	3	6	110%
		A 005C1	180 Cell	11	11	0	22	IV	SNY	17	14	8	0	127%
		A 005C2	180 Cell	11	11	0	22	IV	SNY	17	19	3	0	173%
	006	A 006A1	180 Cell	11	11	0	22	IV	SNY	17	0	22	0	0%
		A 006A2	180 Cell	11	11	0	22	IV	SNY	17	7	15	0	64%
		A 006B1	180 Cell	11	9	0	20	IV	SNY	17	1	15	0	9%
		A 006B2	180 Cell	10	10	0	20	IV	SNY	15	0	20	0	0%
		A 006C1	180 Cell	11	11	0	22	IV	SNY	17	0	22	0	0%
		A 006C2	180 Cell	12	10	0	22	IV	SNY	18	0	22	0	0%
	007	A 007A1	180 Cell	12	10	0	22	IV	SNY	18	13	7	2	108%
		A 007A2	180 Cell	13	9	0	22	IV	SNY	20	15	7	0	115%
		A 007B1	180 Cell	10	10	0	20	IV	SNY	15	9	9	2	90%
		A 007B2	180 Cell	10	10	0	20	IV	SNY	15	12	8	0	120%
		A 007C1	180 Cell	11	11	0	22	IV	SNY	17	12	8	2	109%
		A 007C2	180 Cell	13	9	0	22	IV	SNY	20	13	8	1	100%
	008	A 008A1	180 Cell	11	11	0	22	IV	VAR	17	11	9	2	100%
		A 008A2	180 Cell	11	11	0	22	IV	VAR	17	5	16	1	45%
		A 008B1	180 Cell	10	10	0	20	IV	VAR	15	5	13	2	50%
		A 008B2	180 Cell	10	10	0	20	IV	VAR	15	0	20	0	0%
		A 008C1	180 Cell	10	10	0	20	IV	VAR	15	0	20	0	0%
		A 008C2	180 Cell	10	10	0	20	IV	VAR	15	0	20	0	0%
CCI-Facility A Total				**514**	**486**	**0**	**1000**			**771**	**515**	**424**	**53**	**100%**
CCI-Facility B	001	B 001A1	180 Cell	10	10	0	20	IV	SNY	15	10	6	2	100%
		B 001A2	180 Cell	11	9	0	20	IV	SNY	17	10	9	1	91%
		B 001B1	180 Cell	11	9	0	20	IV	SNY	17	14	5	1	127%
		B 001B2	180 Cell	11	9	0	20	IV	SNY	17	10	4	2	91%
		B 001C1	180 Cell	12	10	0	22	IV	SNY	18	13	4	5	108%
		B 001C2	180 Cell	11	11	0	22	IV	SNY	17	14	6	2	127%
	002	B 002A1	180 Cell	12	10	0	22	IV	SNY	18	13	8	1	108%
		B 002A2	180 Cell	11	11	0	22	IV	SNY	17	10	9	1	91%
		B 002B1	180 Cell	10	10	0	20	IV	SNY	15	12	7	1	120%
		B 002B2	180 Cell	11	9	0	20	IV	SNY	17	14	5	1	127%
		B 002C1	180 Cell	10	10	0	20	IV	SNY	15	10	9	1	100%
		B 002C2	180 Cell	10	10	0	20	IV	SNY	15	13	6	1	130%
	003	B 003A1	180 Cell	10	10	0	20	IV	SNY	15	12	5	1	120%
		B 003A2	180 Cell	10	10	0	20	IV	SNY	15	13	6	1	130%
		B 003B1	180 Cell	10	10	0	20	IV	SNY	15	12	6	2	120%
		B 003B2	180 Cell	10	10	0	20	IV	SNY	15	13	3	4	130%
		B 003C1	180 Cell	11	11	0	22	IV	SNY	17	13	8	1	118%
		B 003C2	180 Cell	11	11	0	22	IV	SNY	17	15	5	2	136%
	004	B 004A1	180 Cell	11	11	0	22	IV	SNY	17	17	3	2	155%
		B 004A2	180 Cell	11	11	0	22	IV	SNY	17	16	4	2	145%
		B 004B1	180 Cell	10	10	0	20	IV	SNY	15	10	8	0	100%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CCI-Facility B	004	B 004B2	180 Cell	10	10	0	20	IV	SNY	15	16	3	1	160%
		B 004C1	180 Cell	10	10	0	20	IV	SNY	15	14	5	1	140%
		B 004C2	180 Cell	11	9	0	20	IV	SNY	17	9	4	5	82%
	005	B 005A1	180 Cell	11	9	0	20	IV	SNY	17	12	7	1	109%
		B 005A2	180 Cell	10	10	0	20	IV	SNY	15	12	7	1	120%
		B 005B1	180 Cell	10	10	0	20	IV	SNY	15	16	4	0	160%
		B 005B2	180 Cell	10	10	0	20	IV	SNY	15	11	5	4	110%
		B 005C1	180 Cell	13	9	0	22	IV	SNY	20	13	9	0	100%
		B 005C2	180 Cell	12	10	0	22	IV	SNY	18	10	10	0	83%
	006	B 006A1	180 Cell	11	11	0	22	IV	SNY	17	11	10	1	100%
		B 006A2	180 Cell	12	10	0	22	IV	SNY	18	15	2	1	125%
		B 006B1	180 Cell	10	10	0	20	IV	SNY	15	10	7	1	100%
		B 006B2	180 Cell	10	10	0	20	IV	SNY	15	15	5	0	150%
		B 006C1	180 Cell	11	11	0	22	IV	SNY	17	0	22	0	0%
		B 006C2	180 Cell	11	11	0	22	IV	SNY	17	0	22	0	0%
	007	B 007A1	180 Cell	11	11	0	22	IV	SNY	17	0	22	0	0%
		B 007A2	180 Cell	12	10	0	22	IV	SNY	18	0	22	0	0%
		B 007B1	180 Cell	11	9	0	20	IV	SNY	17	10	8	2	91%
		B 007B2	180 Cell	10	10	0	20	IV	SNY	15	11	7	2	110%
		B 007C1	180 Cell	12	10	0	22	IV	SNY	18	0	20	0	0%
		B 007C2	180 Cell	11	11	0	22	IV	SNY	17	0	22	0	0%
	008	B 008A1	180 Cell	11	11	0	22	NA	ASU	14	10	11	1	91%
		B 008A2	180 Cell	11	11	0	22	NA	ASU	14	11	9	2	100%
		B 008B1	180 Cell	10	10	0	20	NA	ASU	13	8	12	0	80%
		B 008B2	180 Cell	10	10	0	20	NA	ASU	13	11	6	3	110%
		B 008C1	180 Cell	10	10	0	20	NA	ASU	13	9	9	2	90%
		B 008C2	180 Cell	10	10	0	20	NA	ASU	13	13	6	1	130%
	INF	B INF 1	Cell	16	0	0	16	NA	OHU	16	4	1	0	25%
CCI-Facility B Total				**531**	**485**	**0**	**1016**			**773**	**515**	**403**	**63**	**97%**
CCI-Facility C	001	C 001 1	270 Cell	50	50	0	100	III	VAR	75	0	98	0	0%
		C 001 2	270 Cell	50	50	0	100	III	VAR	75	0	96	0	0%
	002	C 002 1	270 Cell	50	50	0	100	III	SNY	75	60	36	2	120%
		C 002 2	270 Cell	50	50	0	100	III	SNY	75	72	27	1	144%
	003	C 003 1	270 Cell	51	49	0	100	III	SNY	77	79	17	4	155%
		C 003 2	270 Cell	50	50	0	100	III	SNY	75	82	13	3	164%
	004	C 004 1	270 Cell	50	50	0	100	III	SNY	75	80	16	4	160%
		C 004 2	270 Cell	50	50	0	100	III	SNY	75	83	10	5	166%
	005	C 005 1	270 Cell	50	50	0	100	III	SNY	75	69	23	5	138%
		C 005 2	270 Cell	51	49	0	100	III	SNY	77	78	17	5	153%
CCI-Facility C Total				**502**	**498**	**0**	**1000**			**753**	**603**	**353**	**29**	**120%**
CCI-Facility D	009	D 009E1	Cell	15	9	0	24	NA	VAR	15	0	24	0	0%
		D 009W1	Cell	24	0	0	24	NA	VAR	24	0	24	0	0%
	DORM 1	D 00111	Dorm	83	83	0	166	II	PF	125	124	42	0	149%
	DORM 2	D 00121	Dorm	83	83	0	166	II	PF	125	130	36	0	157%
	DORM 3	D 00132	Dorm	80	80	0	160	II	PF	120	102	58	0	127%
	DORM 4	D 00142	Dorm	80	80	0	160	II	PF	120	104	56	0	130%
	DORM 5	D 00251	Dorm	83	83	0	166	II	PF	125	104	62	0	125%
	DORM 6	D 00261	Dorm	83	83	0	166	II	PF	125	105	61	0	127%
	DORM 7	D 00272	Dorm	80	80	0	160	II	PF	120	113	47	0	141%
	DORM 8	D 00282	Dorm	81	80	0	161	II	PF	122	106	54	0	131%
CCI-Facility D Total				**692**	**661**	**0**	**1353**			**1019**	**888**	**464**	**0**	**128%**
CCI-Facility E	Briggs Hall	E BH 1	Dorm	136	63	0	199	I	PF	204	98	101	0	72%
	Clark Hall	E CHL 1	Dorm	83	83	0	166	I	PF	125	0	166	0	0%
		E CHU 2	Dorm	83	83	0	166	I	PF	125	0	166	0	0%
	Davis Hall	E DHL 1	Dorm	27	23	0	50	I	VAR	41	32	18	0	119%
		E DHU 2	Dorm	22	22	0	44	I	VAR	33	1	43	0	5%
	Rex Deal	E RD 1	Dorm	52	52	0	104	I	PF	78	0	104	0	0%
	Van Weston	E VWL 1	Dorm	51	51	0	102	I	PF	77	66	36	0	129%
		E VWU 2	Dorm	67	49	0	116	I	PF	101	59	56	0	88%
	Willard Hall	E WHL 1	Dorm	33	30	0	63	I	PF	50	0	63	0	0%
		E WHU 2	Dorm	21	21	0	42	I	PF	32	0	42	0	0%
CCI-Facility E Total				**575**	**477**	**0**	**1052**			**863**	**256**	**795**	**0**	**45%**
Grand Total				**2822**	**2607**	**0**	**5429**			**4186**	**2781**	**2441**	**145**	**99%**

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CCWF Female Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CCWF-Central Service	FIR	S FIR 1	Dorm	10	0	0	10	I	FH	10	4	6	0	40%
	INF	S INF 1	Cell	2	0	24	26	NA	CTC	2	22	4	0	1100%
				11	0	1	12		MCB	11	6	6	0	55%
CCWF-Central Service Total				**23**	**0**	**25**	**48**			**23**	**32**	**16**	**0**	**139%**
CCWF-Facility A	501	A 501 1	Dorm	127	127	0	254	NA	RC	191	123	130	0	97%
	502	A 502 1	Dorm	128	128	0	256	NA	RC	192	116	139	0	91%
	503	A 503 1	270 Cell	50	50	0	100	NA	VAR	75	65	34	0	130%
		A 503 2	270 Cell	50	50	0	100	NA	VAR	75	81	19	0	162%
	504	A 504 1	270 Cell	31	31	0	62	NA	ASU	39	30	28	4	97%
				19	19	0	38		DR	19	17	21	0	89%
		A 504 2	270 Cell	45	45	0	90	NA	ASU	56	52	33	5	116%
				5	5	0	10		DR	5	0	10	0	0%
CCWF-Facility A Total				**455**	**455**	**0**	**910**			**652**	**484**	**414**	**9**	**106%**
CCWF-Facility B	505	B 505 1	Dorm	119	119	0	238	NA	GP	179	52	186	0	44%
	506	B 506 1	Dorm	128	128	0	256	NA	GP	192	146	110	0	114%
	507	B 507 1	Dorm	128	128	0	256	NA	GP	192	195	61	0	152%
	508	B 508 1	Dorm	78	42	0	120	NA	EOP	117	54	66	0	69%
				48	48	0	96		GP	72	12	84	0	25%
CCWF-Facility B Total				**501**	**465**	**0**	**966**			**752**	**459**	**507**	**0**	**92%**
CCWF-Facility C	509	C 509 1	Dorm	128	128	0	256	NA	GP	192	185	71	0	145%
	510	C 510 1	Dorm	128	128	0	256	NA	GP	192	176	80	0	138%
	511	C 511 1	Dorm	128	128	0	256	NA	GP	192	185	71	0	145%
	512	C 512 1	Dorm	128	128	0	256	NA	GP	192	164	92	0	128%
CCWF-Facility C Total				**512**	**512**	**0**	**1024**			**768**	**710**	**314**	**0**	**139%**
CCWF-Facility D	513	D 513 1	Dorm	128	128	0	256	NA	GP	192	212	44	0	166%
	514	D 514 1	Dorm	128	128	0	256	NA	GP	192	186	70	0	145%
	515	D 515 1	Dorm	128	128	0	256	NA	GP	192	185	71	0	145%
	516	D 516 1	Dorm	128	128	0	256	NA	GP	192	119	130	7	93%
CCWF-Facility D Total				**512**	**512**	**0**	**1024**			**768**	**702**	**315**	**7**	**137%**
Grand Total				**2003**	**1944**	**25**	**3972**			**2962**	**2387**	**1566**	**16**	**119%**

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CEN Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CEN-AD SEG	001	Z 001 1	Cell	100	100	0	200	NA	ASU	125	72	103	25	72%
CEN-AD SEG Total				**100**	**100**	**0**	**200**			**125**	**72**	**103**	**25**	**72%**
CEN-Central Service	INF	S INF 1	Cell	0	0	13	13	NA	CTC	0	6	6	0	
CEN-Central Service Total				**0**	**0**	**13**	**13**			**0**	**6**	**6**	**0**	
CEN-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	GP	75	75	24	1	150%
		A 001 2	270 Cell	50	50	0	100	III	GP	75	78	20	0	156%
	002	A 002 1	270 Cell	50	50	0	100	III	GP	75	71	26	2	142%
		A 002 2	270 Cell	50	50	0	100	III	GP	75	79	21	0	158%
	003	A 003 1	270 Cell	50	50	0	100	III	GP	75	70	29	1	140%
		A 003 2	270 Cell	50	50	0	100	III	GP	75	63	35	2	126%
	004	A 004 1	270 Cell	51	49	0	100	III	GP	77	53	44	0	104%
		A 004 2	270 Cell	50	50	0	100	III	GP	75	94	6	0	188%
	005	A 005 1	270 Cell	50	50	0	100	III	VAR	75	2	98	0	4%
		A 005 2	270 Cell	50	50	0	100	III	VAR	75	0	100	0	0%
CEN-Facility A Total				**501**	**499**	**0**	**1000**			**752**	**585**	**403**	**6**	**117%**
CEN-Facility B	001	B 001 1	270 Cell	50	50	0	100	III	GP	75	73	27	0	146%
		B 001 2	270 Cell	50	50	0	100	III	GP	75	83	16	1	166%
	002	B 002 1	270 Cell	50	50	0	100	III	GP	75	81	17	2	162%
		B 002 2	270 Cell	50	50	0	100	III	GP	75	93	5	2	186%
	003	B 003 1	270 Cell	50	50	0	100	III	GP	75	75	24	1	150%
		B 003 2	270 Cell	50	50	0	100	III	GP	75	86	10	4	172%
	004	B 004 1	270 Cell	50	50	0	100	III	GP	75	11	89	0	22%
		B 004 2	270 Cell	50	50	0	100	III	GP	75	9	91	0	18%
	005	B 005 1	270 Cell	50	50	0	100	III	GP	75	86	14	0	172%
		B 005 2	270 Cell	50	50	0	100	III	GP	75	93	7	0	186%
CEN-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**690**	**300**	**10**	**138%**
CEN-Facility C	001	C 001 1	270 Cell	50	50	0	100	IV	GP	75	70	28	2	140%
		C 001 2	270 Cell	50	50	0	100	IV	GP	75	77	20	3	154%
	002	C 002 1	270 Cell	50	50	0	100	IV	GP	75	66	25	4	132%
		C 002 2	270 Cell	50	50	0	100	IV	GP	75	83	14	3	166%
	003	C 003 1	270 Cell	50	50	0	100	IV	GP	75	78	20	0	156%
		C 003 2	270 Cell	50	50	0	100	IV	GP	75	79	19	2	158%
	004	C 004 1	270 Cell	50	50	0	100	IV	GP	75	73	26	1	146%
		C 004 2	270 Cell	50	50	0	100	IV	GP	75	89	9	2	178%
	005	C 005 1	270 Cell	50	50	0	100	IV	GP	75	73	24	1	146%
		C 005 2	270 Cell	50	50	0	100	IV	GP	75	82	17	1	164%
CEN-Facility C Total				**500**	**500**	**0**	**1000**			**750**	**770**	**202**	**19**	**154%**
CEN-Facility D	001	D 001 1	270 Cell	50	50	0	100	III	SNY	75	86	11	3	172%
		D 001 2	270 Cell	50	50	0	100	III	SNY	75	90	5	5	180%
	002	D 002 1	270 Cell	50	50	0	100	III	SNY	75	91	6	3	182%
		D 002 2	270 Cell	50	50	0	100	III	SNY	75	85	14	1	170%
	003	D 003 1	270 Cell	50	50	0	100	III	SNY	75	85	14	1	170%
		D 003 2	270 Cell	50	50	0	100	III	SNY	75	94	4	2	188%
	004	D 004 1	270 Cell	50	50	0	100	III	SNY	75	73	21	2	146%
		D 004 2	270 Cell	50	50	0	100	III	SNY	75	75	25	0	150%
	005	D 005 1	270 Cell	50	50	0	100	III	VAR	75	13	87	0	26%
		D 005 2	270 Cell	50	50	0	100	III	VAR	75	10	90	0	20%
CEN-Facility D Total				**500**	**500**	**0**	**1000**			**750**	**702**	**277**	**17**	**140%**
CEN-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	40	160	0	40%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	41	159	0	41%
	FIR	M FIR 1	Dorm	8	0	0	8	I	FH	8	6	2	0	75%
CEN-MSF Total				**208**	**200**	**0**	**408**			**308**	**87**	**321**	**0**	**42%**
Grand Total				**2309**	**2299**	**13**	**4621**			**3435**	**2912**	**1612**	**77**	**126%**

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CHCF Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CHCF-Facility A	Building 301	A 301A1	Cell	30	0	0	30	NA	MCB	30	22	8	0	73%
		A 301B1	Cell	30	0	0	30	NA	MCB	30	0	30	0	0%
	Building 302	A 302A1	Cell	39	0	0	39	NA	ACU	39	35	4	0	90%
		A 302B1	Cell	20	0	0	20	NA	MCB	20	2	18	0	10%
				18	0	0	18		PIP	18	12	6	0	67%
	Building 304	A 304 1	Cell	94	0	0	94	II	PF	94	70	20	2	74%
		A 304 2	Cell	100	2	0	102	II	PF	100	92	7	3	92%
CHCF-Facility A Total				**331**	**2**	**0**	**333**			**331**	**233**	**93**	**5**	**70%**
CHCF-Facility B	Building 301	B 301A1	Cell	18	0	0	18	NA	ACU	18	12	6	0	67%
				12	0	0	12		ICF	12	10	1	0	83%
		B 301B1	Cell	25	0	0	25	NA	PIP	25	24	1	0	96%
	Building 302	B 302A1	Cell	30	0	0	30	NA	ACU	30	26	4	0	87%
		B 302B1	Cell	30	0	0	30	NA	ACU	30	21	8	0	70%
	Building 303	B 303A1	Cell	30	0	0	30	NA	ICF	30	29	1	0	97%
		B 303B1	Cell	30	0	0	30	NA	ICF	30	29	1	0	97%
	Building 304	B 304A1	Cell	30	0	0	30	NA	ACU	30	28	2	0	93%
		B 304B1	Cell	30	0	0	30	NA	ICF	30	30	0	0	100%
	Building 305	B 305A1	Cell	30	0	0	30	NA	ICF	30	30	0	0	100%
		B 305B1	Cell	30	0	0	30	NA	ICF	30	28	2	0	93%
	Building 306	B 306A1	Cell	30	0	0	30	NA	ICF	30	28	2	0	93%
		B 306B1	Cell	30	0	0	30	NA	ICF	30	29	1	0	97%
	Building 307	B 307A1	Cell	30	0	0	30	NA	ICF	30	29	1	0	97%
		B 307B1	Cell	30	0	0	30	NA	ICF	30	29	1	0	97%
	Building 308	B 308A1	Cell	30	0	0	30	NA	ICF	30	30	0	0	100%
		B 308B1	Cell	30	0	0	30	NA	ICF	30	28	2	0	93%
CHCF-Facility B Total				**475**	**0**	**0**	**475**			**475**	**440**	**33**	**0**	**93%**
CHCF-Facility C	Building 301	C 301A1	Cell	6	0	0	6	NA	OHU	6	6	0	0	100%
			Dorm	44	0	0	44	NA	OHU	44	44	0	0	100%
		C 301B1	Cell	6	0	0	6	NA	OHU	6	5	1	0	83%
			Dorm	44	0	0	44	NA	OHU	44	41	3	0	93%
	Building 302	C 302A1	Cell	48	0	0	48	NA	OHU	48	48	0	0	100%
		C 302B1	Cell	48	0	0	48	NA	OHU	48	47	1	0	98%
	Building 303	C 303A1	Cell	48	0	0	48	NA	OHU	48	43	4	0	90%
		C 303B1	Cell	48	0	0	48	NA	OHU	48	47	0	0	98%
	Building 304	C 304A1	Cell	6	0	0	6	NA	OHU	6	5	1	0	83%
			Dorm	44	0	0	44	NA	OHU	44	43	1	0	98%
		C 304B1	Cell	6	0	0	6	NA	OHU	6	6	0	0	100%
			Dorm	44	0	0	44	NA	OHU	44	40	3	0	91%
	Building 305	C 305A1	Cell	6	0	0	6	NA	OHU	6	6	0	0	100%
			Dorm	44	0	0	44	NA	OHU	44	43	1	0	98%
		C 305B1	Cell	6	0	0	6	NA	OHU	6	6	0	0	100%
			Dorm	44	0	0	44	NA	OHU	44	43	0	0	98%
	Building 306	C 306A1	Cell	6	0	0	6	NA	OHU	6	6	0	0	100%
			Dorm	44	0	0	44	NA	OHU	44	39	2	0	89%
		C 306B1	Cell	6	0	0	6	NA	OHU	6	6	0	0	100%
			Dorm	44	0	0	44	NA	OHU	44	39	4	0	89%
CHCF-Facility C Total				**592**	**0**	**0**	**592**			**592**	**563**	**21**	**0**	**95%**
CHCF-Facility D	Building 301	D 301A1	Cell	30	0	0	30	NA	CTC	30	27	0	0	90%
		D 301B1	Cell	30	0	0	30	NA	CTC	30	28	2	0	93%
	Building 302	D 302A1	Cell	30	0	0	30	NA	CTC	30	29	0	0	97%
		D 302B1	Cell	30	0	0	30	NA	CTC	30	30	0	0	100%
	Building 303	D 303A1	Cell	30	0	0	30	NA	CTC	30	27	1	0	90%
		D 303B1	Cell	30	0	0	30	NA	CTC	30	29	1	0	97%
	Building 304	D 304A1	Cell	30	0	0	30	NA	CTC	30	29	0	0	97%
		D 304B1	Cell	30	0	0	30	NA	CTC	30	30	0	0	100%
	Building 305	D 305A1	Cell	30	0	0	30	NA	CTC	30	27	1	0	90%
		D 305B1	Cell	30	0	0	30	NA	CTC	30	29	0	0	97%
	Building 306	D 306A1	Cell	30	0	0	30	NA	CTC	30	30	0	0	100%
		D 306B1	Cell	30	0	0	30	NA	CTC	30	29	1	0	97%
	Building 307	D 307A1	Cell	30	0	0	30	NA	OHU	30	24	6	0	80%
		D 307B1	Cell	30	0	0	30	NA	OHU	30	21	8	0	70%
CHCF-Facility D Total				**420**	**0**	**0**	**420**			**420**	**389**	**20**	**0**	**93%**
CHCF-Facility E	301	E 301A1	Cell	25	0	0	25	NA	ASU	25	3	22	0	12%
		E 301A2	Cell	25	0	0	25	NA	ASU	25	8	17	0	32%
		E 301B1	Cell	40	10	0	50	II	EOP	40	11	36	1	28%
		E 301B2	Cell	35	15	0	50	II	EOP	35	13	37	0	37%
		E 301C1	Cell	42	0	0	42	II	EOP	42	27	13	1	64%
		E 301C2	Cell	35	15	0	50	II	EOP	35	26	19	5	74%
		E 301D1	Cell	40	2	0	42	II	EOP	40	27	11	3	68%
		E 301D2	Cell	35	15	0	50	II	EOP	35	31	17	2	89%
		E 301E1	Cell	40	8	0	48	II	EOP	40	27	15	6	68%
		E 301E2	Cell	35	15	0	50	II	EOP	35	32	16	2	91%

Generated by :
JERRY.GOLD

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CHCF-Facility E	301	E 301F1	Cell	40	8	0	48	II	EOP	40	26	20	1	65%
		E 301F2	Cell	35	15	0	50	II	EOP	35	23	24	1	66%
	302	E 302A1	Dorm	88	0	0	88	II	PF	88	80	8	0	91%
		E 302B1	Dorm	89	0	0	89	II	PF	89	65	23	0	73%
	303	E 303A1	Dorm	88	0	0	88	II	PF	88	64	24	0	73%
		E 303B1	Dorm	89	0	0	89	II	PF	89	58	17	0	65%
	304	E 304A1	Dorm	88	0	0	88	II	PF	88	68	20	0	77%
		E 304B1	Dorm	89	0	0	89	II	PF	89	76	12	0	85%
	305	E 305A1	Dorm	88	0	0	88	II	PF	88	63	25	0	72%
		E 305B1	Dorm	89	0	0	89	II	PF	89	57	32	0	64%
CHCF-Facility E Total				**1135**	**103**	**0**	**1238**			**1135**	**785**	**408**	**22**	**69%**
Grand Total				**2953**	**105**	**0**	**3058**			**2953**	**2410**	**575**	**27**	**82%**

Generated by :
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CIM Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CIM-Facility A	Angeles	A AH 1	Dorm	80	80	0	160	II	PF	120	81	27	0	101%
	Borrego	A BH 1	Dorm	80	80	0	160	II	PF	120	83	23	0	104%
	Cleveland	A CH 1	Dorm	80	80	0	160	II	PF	120	82	23	0	102%
	Joshua	A JH 1	Dorm	80	80	0	160	II	PF	120	72	32	0	90%
	Laguna	A LH 1	Dorm	80	80	0	160	II	PF	120	80	28	0	100%
	Mariposa	A MH 1	Dorm	80	80	0	160	II	PF	120	87	27	0	109%
	Otay	A OH 1	Dorm	80	80	0	160	II	PF	120	81	26	0	101%
	Sequoia	A SH 1	Dorm	80	80	0	160	II	PF	120	83	25	0	104%
CIM-Facility A Total				**640**	**640**	**0**	**1280**			**960**	**649**	**211**	**0**	**101%**
CIM-Facility B	Birch Hall	B BH 1	Cell	50	0	0	50	II	PF	50	24	22	0	48%
		B BH 2	Cell	52	0	0	52	II	PF	52	26	25	0	50%
		B BH 3	Cell	52	0	0	52	II	PF	52	37	14	0	71%
	Cypress Hall	B CH 1	Cell	34	17	0	51	NA	VAR	51	7	43	0	21%
		B CH 2	Cell	34	34	0	68	NA	VAR	51	27	35	0	79%
		B CH 3	Cell	34	34	0	68	NA	VAR	51	0	60	0	0%
	Madrone Hall	B MH 1	Cell	35	1	0	36	II	PF	35	24	10	0	69%
		B MH 2	Cell	34	0	0	34	II	PF	34	24	7	0	71%
		B MH 3	Cell	34	0	0	34	II	PF	34	24	8	0	71%
	Palm Hall	B PH 1	Cell	32	17	0	49	NA	ASU	32	14	33	1	44%
		B PH 2	Cell	34	34	0	68	NA	ASU	34	28	39	1	82%
		B PH 3	Cell	34	34	0	68	NA	ASU	34	23	43	0	68%
	Sycamore Hall	B SH 1	Cell	31	31	0	62	II	PF	47	20	38	0	65%
		B SH 2	Cell	34	34	0	68	II	PF	51	17	51	0	50%
		B SH 3	Cell	34	34	0	68	II	PF	51	14	54	0	41%
CIM-Facility B Total				**558**	**270**	**0**	**828**			**659**	**309**	**482**	**2**	**55%**
CIM-Facility C	Alpine	C A 1	Cell	50	50	0	100	II	PF	75	93	7	0	186%
		C A 2	Cell	50	50	0	100	II	PF	75	97	2	1	194%
	Butte	C B 1	Cell	50	50	0	100	II	PF	75	88	9	1	176%
		C B 2	Cell	50	50	0	100	II	PF	75	89	9	1	178%
	Colusa	C C 1	Cell	50	50	0	100	II	PF	75	78	19	1	156%
		C C 2	Cell	50	50	0	100	II	PF	75	81	12	2	162%
	Del Norte	C DEL 1	Cell	50	50	0	100	II	VAR	75	45	43	0	90%
		C DEL 2	Cell	50	50	0	100	II	VAR	75	18	80	0	36%
CIM-Facility C Total				**400**	**400**	**0**	**800**			**600**	**589**	**181**	**6**	**147%**
CIM-Facility D	Alder	D AH 1	Dorm	100	100	0	200	I	PF	150	105	50	0	105%
	Cedar	D CH A1	Dorm	24	24	0	48	I	PF	36	0	48	0	0%
		D CH B1	Dorm	30	30	0	60	I	PF	45	0	48	0	0%
		D CH C1	Dorm	30	30	0	60	I	PF	45	0	48	0	0%
		D CH D1	Dorm	16	16	0	32	I	PF	24	0	32	0	0%
	Elm	D EH 1	Dorm	156	0	0	156	I	PF	156	76	51	0	49%
	FIR	D FIR 1	Dorm	10	0	0	10	I	FH	10	8	2	0	80%
	Infirmary	D OHU 1	Cell	34	0	0	34	NA	MCB	34	23	8	0	68%
				3	0	34	37		OHU	3	37	0	0	1233%
			Dorm	0	0	5	5	NA	OHU	0	5	0	0	
			Room	0	0	2	2	NA	OHU	0	2	0	0	
	Juniper	D JH 1	Dorm	100	100	0	200	I	PF	150	104	52	0	104%
	Magnolia	D MH 1	Dorm	100	100	0	200	I	PF	150	118	38	0	118%
	Oak	D OH A1	Dorm	20	20	0	40	I	PF	30	0	40	0	0%
		D OH B1	Dorm	30	30	0	60	I	PF	45	0	60	0	0%
		D OH C1	Dorm	30	30	0	60	I	PF	45	0	60	0	0%
		D OH D1	Dorm	20	20	0	40	I	PF	30	0	40	0	0%
	South Dorm	D SD N1	Cell	26	26	0	52	I	PF	39	18	34	0	69%
		D SD S1	Cell	26	26	0	52	I	PF	39	19	33	0	73%
	Spruce Hall	D SH 1	Dorm	100	100	0	200	I	PF	150	108	48	0	108%
	West Dorm	D WD N1	Cell	56	56	0	112	I	PF	84	0	108	0	0%
		D WD N2	Cell	56	56	0	112	I	PF	84	52	58	0	93%
		D WD S1	Cell	56	56	0	112	I	PF	84	56	56	0	100%
		D WD S2	Cell	56	56	0	112	I	PF	84	52	60	0	93%
	Willow	D WH 1	Dorm	100	100	0	200	I	PF	150	102	54	0	102%
CIM-Facility D Total				**1179**	**976**	**41**	**2196**			**1667**	**885**	**1028**	**0**	**75%**
Grand Total				**2777**	**2286**	**41**	**5104**			**3886**	**2432**	**1902**	**8**	**88%**

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CIW Female Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CIW-CAMPS	001	X13001 1	Dorm	100	0	0	100	I	CMP	100	20	80	0	20%
		X14001 1	Dorm	120	0	0	120	I	CMP	120	22	98	0	18%
CIW-CAMPS Total				**220**	**0**	**0**	**220**			**220**	**42**	**178**	**0**	**19%**
CIW-Central Service	INF	S INF 1	Cell	6	0	2	8	NA	CTC	6	7	0	0	117%
				0	0	10	10		MCB	0	2	8	0	
	Psychiatric Inpatient Program	S PIPA1	Cell	21	0	0	21	NA	PIP	21	12	9	0	57%
		S PIPB1	Cell	24	0	0	24	NA	PIP	24	8	16	0	33%
CIW-Central Service Total				**51**	**0**	**12**	**63**			**51**	**29**	**33**	**0**	**57%**
CIW-Facility A	Barneberg	A BAUA1	Cell	60	60	0	120	NA	GP	90	81	9	1	135%
		A BAUB1	Cell	60	60	0	120	NA	GP	90	77	38	0	128%
	Emmons	A EMUA1	Cell	60	60	0	120	NA	GP	90	77	43	0	128%
		A EMUB1	Cell	60	60	0	120	NA	GP	90	69	39	1	115%
	GP Hall	A RCU 1	Cell	110	110	0	220	NA	VAR	165	0	216	0	0%
	Harrison	A HAUA1	Cell	60	60	0	120	NA	GP	90	88	29	0	147%
		A HAUB1	Cell	60	60	0	120	NA	GP	90	46	74	0	77%
	Latham	A LAUA1	Cell	60	60	0	120	NA	GP	90	81	38	1	135%
		A LAUB1	Cell	60	60	0	120	NA	GP	90	75	45	0	125%
	Miller	A MIUA1	Cell	60	60	0	120	NA	GP	90	82	33	0	137%
		A MIUB1	Cell	60	60	0	120	NA	GP	90	6	98	0	10%
	OPU	A OPU 1	Cell	14	0	0	14	NA	OHU	14	5	8	0	36%
			Dorm	2	0	0	2	NA	OHU	2	0	2	0	0%
	SHU	A SHU 1	270 Cell	33	33	0	66	NA	ASU	41	3	58	0	9%
				17	17	0	34		SHU	20	6	28	0	35%
		A SHU 2	270 Cell	33	33	0	66	NA	ASU	41	0	66	0	0%
				17	17	0	34		SHU	20	0	34	0	0%
	Support Care	A SCU 1	Cell	47	47	0	94	NA	EOP	71	38	49	5	81%
		A SCUB1	Cell	10	0	0	10	NA	ASU	10	2	8	0	20%
				10	0	0	10		PSU	10	4	6	0	40%
	WIU	A WIUA1	Cell	59	61	0	120	NA	GP	89	79	35	2	134%
		A WIUB1	Cell	59	61	0	120	NA	GP	89	79	39	0	134%
	Walker Unit	A WAU 1	Cell	2	0	17	19	NA	MCB	2	2	17	0	100%
CIW-Facility A Total				**1013**	**979**	**17**	**2009**			**1474**	**900**	**1012**	**10**	**89%**
Grand Total				**1284**	**979**	**29**	**2292**			**1745**	**971**	**1223**	**10**	**76%**

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CMC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CMC-Central Service	HOS	S HOS 1	Cell	0	0	15	15	NA	CTC	0	13	1	0	
			Dorm	0	0	22	22	NA	CTC	0	19	3	0	
CMC-Central Service Total				**0**	**0**	**37**	**37**			**0**	**32**	**4**	**0**	
CMC-Facility A	001	A 001 1	Cell	100	0	0	100	III	PF	100	59	35	0	59%
		A 001 2	Cell	100	0	0	100	III	PF	100	52	33	0	52%
		A 001 3	Cell	100	0	0	100	III	PF	100	59	36	0	59%
	002	A 002 1	Cell	100	0	0	100	III	PF	100	81	17	0	81%
		A 002 2	Cell	100	0	0	100	III	PF	100	56	44	0	56%
		A 002 3	Cell	100	0	0	100	III	PF	100	71	29	0	71%
CMC-Facility A Total				**600**	**0**	**0**	**600**			**600**	**378**	**194**	**0**	**63%**
CMC-Facility B	003	B 003 1	Cell	100	0	0	100	III	PF	100	73	23	0	73%
		B 003 2	Cell	100	0	0	100	III	PF	100	75	24	0	75%
		B 003 3	Cell	100	0	0	100	III	PF	100	75	22	0	75%
	004	B 004 1	Cell	97	0	0	97	NA	ASU	97	33	64	0	34%
		B 004 2	Cell	90	0	0	90	NA	ASU	90	33	51	0	37%
		B 004 3	Cell	94	0	0	94	NA	ASU	94	26	63	0	28%
CMC-Facility B Total				**581**	**0**	**0**	**581**			**581**	**315**	**247**	**0**	**54%**
CMC-Facility C	005	C 005 1	Cell	100	0	0	100	III	VAR	100	4	94	0	4%
		C 005 2	Cell	100	0	0	100	III	VAR	100	22	74	0	22%
		C 005 3	Cell	100	0	0	100	III	VAR	100	3	96	0	3%
	006	C 006 1	Cell	100	0	0	100	III	PF	100	93	3	0	93%
		C 006 2	Cell	100	0	0	100	III	PF	100	91	6	0	91%
		C 006 3	Cell	100	0	0	100	III	PF	100	87	6	0	87%
CMC-Facility C Total				**600**	**0**	**0**	**600**			**600**	**300**	**279**	**0**	**50%**
CMC-Facility D	007	D 007 1	Cell	52	0	0	52	II	EOP	52	37	12	0	71%
				40	0	0	40	III	PF	40	0	1	0	0%
		D 007 2	Cell	100	0	0	100	II	EOP	100	97	2	0	97%
		D 007 3	Cell	100	0	0	100	II	EOP	100	99	0	0	99%
	008	D 008 1	Cell	100	0	0	100	III	EOP	100	74	24	0	74%
		D 008 2	Cell	100	0	0	100	III	EOP	100	89	6	0	89%
		D 008 3	Cell	100	0	0	100	III	EOP	100	92	2	0	92%
CMC-Facility D Total				**592**	**0**	**0**	**592**			**592**	**488**	**47**	**0**	**82%**
CMC-Facility E	001	E 001 1	Dorm	44	29	0	73	II	PF	66	58	7	0	132%
	003	E 003 1	Dorm	45	29	0	74	II	PF	45	58	7	0	129%
	004	E 004 1	Dorm	48	28	0	76	II	PF	48	60	5	0	125%
	005	E 005 1	Dorm	41	27	0	68	II	PF	62	55	10	0	134%
	006	E 006 1	Dorm	43	30	0	73	II	PF	65	58	7	0	135%
	007	E 007 1	Dorm	37	28	0	65	II	PF	56	60	5	0	162%
	008	E 008 1	Dorm	37	28	0	65	II	PF	56	57	8	0	154%
	009	E 009 1	Dorm	40	28	0	68	II	PF	60	57	8	0	143%
	010	E 010 1	Dorm	49	26	0	75	II	PF	74	59	6	0	120%
CMC-Facility E Total				**384**	**253**	**0**	**637**			**530**	**522**	**63**	**0**	**136%**
CMC-Facility F	011	F 011 1	Dorm	37	28	0	65	II	PF	56	47	18	0	127%
	012	F 012 1	Dorm	41	28	0	69	II	PF	62	53	15	0	129%
	013	F 013 1	Dorm	41	28	0	69	II	PF	62	56	13	0	137%
	014	F 014 1	Dorm	41	28	0	69	II	PF	62	58	11	0	141%
	015	F 015 1	Dorm	41	29	0	70	II	PF	62	57	12	0	139%
	016	F 016 1	Dorm	41	28	0	69	II	PF	62	61	8	0	149%
	017	F 017 1	Dorm	41	28	0	69	II	PF	62	55	10	0	134%
	018	F 018 1	Dorm	41	28	0	69	II	PF	62	55	14	0	134%
	019	F 019 1	Dorm	41	28	0	69	II	PF	62	61	8	0	149%
	020	F 020 1	Dorm	41	28	0	69	II	PF	62	60	9	0	146%
CMC-Facility F Total				**406**	**281**	**0**	**687**			**609**	**563**	**118**	**0**	**139%**
CMC-Facility G	022	G 022 1	Dorm	45	12	0	57	II	PF	68	49	4	0	109%
	023	G 023 1	Dorm	45	14	0	59	II	PF	68	53	2	0	118%
	024	G 024 1	Dorm	45	29	0	74	II	PF	68	52	17	0	116%
	025	G 025 1	Dorm	45	31	0	76	II	PF	68	60	9	0	133%
	026	G 026 1	Dorm	44	30	0	74	II	PF	66	65	3	0	148%
	027	G 027 1	Dorm	43	0	0	43	II	PF	65	36	3	0	84%
	028	G 028 1	Dorm	33	0	0	33	II	PF	33	24	5	0	73%
CMC-Facility G Total				**300**	**116**	**0**	**416**			**434**	**339**	**43**	**0**	**113%**
CMC-Facility H	Building 001	H 001A1	Cell	25	0	0	25	NA	MCB	25	16	9	0	64%
		H 001B1	Cell	13	0	0	13	NA	MCB	13	10	3	0	77%
				12	0	0	12		PIP	12	9	3	0	75%
CMC-Facility H Total				**50**	**0**	**0**	**50**			**50**	**35**	**15**	**0**	**70%**
CMC-MSF	030	M 030 1	Dorm	37	8	0	45	I	WC	56	31	14	0	84%
	031	M 031 1	Dorm	37	7	0	44	I	WC	56	0	44	0	0%
	032	M 032 1	Dorm	37	7	0	44	I	WC	56	17	27	0	46%
	033	M 033 1	Dorm	28	5	0	33	I	WC	42	24	9	0	86%
	034	M 034 1	Dorm	28	5	0	33	I	WC	42	28	5	0	100%
	FIR	M FIR 1	Dorm	12	0	0	12	I	FH	12	3	9	0	25%
CMC-MSF Total				**179**	**32**	**0**	**211**			**263**	**103**	**108**	**0**	**58%**

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
Grand Total				**3692**	**682**	**37**	**4411**			**4258**	**3075**	**1118**	**0**	**83%**

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CMF Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CMF-Central Service	CTC	S CTCA1	Cell	25	0	0	25	NA	MCB	25	25	0	0	100%
		S CTCB1	Cell	25	0	0	25	NA	MCB	25	23	2	0	92%
CMF-Central Service Total				**50**	**0**	**0**	**50**			**50**	**48**	**2**	**0**	**96%**
CMF-Facility A	A	A A 2	Dorm	44	0	0	44	NA	ICF	44	37	7	0	84%
		A A 3	Dorm	40	0	0	40	NA	ICF	40	24	16	0	60%
	G	A G 1	Cell	16	0	0	16	NA	CTC	16	15	0	0	94%
			Dorm	11	0	0	11	NA	CTC	11	10	1	0	91%
		A G 2	Cell	16	0	0	16	NA	CTC	16	16	0	0	100%
			Dorm	12	0	0	12	NA	CTC	12	11	1	0	92%
		A G 3	Cell	17	0	0	17	NA	OHU	17	17	0	0	100%
			Dorm	30	0	0	30	NA	OHU	30	29	1	0	97%
	H	A H 1	Cell	21	0	0	21	III	VAR	23	19	2	0	90%
			Dorm	22	14	0	36	III	VAR	33	0	36	0	0%
		A H 2	Cell	21	21	0	42	III	PF	23	3	31	0	14%
			Dorm	30	20	0	50	III	PF	45	0	1	0	0%
		A H 3	Cell	21	21	0	42	III	PF	23	21	11	10	100%
			Dorm	30	20	0	50	III	PF	45	36	4	0	120%
	I	A I 1	Cell	36	38	0	74	III	VAR	40	0	73	0	0%
			Dorm	10	2	0	12	III	VAR	15	0	12	0	0%
		A I 2	Cell	38	38	0	76	III	PF	42	35	31	9	92%
			Dorm	6	0	0	6	III	PF	9	5	1	0	83%
		A I 3	Cell	38	0	0	38	NA	ASU	38	24	14	0	63%
	J	A J 1	Dorm	92	46	0	138	II	PF	138	95	7	0	103%
		A J 2	Dorm	76	38	0	114	II	PF	114	92	7	0	121%
		A J 3	Dorm	76	38	0	114	II	PF	114	95	2	0	125%
	L	A L 1	Cell	29	27	0	56	NA	ICF	29	45	11	0	155%
				6	6	0	12		PIP	6	6	6	0	100%
		A L 2	Cell	38	38	0	76	II	EOP	57	65	7	4	171%
		A L 3	Cell	37	0	0	37	II	EOP	56	37	0	0	100%
	M	A M 1	Cell	37	37	0	74	II	EOP	56	62	9	3	168%
		A M 2	Cell	38	38	0	76	II	EOP	57	62	10	2	163%
		A M 3	Cell	38	0	0	38	NA	ASU	38	18	20	0	47%
	N	A N 1	Cell	36	37	0	73	II	EOP	54	53	9	11	147%
		A N 2	Cell	38	38	0	76	II	EOP	57	62	9	3	163%
		A N 3	Cell	39	36	0	75	II	EOP	59	59	11	5	151%
	P	A P 1	Cell	32	0	0	32	NA	ACU	32	28	4	0	88%
		A P 2	Cell	36	0	0	36	NA	ACU	36	29	7	0	81%
		A P 3	Cell	30	0	0	30	NA	ICF	30	30	0	0	100%
	Q	A Q 1	Cell	29	0	0	29	NA	ACU	29	29	0	0	100%
		A Q 2	Cell	31	0	0	31	NA	ACU	31	29	2	0	94%
		A Q 3	Cell	30	0	0	30	NA	ACU	30	27	3	0	90%
	R	A R 1	Dorm	26	16	0	42	II	PF	39	23	1	0	88%
	S	A S 1	Cell	30	0	0	30	NA	ACU	30	30	0	0	100%
		A S 2	Cell	30	0	0	30	NA	ACU	30	30	0	0	100%
		A S 3	Cell	18	0	0	18	NA	VAR	18	0	18	0	0%
	T	A T 1	Cell	42	0	0	42	III	PF	46	38	4	0	90%
		A T 2	Cell	58	0	0	58	III	PF	64	51	7	0	88%
		A T 3	Cell	58	0	0	58	III	PF	64	27	31	0	47%
	U	A U 1	Cell	40	0	0	40	III	PF	44	30	10	0	75%
		A U 2	Cell	58	0	0	58	III	PF	64	44	14	0	76%
		A U 3	Cell	58	0	0	58	III	PF	64	34	24	0	59%
	V	A V 1	Cell	42	0	0	42	III	PF	46	36	6	0	86%
		A V 2	Cell	58	0	0	58	III	PF	64	48	10	0	83%
		A V 3	Cell	58	0	0	58	III	PF	64	43	14	0	74%
	W	A W 1	Cell	41	0	0	41	NA	VAR	41	12	28	0	29%
		A W 2	Cell	42	0	0	42	NA	ASU	42	10	32	0	24%
		A W 3	Cell	42	0	0	42	NA	VAR	42	0	42	0	0%
	X	A X 1	Cell	4	0	0	4	NA	HSP	4	3	1	0	75%
			Dorm	13	0	0	13	NA	HSP	13	13	0	0	100%
	Y	A Y 1	Dorm	21	21	0	42	III	PF	31	18	23	0	86%
CMF-Facility A Total				**1966**	**590**	**0**	**2556**			**2351**	**1715**	**631**	**47**	**87%**
CMF-Facility B	DC	B DC 1	Dorm	100	50	0	150	II	PF	150	110	3	0	110%
	DD	B DD 1	Dorm	88	62	0	150	II	PF	132	84	21	0	95%
CMF-Facility B Total				**188**	**112**	**0**	**300**			**282**	**194**	**24**	**0**	**103%**
CMF-Facility C	HTC	C HTCA1	Cell	16	0	0	16	NA	ICF	16	16	0	0	100%
		C HTCB1	Cell	16	0	0	16	NA	ICF	16	16	0	0	100%
		C HTCC1	Cell	16	0	0	16	NA	PIP	16	5	11	0	31%
		C HTCD1	Cell	16	0	0	16	NA	PIP	16	0	16	0	0%
CMF-Facility C Total				**64**	**0**	**0**	**64**			**64**	**37**	**27**	**0**	**58%**
CMF-MSF	001	M 001 1	Dorm	18	2	0	20	I	WC	21	6	14	0	33%
	002	M 002 1	Dorm	18	3	0	21	I	WC	21	6	15	0	33%
	003	M 003 1	Dorm	18	0	0	18	I	WC	21	6	12	0	33%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CMF-MSF	004	M 004 1	Dorm	18	0	0	18	I	WC	21	0	18	0	0%
	005	M 005 1	Dorm	9	12	0	21	I	WC	10	0	20	0	0%
	FIR	M FIR 1	Dorm	9	7	0	16	I	FH	9	7	9	0	78%
CMF-MSF Total				**90**	**24**	**0**	**114**			**102**	**25**	**88**	**0**	**28%**
Grand Total				**2358**	**726**	**0**	**3084**			**2849**	**2019**	**772**	**47**	**86%**

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COR Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
COR-Central Service	INF	S INFA1	Cell	0	0	24	24	NA	CTC	0	22	1	0	
		S INFB1	Cell	0	0	26	26	NA	CTC	0	21	2	0	
		S INFC1	Cell	0	0	24	24	NA	MCB	0	10	13	0	
		S INFD1	Cell	0	0	18	18	NA	OHU	0	18	0	0	
COR-Central Service Total				**0**	**0**	**92**	**92**			**0**	**71**	**16**	**0**	
COR-Facility 03A	001	03A001 1	270 Cell	50	50	0	100	III	SNY	75	79	14	7	158%
		03A001 2	270 Cell	50	50	0	100	III	SNY	75	81	10	9	162%
	002	03A002 1	270 Cell	50	50	0	100	III	SNY	75	75	19	6	150%
		03A002 2	270 Cell	50	50	0	100	III	SNY	75	83	13	4	166%
	003	03A003 1	270 Cell	50	50	0	100	NA	ASU	63	26	49	7	52%
		03A003 2	270 Cell	50	50	0	100	NA	ASU	63	18	69	5	36%
	004	03A004 1	270 Cell	50	50	0	100	III	SNY	75	56	35	9	112%
		03A004 2	270 Cell	50	50	0	100	III	SNY	75	67	30	3	134%
	005	03A005 1	270 Cell	50	50	0	100	III	SNY	75	70	20	10	140%
		03A005 2	270 Cell	50	50	0	100	III	SNY	75	73	21	4	146%
COR-Facility 03A Total				**500**	**500**	**0**	**1000**			**725**	**628**	**280**	**64**	**126%**
COR-Facility 03B	001	03B001 1	270 Cell	50	50	0	100	II	EOP	75	72	21	7	144%
		03B001 2	270 Cell	50	50	0	100	II	EOP	75	62	17	19	124%
	002	03B002 1	270 Cell	50	50	0	100	II	VAR	75	37	63	0	74%
		03B002 2	270 Cell	50	50	0	100	II	VAR	75	18	82	0	36%
	003	03B003 1	270 Cell	50	50	0	100	II	PF	75	89	3	8	178%
		03B003 2	270 Cell	50	50	0	100	II	PF	75	95	4	1	190%
	004	03B004 1	270 Cell	50	50	0	100	II	PF	75	89	2	9	178%
		03B004 2	270 Cell	50	50	0	100	II	PF	75	93	1	6	186%
	005	03B005 1	270 Cell	50	50	0	100	II	PF	75	89	3	8	178%
		03B005 2	270 Cell	50	50	0	100	II	PF	75	99	1	0	198%
COR-Facility 03B Total				**500**	**500**	**0**	**1000**			**750**	**743**	**197**	**58**	**149%**
COR-Facility 03C	001	03C001 1	270 Cell	50	50	0	100	IV	GP	75	78	19	3	156%
		03C001 2	270 Cell	50	50	0	100	IV	GP	75	79	19	2	158%
	002	03C002 1	270 Cell	50	50	0	100	IV	GP	75	71	26	1	142%
		03C002 2	270 Cell	50	50	0	100	IV	GP	75	74	22	4	148%
	003	03C003 1	270 Cell	50	50	0	100	IV	GP	75	79	20	1	158%
		03C003 2	270 Cell	50	50	0	100	IV	GP	75	70	24	6	140%
	004	03C004 1	270 Cell	50	50	0	100	IV	GP	75	67	30	1	134%
		03C004 2	270 Cell	50	50	0	100	IV	GP	75	84	14	0	168%
	005	03C005 1	270 Cell	50	50	0	100	IV	GP	75	76	22	2	152%
		03C005 2	270 Cell	50	50	0	100	IV	GP	75	73	26	1	146%
COR-Facility 03C Total				**500**	**500**	**0**	**1000**			**750**	**751**	**222**	**21**	**150%**
COR-Facility 04A	A1L	04AA1LA1	Cell	10	10	0	20	NA	LRH	12	1	18	1	10%
		04AA1LA2	Cell	10	10	0	20	NA	LRH	12	0	20	0	0%
		04AA1LB1	Cell	10	0	0	10	IV	GP	10	10	0	0	100%
		04AA1LB2	Cell	10	10	0	20	IV	GP	15	4	12	4	40%
		04AA1LC1	Cell	12	12	0	24	NA	LRH	14	8	12	1	67%
		04AA1LC2	Cell	12	12	0	24	NA	LRH	14	8	13	3	67%
	A1R	04AA1RA1	Cell	10	10	0	20	NA	LRH	12	1	19	0	10%
		04AA1RA2	Cell	10	10	0	20	NA	LRH	12	0	20	0	0%
		04AA1RB1	Cell	10	10	0	20	NA	LRH	12	6	10	4	60%
		04AA1RB2	Cell	10	10	0	20	NA	LRH	12	8	9	3	80%
		04AA1RC1	Cell	12	12	0	24	NA	LRH	14	11	11	2	92%
		04AA1RC2	Cell	12	12	0	24	NA	LRH	14	10	13	1	83%
	A2L	04AA2LA1	Cell	11	9	0	20	NA	LRH	13	8	11	1	73%
		04AA2LA2	Cell	10	10	0	20	NA	LRH	12	7	11	2	70%
		04AA2LB1	Cell	10	10	0	20	NA	LRH	12	2	18	0	20%
		04AA2LB2	Cell	10	10	0	20	NA	LRH	12	0	20	0	0%
		04AA2LC1	Cell	12	12	0	24	NA	LRH	14	11	11	2	92%
		04AA2LC2	Cell	12	12	0	24	NA	LRH	14	10	12	2	83%
	A2R	04AA2RA1	Cell	10	10	0	20	NA	SHU	12	12	4	4	120%
		04AA2RA2	Cell	10	10	0	20	NA	SHU	12	12	6	2	120%
		04AA2RB1	Cell	10	10	0	20	NA	SHU	12	14	3	3	140%
		04AA2RB2	Cell	10	10	0	20	NA	SHU	12	14	5	1	140%
		04AA2RC1	Cell	12	12	0	24	NA	THU	18	6	17	1	50%
		04AA2RC2	Cell	12	12	0	24	NA	THU	18	2	21	1	17%
	A3L	04AA3LA1	Cell	10	10	0	20	NA	DPU	15	8	12	0	80%
		04AA3LA2	Cell	10	10	0	20	NA	DPU	15	8	10	2	80%
		04AA3LB1	Cell	10	10	0	20	NA	DPU	15	3	13	2	30%
		04AA3LB2	Cell	10	10	0	20	NA	DPU	15	0	20	0	0%
		04AA3LC1	Cell	12	12	0	24	NA	DPU	18	0	24	0	0%
		04AA3LC2	Cell	12	12	0	24	NA	DPU	18	0	24	0	0%
	A3R	04AA3RA1	Cell	10	10	0	20	NA	ASU	13	3	17	0	30%
		04AA3RA2	Cell	10	10	0	20	NA	ASU	13	4	12	2	40%
		04AA3RB1	Cell	10	10	0	20	NA	ASU	13	5	14	1	50%
		04AA3RB2	Cell	10	10	0	20	NA	ASU	13	4	15	1	40%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
COR-Facility 04A	A3R	04AA3RC1	Cell	12	12	0	24	NA	ASU	15	5	16	3	42%
		04AA3RC2	Cell	12	12	0	24	NA	ASU	15	3	21	0	25%
	A4L	04AA4LA1	Cell	10	10	0	20	NA	ASU	13	3	14	1	30%
		04AA4LA2	Cell	10	10	0	20	NA	ASU	13	4	16	0	40%
		04AA4LB1	Cell	10	10	0	20	NA	ASU	13	5	12	3	50%
		04AA4LB2	Cell	10	10	0	20	NA	ASU	13	5	13	2	50%
		04AA4LC1	Cell	12	12	0	24	NA	ASU	15	4	20	0	33%
		04AA4LC2	Cell	12	12	0	24	NA	ASU	15	0	24	0	0%
	A4R	04AA4RA1	Cell	12	8	0	20	NA	PHU	12	3	14	3	25%
		04AA4RA2	Cell	10	10	0	20	NA	PHU	10	4	14	2	40%
		04AA4RB1	Cell	10	10	0	20	NA	ASU	13	4	15	1	40%
		04AA4RB2	Cell	10	10	0	20	NA	ASU	13	3	17	0	30%
		04AA4RC1	Cell	12	11	0	23	NA	ASU	15	3	19	0	25%
		04AA4RC2	Cell	12	12	0	24	NA	ASU	15	5	14	3	42%
COR-Facility 04A Total				**515**	**498**	**0**	**1013**			**650**	**251**	**686**	**64**	**49%**
COR-Facility 04B	B1L	04BB1LA1	Cell	10	10	0	20	II	PF	15	18	0	2	180%
		04BB1LA2	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB1LB1	Cell	10	10	0	20	II	PF	15	19	1	0	190%
		04BB1LB2	Cell	10	10	0	20	II	PF	15	17	2	1	170%
		04BB1LC1	Cell	12	12	0	24	II	PF	18	20	0	4	167%
		04BB1LC2	Cell	12	12	0	24	II	PF	18	21	0	3	175%
	B1R	04BB1RA1	Cell	10	10	0	20	II	PF	15	19	0	1	190%
		04BB1RA2	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB1RB1	Cell	10	10	0	20	II	PF	15	16	0	4	160%
		04BB1RB2	Cell	10	10	0	20	II	PF	15	19	0	1	190%
		04BB1RC1	Cell	12	12	0	24	II	PF	18	20	1	3	167%
		04BB1RC2	Cell	12	12	0	24	II	PF	18	23	1	0	192%
	B2L	04BB2LA1	Cell	10	10	0	20	II	PF	15	19	0	1	190%
		04BB2LA2	Cell	10	10	0	20	II	PF	15	19	0	0	190%
		04BB2LB1	Cell	10	10	0	20	II	PF	15	17	1	2	170%
		04BB2LB2	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB2LC1	Cell	12	12	0	24	II	PF	18	22	0	2	183%
		04BB2LC2	Cell	12	12	0	24	II	PF	18	24	0	0	200%
	B2R	04BB2RA1	Cell	10	10	0	20	II	PF	15	17	0	3	170%
		04BB2RA2	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB2RB1	Cell	10	10	0	20	II	PF	15	18	0	2	180%
		04BB2RB2	Cell	10	10	0	20	II	PF	15	18	0	1	180%
		04BB2RC1	Cell	12	12	0	24	II	PF	18	22	1	1	183%
		04BB2RC2	Cell	12	12	0	24	II	PF	18	22	1	0	183%
	B3L	04BB3LA1	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB3LA2	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB3LB1	Cell	10	10	0	20	II	PF	15	16	0	2	160%
		04BB3LB2	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB3LC1	Cell	12	12	0	24	II	PF	18	23	0	1	192%
		04BB3LC2	Cell	12	12	0	24	II	PF	18	24	0	0	200%
	B3R	04BB3RA1	Cell	10	10	0	20	II	PF	15	19	0	1	190%
		04BB3RA2	Cell	10	10	0	20	II	PF	15	19	0	1	190%
		04BB3RB1	Cell	10	10	0	20	II	PF	15	20	0	0	200%
		04BB3RB2	Cell	10	10	0	20	II	PF	15	17	3	0	170%
		04BB3RC1	Cell	12	12	0	24	II	PF	18	21	1	2	175%
		04BB3RC2	Cell	12	12	0	24	II	PF	18	23	1	0	192%
	B4L	04BB4LA1	Cell	10	10	0	20	II	PF	15	4	16	0	40%
		04BB4LA2	Cell	10	10	0	20	II	PF	15	0	20	0	0%
		04BB4LB1	Cell	10	10	0	20	II	PF	15	2	17	0	20%
		04BB4LB2	Cell	10	10	0	20	II	PF	15	0	19	0	0%
		04BB4LC1	Cell	12	12	0	24	II	PF	18	2	22	0	17%
		04BB4LC2	Cell	12	12	0	24	II	PF	18	0	24	0	0%
	B4R	04BB4RA1	Cell	10	10	0	20	II	PF	15	9	7	2	90%
		04BB4RA2	Cell	10	10	0	20	II	PF	15	11	9	0	110%
		04BB4RB1	Cell	10	10	0	20	II	PF	15	9	9	2	90%
		04BB4RB2	Cell	10	10	0	20	II	PF	15	10	8	1	100%
		04BB4RC1	Cell	12	12	0	24	II	PF	18	7	16	1	58%
		04BB4RC2	Cell	12	12	0	24	II	PF	18	11	13	0	92%
COR-Facility 04B Total				**512**	**512**	**0**	**1024**			**768**	**777**	**193**	**44**	**152%**
COR-MSF	003	M 003 1	Dorm	48	48	0	96	I	WC	72	0	80	0	0%
		M 003 2	Dorm	48	48	0	96	I	WC	72	0	80	0	0%
	004	M 004 1	Dorm	48	48	0	96	I	WC	72	22	58	0	46%
		M 004 2	Dorm	46	46	0	92	I	WC	69	21	55	0	46%
	005	M 005 1	Dorm	100	100	0	200	I	WC	150	0	96	0	0%
	FIR	M FIR 1	Dorm	10	0	0	10	I	FH	10	4	6	0	40%
COR-MSF Total				**300**	**290**	**0**	**590**			**445**	**47**	**375**	**0**	**16%**
COR-STRH	001	Z 001A1	Cell	12	12	0	24	NA	SRH	15	5	18	1	42%
		Z 001B1	Cell	12	12	0	24	NA	SRH	15	10	12	2	83%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
COR-STRH	001	Z 001C1	Cell	12	12	0	24	NA	SRH	15	7	15	2	58%
		Z 001D1	Cell	12	12	0	24	NA	SRH	15	9	14	1	75%
		Z 001E1	Cell	12	12	0	24	NA	SRH	15	8	15	1	67%
		Z 001F1	Cell	14	14	0	28	NA	SRH	18	10	16	2	71%
		Z 001G1	Cell	14	14	0	28	NA	SRH	18	11	16	1	79%
		Z 001H1	Cell	12	12	0	24	NA	SRH	15	8	14	2	67%
COR-STRH Total				**100**	**100**	**0**	**200**			**125**	**68**	**120**	**12**	**68%**
Grand Total				**2927**	**2900**	**92**	**5919**			**4213**	**3336**	**2089**	**263**	**114%**

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CRC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CRC-Central Service	INF	S INF 1	Dorm	4	0	0	4	NA	OHU	4	2	2	0	50%
			Room	6	0	0	6	NA	OHU	6	5	1	0	83%
CRC-Central Service Total				**10**	**0**	**0**	**10**			**10**	**7**	**3**	**0**	**70%**
CRC-Facility A	101	A 101 1	Dorm	40	40	0	80	II	PF	60	77	3	0	193%
	102	A 102 2	Dorm	40	40	0	80	II	PF	60	13	67	0	33%
	103	A 103 3	Dorm	40	40	0	80	II	PF	60	78	2	0	195%
	104	A 104 3	Dorm	40	40	0	80	II	PF	60	0	80	0	0%
	105	A 105 4	Dorm	40	40	0	80	II	PF	60	73	7	0	183%
	106	A 106 5	Dorm	40	40	0	80	II	PF	60	0	80	0	0%
	107	A 107 5	Dorm	40	40	0	80	II	PF	60	77	3	0	193%
	108	A 108 5	Dorm	40	40	0	80	II	PF	60	77	2	0	193%
	109	A 109 6	Dorm	40	40	0	80	II	PF	60	78	2	0	195%
	110	A 110 6	Dorm	40	40	0	80	II	PF	60	1	79	0	3%
	111	A 111 7	Dorm	40	40	0	80	II	PF	60	74	6	0	185%
	112	A 112 7	Dorm	40	40	0	80	II	PF	60	54	26	0	135%
CRC-Facility A Total				**480**	**480**	**0**	**960**			**720**	**602**	**357**	**0**	**125%**
CRC-Facility B	201	B 201 1	Dorm	50	50	0	100	II	PF	75	96	4	0	192%
	202	B 202 1	Dorm	50	50	0	100	II	PF	75	0	100	0	0%
	203	B 203 1	Dorm	50	50	0	100	II	PF	75	14	86	0	28%
	204	B 204 1	Dorm	50	50	0	100	II	PF	75	0	100	0	0%
	205	B 205 1	Dorm	50	50	0	100	II	PF	75	94	6	0	188%
	206	B 206 1	Dorm	50	50	0	100	II	PF	75	93	7	0	186%
	207	B 207 1	Dorm	50	50	0	100	II	PF	75	0	100	0	0%
	208	B 208 1	Dorm	50	50	0	100	II	PF	75	91	9	0	182%
	209	B 209 1	Dorm	50	50	0	100	II	PF	75	88	12	0	176%
	210	B 210 1	Dorm	50	50	0	100	II	PF	75	93	7	0	186%
	214	B 214 1	Dorm	100	100	0	200	II	PF	150	166	34	0	166%
CRC-Facility B Total				**600**	**600**	**0**	**1200**			**900**	**735**	**465**	**0**	**123%**
CRC-Facility C	302	C 302 1	Dorm	50	50	0	100	II	PF	75	1	99	0	2%
	303	C 303 1	Dorm	50	50	0	100	II	PF	75	1	99	0	2%
	304	C 304 1	Dorm	50	50	0	100	II	PF	75	0	100	0	0%
	305	C 305 1	Dorm	50	50	0	100	II	PF	75	20	80	0	40%
	306	C 306 1	Dorm	50	50	0	100	II	PF	75	95	5	0	190%
	307	C 307 1	Dorm	50	50	0	100	II	PF	75	84	16	0	168%
	308	C 308 1	Dorm	50	50	0	100	II	PF	75	50	50	0	100%
	309	C 309 1	Dorm	50	50	0	100	II	PF	75	97	3	0	194%
	310	C 310 1	Dorm	50	50	0	100	II	PF	75	88	12	0	176%
	311	C 311 1	Dorm	52	25	0	77	II	PF	78	0	77	0	0%
	312	C 312 1	Dorm	50	50	0	100	II	PF	75	96	4	0	192%
	313	C 313 1	Dorm	50	50	0	100	II	PF	75	94	6	0	188%
	314	C 314 1	Dorm	32	32	0	64	II	PF	48	16	48	0	50%
	315	C 315 1	Dorm	31	31	0	62	II	PF	47	41	21	0	132%
	FIR	C FIR 2	Dorm	9	0	0	9	I	FH	9	8	1	0	89%
CRC-Facility C Total				**674**	**638**	**0**	**1312**			**1007**	**691**	**621**	**0**	**103%**
CRC-Facility D	401	D 401 3	Dorm	43	43	0	86	II	PF	65	85	1	0	198%
	402	D 402 3	Dorm	50	50	0	100	II	PF	75	97	3	0	194%
	403	D 403 2	Dorm	47	47	0	94	II	PF	71	92	2	0	196%
	404	D 404 2	Dorm	50	50	0	100	II	PF	75	97	3	0	194%
	405	D 405 3	Dorm	48	48	0	96	II	PF	72	9	87	0	19%
	406	D 406 3	Dorm	42	42	0	84	II	PF	63	12	72	0	29%
	407	D 407 1	Dorm	40	40	0	80	II	PF	60	0	80	0	0%
	408	D 408 1	Dorm	40	40	0	80	II	PF	60	1	79	0	3%
	409	D 409 1	Dorm	40	40	0	80	II	PF	60	76	4	0	190%
CRC-Facility D Total				**400**	**400**	**0**	**800**			**600**	**469**	**331**	**0**	**117%**
Grand Total				**2164**	**2118**	**0**	**4282**			**3237**	**2504**	**1777**	**0**	**116%**

Generated by :
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CTF Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CTF-Facility A	Fremont	A FD 1	Dorm	100	100	0	200	II	PF	150	80	119	0	80%
	Lassen	A LA A1	Cell	44	44	0	88	II	PF	66	85	3	0	193%
		A LA A2	Cell	56	56	0	112	II	PF	84	108	2	2	193%
		A LA A3	Cell	56	56	0	112	II	PF	84	111	1	0	198%
		A LA B1	Cell	43	43	0	86	II	PF	65	76	10	0	177%
		A LA B2	Cell	52	52	0	104	II	PF	78	93	8	2	179%
		A LA B3	Cell	52	52	0	104	II	PF	78	102	1	1	196%
	Ranier	A RA A1	Cell	44	44	0	88	II	PF	66	74	13	1	168%
		A RA A2	Cell	56	56	0	112	II	PF	84	105	6	1	188%
		A RA A3	Cell	56	56	0	112	II	PF	84	105	5	1	188%
		A RA B1	Cell	43	43	0	86	II	PF	65	69	16	1	160%
		A RA B2	Cell	52	52	0	104	II	PF	78	88	9	7	169%
		A RA B3	Cell	52	52	0	104	II	PF	78	97	4	3	187%
CTF-Facility A Total				**706**	**706**	**0**	**1412**			**1059**	**1193**	**197**	**19**	**169%**
CTF-Facility B	Shasta	B SH A1	Cell	43	43	0	86	II	PF	65	61	22	3	142%
		B SH A2	Cell	55	55	0	110	II	PF	83	87	15	8	158%
		B SH A3	Cell	55	55	0	110	II	PF	83	100	10	0	182%
		B SH B1	Cell	42	42	0	84	II	PF	63	84	0	0	200%
		B SH B2	Cell	51	51	0	102	II	PF	77	99	1	2	194%
		B SH B3	Cell	51	51	0	102	II	PF	77	97	1	3	190%
	Toro	B TD 1	Dorm	100	100	0	200	II	PF	150	105	95	0	105%
	Whitney	B WH A1	Cell	43	43	0	86	II	PF	65	80	3	3	186%
		B WH A2	Cell	55	55	0	110	II	PF	83	106	2	2	193%
		B WH A3	Cell	55	55	0	110	II	PF	83	104	2	4	189%
		B WH B1	Cell	42	42	0	84	II	PF	63	78	3	2	186%
		B WH B2	Cell	51	51	0	102	II	PF	77	90	4	8	176%
		B WH B3	Cell	51	51	0	102	II	PF	77	99	2	0	194%
CTF-Facility B Total				**694**	**694**	**0**	**1388**			**1041**	**1190**	**160**	**35**	**171%**
CTF-Facility C	B Wing	C BW 1	Cell	37	37	0	74	II	GP	56	61	12	1	165%
		C BW 2	Cell	45	45	0	90	II	GP	68	78	10	2	173%
		C BW 3	Cell	45	45	0	90	II	GP	68	76	14	0	169%
	C Wing	C CW 1	Cell	37	37	0	74	II	GP	56	59	13	1	159%
		C CW 2	Cell	45	45	0	90	II	GP	68	85	5	0	189%
		C CW 3	Cell	45	45	0	90	II	GP	68	84	6	0	187%
	D Wing	C DW 1	Cell	37	37	0	74	II	GP	56	71	2	1	192%
		C DW 2	Cell	45	45	0	90	II	GP	68	87	0	3	193%
		C DW 3	Cell	45	45	0	90	II	GP	68	88	0	2	196%
	E Wing	C EW 1	Cell	37	37	0	74	II	GP	56	67	5	2	181%
		C EW 2	Cell	45	45	0	90	II	GP	68	84	6	0	187%
		C EW 3	Cell	45	45	0	90	II	GP	68	84	4	2	187%
	F Wing	C FW 1	Cell	53	53	0	106	II	GP	80	92	10	4	174%
		C FW 2	Cell	61	61	0	122	II	GP	92	114	5	3	187%
		C FW 3	Cell	61	61	0	122	II	GP	92	118	3	1	193%
	G Wing	C GW 1	Cell	53	53	0	106	II	GP	80	81	22	3	153%
		C GW 2	Cell	61	61	0	122	II	GP	92	107	14	1	175%
		C GW 3	Cell	61	61	0	122	II	GP	92	112	7	3	184%
	INF	C INF 2	Cell	4	0	6	10	NA	OHU	4	4	6	0	100%
			Dorm	8	0	5	13	NA	OHU	8	7	6	0	88%
	X Wing	C XW 1	Cell	39	36	1	76	II	GP	59	55	20	1	141%
		C XW 2	Cell	46	46	0	92	II	GP	69	86	4	2	187%
		C XW 3	Cell	46	46	0	92	II	GP	69	89	3	0	193%
	Y Wing	C YW 1	Cell	37	37	0	74	II	VAR	56	14	60	0	38%
		C YW 2	Cell	46	46	0	92	II	VAR	69	21	69	2	46%
		C YW 3	Cell	46	46	0	92	II	VAR	69	6	86	0	13%
	Z Wing	C ZW 1	Cell	40	40	0	80	II	GP	60	62	17	1	155%
		C ZW 2	Cell	46	46	0	92	II	GP	69	80	9	3	174%
		C ZW 3	Cell	46	46	0	92	II	GP	69	89	2	1	193%
CTF-Facility C Total				**1262**	**1247**	**12**	**2521**			**1887**	**2061**	**420**	**39**	**163%**
CTF-Facility D	002	D 002 1	Dorm	100	100	0	200	I	PF	150	103	97	0	103%
	003	D 003 1	Dorm	80	80	0	160	I	PF	120	0	160	0	0%
	004	D 004 1	Dorm	80	80	0	160	I	PF	120	0	160	0	0%
	005	D 005 1	Dorm	80	80	0	160	I	PF	120	0	160	0	0%
	006	D 006 1	Dorm	80	80	0	160	I	PF	120	0	160	0	0%
	007	D 007 1	Dorm	80	80	0	160	I	PF	120	0	160	0	0%
	FIR	D FIR 1	Dorm	6	6	0	12	I	FH	6	6	6	0	100%
CTF-Facility D Total				**506**	**506**	**0**	**1012**			**756**	**109**	**903**	**0**	**22%**
Grand Total				**3168**	**3153**	**12**	**6333**			**4743**	**4553**	**1680**	**93**	**144%**

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CVSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
CVSP-Central Service	AHU	S CH 1	Closed Ward	14	0	0	14	II	OHU	14	4	10	0	29%
CVSP-Central Service Total				**14**	**0**	**0**	**14**			**14**	**4**	**10**	**0**	**29%**
CVSP-Facility A	001	A 001 1	270 Dorm	68	68	0	136	II	PF	102	108	28	0	159%
		A 001 2	270 Dorm	62	62	0	124	II	PF	93	103	21	0	166%
	002	A 002 1	270 Dorm	68	68	0	136	II	PF	102	115	21	0	169%
		A 002 2	270 Dorm	62	62	0	124	II	PF	93	99	25	0	160%
	003	A 003 1	270 Cell	50	50	0	100	NA	VAR	63	37	63	0	74%
		A 003 2	270 Cell	50	50	0	100	NA	VAR	63	42	58	0	84%
CVSP-Facility A Total				**360**	**360**	**0**	**720**			**515**	**504**	**216**	**0**	**140%**
CVSP-Facility B	003	B 003 1	270 Dorm	68	68	0	136	II	PF	102	111	24	0	163%
		B 003 2	270 Dorm	62	62	0	124	II	PF	93	108	16	0	174%
	004	B 004 1	270 Dorm	68	68	0	136	II	PF	102	106	29	0	156%
		B 004 2	270 Dorm	62	62	0	124	II	PF	93	103	21	0	166%
	005	B 005 1	270 Dorm	68	68	0	136	II	PF	102	107	29	0	157%
		B 005 2	270 Dorm	62	62	0	124	II	PF	93	106	18	0	171%
CVSP-Facility B Total				**390**	**390**	**0**	**780**			**585**	**641**	**137**	**0**	**164%**
CVSP-Facility C	006	C 006 1	270 Dorm	68	68	0	136	II	PF	102	100	36	0	147%
		C 006 2	270 Dorm	62	62	0	124	II	PF	93	102	21	0	165%
	007	C 007 1	270 Dorm	68	68	0	136	II	PF	102	110	26	0	162%
		C 007 2	270 Dorm	62	62	0	124	II	PF	93	99	25	0	160%
	008	C 008 1	270 Dorm	68	68	0	136	II	PF	102	100	36	0	147%
		C 008 2	270 Dorm	62	62	0	124	II	PF	93	104	19	0	168%
CVSP-Facility C Total				**390**	**390**	**0**	**780**			**585**	**615**	**163**	**0**	**158%**
CVSP-Facility D	009	D 009 1	270 Dorm	68	68	0	136	II	PF	102	94	42	0	138%
		D 009 2	270 Dorm	62	62	0	124	II	PF	93	84	40	0	135%
	010	D 010 1	270 Dorm	68	68	0	136	II	PF	102	101	35	0	149%
		D 010 2	270 Dorm	62	62	0	124	II	PF	93	95	29	0	153%
	011	D 011 1	270 Dorm	68	30	0	98	II	VAR	102	1	96	0	1%
		D 011 2	270 Dorm	62	37	0	99	II	VAR	93	0	99	0	0%
CVSP-Facility D Total				**390**	**327**	**0**	**717**			**585**	**375**	**341**	**0**	**96%**
CVSP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	44	156	0	44%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	45	155	0	45%
	FIR	M FIR 1	Dorm	8	2	0	10	I	FH	8	9	1	0	113%
CVSP-MSF Total				**208**	**202**	**0**	**410**			**308**	**98**	**312**	**0**	**47%**
Grand Total				**1752**	**1669**	**0**	**3421**			**2592**	**2237**	**1179**	**0**	**128%**

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FOL Female Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
FOL-Facility B	FWF A Dorm 1st Tier	B 001A1	Dorm	93	29	0	122	NA	GP	122	78	44	0	84%
	FWF A Dorm 2nd Tier	B 001A2	Dorm	105	21	0	126	NA	GP	138	67	59	0	64%
	FWF B Dorm 1st Tier	B 001B1	Dorm	99	40	0	139	NA	GP	130	52	87	0	53%
	FWF B Dorm 2nd Tier	B 001B2	Dorm	99	44	0	143	NA	GP	130	41	102	0	41%
FOL-Facility B Total				**396**	**134**	**0**	**530**			**521**	**238**	**292**	**0**	**60%**
Grand Total				**396**	**134**	**0**	**530**			**521**	**238**	**292**	**0**	**60%**

FOL Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
FOL-Facility A	001	A 001A1	Cell	32	32	0	64	II	GP	48	47	16	1	147%
		A 001A2	Cell	32	32	0	64	II	GP	48	48	14	2	150%
		A 001A3	Cell	32	32	0	64	II	GP	48	50	12	2	156%
		A 001A4	Cell	32	32	0	64	II	GP	48	42	22	0	131%
		A 001A5	Cell	32	32	0	64	II	GP	48	38	26	0	119%
		A 001B1	Cell	31	31	0	62	II	GP	47	0	62	0	0%
		A 001B2	Cell	32	32	0	64	II	GP	48	54	10	0	169%
		A 001B3	Cell	32	32	0	64	II	GP	48	51	12	1	159%
		A 001B4	Cell	31	31	0	62	II	GP	47	44	18	0	142%
		A 001B5	Cell	31	31	0	62	II	GP	47	34	27	1	110%
		A 001C1	Cell	32	32	0	64	II	GP	48	32	32	0	100%
		A 001C2	Cell	31	31	0	62	II	GP	47	54	7	1	174%
		A 001C3	Cell	31	31	0	62	II	GP	47	48	14	0	155%
		A 001C4	Cell	32	32	0	64	II	GP	48	47	17	0	147%
		A 001C5	Cell	32	32	0	64	II	GP	48	35	28	1	109%
		A 001D1	Cell	30	30	0	60	II	GP	45	46	14	0	153%
		A 001D2	Cell	32	32	0	64	II	GP	48	51	12	1	159%
		A 001D3	Cell	32	32	0	64	II	GP	48	43	21	0	134%
		A 001D4	Cell	32	32	0	64	II	GP	48	41	22	1	128%
		A 001D5	Cell	32	32	0	64	II	GP	48	34	30	0	106%
	002	A 002A1	Cell	32	30	0	62	III	GP	48	0	62	0	0%
		A 002A2	Cell	30	30	0	60	III	GP	45	26	31	3	87%
		A 002A3	Cell	31	31	0	62	III	GP	47	57	5	0	184%
		A 002A4	Cell	31	31	0	62	III	GP	47	53	9	0	171%
		A 002A5	Cell	31	31	0	62	III	GP	47	53	9	0	171%
		A 002B1	Cell	31	31	0	62	III	GP	47	56	6	0	181%
		A 002B2	Cell	31	31	0	62	III	GP	47	14	46	2	45%
		A 002B3	Cell	31	31	0	62	III	GP	47	55	5	2	177%
		A 002B4	Cell	31	31	0	62	III	GP	47	50	11	1	161%
		A 002B5	Cell	31	31	0	62	III	GP	47	50	11	1	161%
	003	A 003A1	Cell	39	39	0	78	II	GP	59	61	16	1	156%
		A 003A2	Cell	40	40	0	80	II	GP	60	62	17	1	155%
		A 003A3	Cell	40	40	0	80	II	GP	60	63	16	1	158%
		A 003A4	Cell	40	40	0	80	II	GP	60	63	17	0	158%
		A 003A5	Cell	40	40	0	80	II	GP	60	62	18	0	155%
		A 003B1	Cell	40	40	0	80	II	GP	60	57	23	0	143%
		A 003B2	Cell	40	40	0	80	II	GP	60	21	59	0	53%
		A 003B3	Cell	40	40	0	80	II	GP	60	62	16	2	155%
		A 003B4	Cell	40	40	0	80	II	GP	60	66	14	0	165%
		A 003B5	Cell	40	40	0	80	II	GP	60	61	19	0	153%
	004	A 004A1	Cell	23	0	0	23	NA	ASU	23	8	15	0	35%
		A 004A2	Cell	22	22	0	44	NA	VAR	22	1	43	0	5%
		A 004A3	Cell	23	23	0	46	NA	ASU	23	3	43	0	13%
		A 004B1	Cell	23	0	0	23	NA	ASU	23	14	9	0	61%
		A 004B2	Cell	23	23	0	46	NA	VAR	23	0	46	0	0%
		A 004B3	Cell	23	23	0	46	NA	ASU	23	18	23	5	78%
	005	A 005A1	Cell	39	39	0	78	II	GP	59	54	24	0	138%
		A 005A2	Cell	41	41	0	82	II	GP	62	56	26	0	137%
		A 005B1	Cell	39	39	0	78	II	GP	59	59	19	0	151%
		A 005B2	Cell	41	41	0	82	II	GP	62	58	24	0	141%
		A 005C1	Cell	39	39	0	78	II	GP	59	55	22	1	141%
		A 005C2	Cell	41	41	0	82	II	GP	62	60	22	0	146%
		A 005D1	Cell	40	40	0	80	II	GP	60	37	41	1	93%
		A 005D2	Cell	41	41	0	82	II	GP	62	16	66	0	39%
FOL-Facility A Total				**1800**	**1752**	**0**	**3552**			**2632**	**2270**	**1249**	**32**	**126%**
FOL-MSF	001	M 001 1	Dorm	18	3	0	21	I	WC	27	0	21	0	0%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
FOL-MSF	002	M 002 1	Dorm	18	3	0	21	I	WC	27	9	12	0	50%
	003	M 003 1	Dorm	18	3	0	21	I	WC	27	9	12	0	50%
	004	M 004 1	Dorm	18	3	0	21	I	WC	27	8	13	0	44%
	005	M 005 1	Dorm	18	3	0	21	I	VAR	27	1	20	0	6%
	006	M 006 1	Dorm	18	3	0	21	I	VAR	27	0	21	0	0%
	007	M 007 1	Dorm	27	27	0	54	I	WC	41	17	37	0	63%
	008	M 008 1	Dorm	27	27	0	54	I	WC	41	17	37	0	63%
	009	M 009 1	Dorm	34	34	0	68	I	WC	51	24	44	0	71%
	010	M 010 1	Dorm	27	27	0	54	I	WC	41	18	36	0	67%
	011	M 011 1	Dorm	27	27	0	54	I	WC	41	17	37	0	63%
	FIR	M FIR 1	Dorm	15	0	0	15	I	FH	15	8	7	0	53%
FOL-MSF Total				**265**	**160**	**0**	**425**			**390**	**128**	**297**	**0**	**48%**
Grand Total				**2065**	**1912**	**0**	**3977**			**3022**	**2398**	**1546**	**32**	**116%**

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HDSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
HDSP-Central Service	INF	S INF 1	Cell	0	0	20	20	NA	CTC	0	12	7	0	
				0	0	10	10		MCB	0	4	6	0	
HDSP-Central Service Total				**0**	**0**	**30**	**30**			**0**	**16**	**13**	**0**	
HDSP-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	SNY	75	81	17	2	162%
		A 001 2	270 Cell	50	50	0	100	III	SNY	75	85	11	3	170%
	002	A 002 1	270 Cell	50	50	0	100	III	SNY	75	64	29	7	128%
		A 002 2	270 Cell	50	50	0	100	III	SNY	75	69	27	4	138%
	003	A 003 1	270 Cell	50	50	0	100	III	SNY	75	70	29	1	140%
		A 003 2	270 Cell	50	50	0	100	III	SNY	75	79	17	4	158%
	004	A 004 1	270 Cell	50	50	0	100	III	VAR	75	73	18	9	146%
		A 004 2	270 Cell	50	50	0	100	III	VAR	75	82	17	1	164%
	005	A 005 1	270 Cell	50	50	0	100	III	SNY	75	53	25	6	106%
		A 005 2	270 Cell	50	50	0	100	III	SNY	75	62	34	4	124%
HDSP-Facility A Total				**500**	**500**	**0**	**1000**			**750**	**718**	**224**	**41**	**144%**
HDSP-Facility B	001	B 001 1	270 Cell	50	50	0	100	IV	SNY	75	88	5	5	176%
		B 001 2	270 Cell	50	50	0	100	IV	SNY	75	86	7	5	172%
	002	B 002 1	270 Cell	50	50	0	100	IV	SNY	75	64	20	10	128%
		B 002 2	270 Cell	50	50	0	100	IV	SNY	75	86	12	2	172%
	003	B 003 1	270 Cell	50	50	0	100	IV	SNY	75	81	16	3	162%
		B 003 2	270 Cell	50	50	0	100	IV	SNY	75	83	14	3	166%
	004	B 004 1	270 Cell	50	50	0	100	IV	SNY	75	74	16	8	148%
		B 004 2	270 Cell	50	50	0	100	IV	SNY	75	76	19	5	152%
	005	B 005 1	270 Cell	50	50	0	100	IV	SNY	75	72	22	6	144%
		B 005 2	270 Cell	50	50	0	100	IV	SNY	75	89	10	0	178%
HDSP-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**799**	**141**	**47**	**160%**
HDSP-Facility C	001	C 001 1	180 Cell	32	32	0	64	IV	VAR	48	1	63	0	3%
		C 001 2	180 Cell	32	32	0	64	IV	VAR	48	0	64	0	0%
	002	C 002 1	180 Cell	32	32	0	64	IV	GP	48	52	3	1	163%
		C 002 2	180 Cell	32	32	0	64	IV	GP	48	55	6	3	172%
	003	C 003 1	180 Cell	32	32	0	64	IV	GP	48	56	5	1	175%
		C 003 2	180 Cell	32	32	0	64	IV	GP	48	59	4	1	184%
	004	C 004 1	180 Cell	32	32	0	64	IV	GP	48	59	5	0	184%
		C 004 2	180 Cell	32	32	0	64	IV	GP	48	52	12	0	163%
	005	C 005 1	180 Cell	32	32	0	64	IV	GP	48	57	7	0	178%
		C 005 2	180 Cell	32	32	0	64	IV	GP	48	59	3	2	184%
	006	C 006 1	180 Cell	32	32	0	64	IV	GP	48	55	7	2	172%
		C 006 2	180 Cell	32	32	0	64	IV	GP	48	56	7	1	175%
	007	C 007 1	180 Cell	32	32	0	64	IV	GP	48	55	6	3	172%
		C 007 2	180 Cell	32	32	0	64	IV	GP	48	57	5	0	178%
	008	C 008 1	180 Cell	32	32	0	64	IV	GP	48	50	13	1	156%
		C 008 2	180 Cell	32	32	0	64	IV	GP	48	51	13	0	159%
HDSP-Facility C Total				**512**	**512**	**0**	**1024**			**768**	**774**	**223**	**15**	**151%**
HDSP-Facility D	001	D 001 1	180 Cell	32	32	0	64	IV	GP	48	49	12	3	153%
		D 001 2	180 Cell	32	32	0	64	IV	GP	48	48	13	1	150%
	002	D 002 1	180 Cell	32	32	0	64	IV	GP	48	54	10	0	169%
		D 002 2	180 Cell	32	32	0	64	IV	GP	48	52	12	0	163%
	003	D 003 1	180 Cell	32	32	0	64	IV	GP	48	55	8	1	172%
		D 003 2	180 Cell	32	32	0	64	IV	GP	48	52	11	1	163%
	004	D 004 1	180 Cell	32	32	0	64	IV	GP	48	56	5	3	175%
		D 004 2	180 Cell	32	32	0	64	IV	GP	48	55	8	1	172%
	005	D 005 1	180 Cell	32	32	0	64	IV	GP	48	54	7	1	169%
		D 005 2	180 Cell	32	32	0	64	IV	GP	48	56	7	1	175%
	006	D 006 1	180 Cell	32	32	0	64	IV	GP	48	55	6	3	172%
		D 006 2	180 Cell	32	32	0	64	IV	GP	48	55	8	1	172%
	007	D 007 1	180 Cell	32	32	0	64	IV	GP	48	46	12	4	144%
		D 007 2	180 Cell	32	32	0	64	IV	GP	48	51	8	1	159%
	008	D 008 1	180 Cell	32	32	0	64	IV	GP	48	27	33	0	84%
		D 008 2	180 Cell	32	32	0	64	IV	GP	48	16	46	0	50%
HDSP-Facility D Total				**512**	**512**	**0**	**1024**			**768**	**781**	**206**	**21**	**153%**
HDSP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	24	176	0	24%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	23	177	0	23%
HDSP-MSF Total				**200**	**200**	**0**	**400**			**300**	**47**	**353**	**0**	**24%**
HDSP-STRH	001	Z 001 1	Cell	100	100	0	200	NA	SRH	125	96	88	16	96%
HDSP-STRH Total				**100**	**100**	**0**	**200**			**125**	**96**	**88**	**16**	**96%**
Grand Total				**2324**	**2324**	**30**	**4678**			**3461**	**3231**	**1248**	**140**	**139%**

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ISP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
ISP-Central Service	INF	S INF 1	Cell	0	0	14	14	NA	OHU	0	0	0	0	
ISP-Central Service Total				**0**	**0**	**14**	**14**			**0**	**0**	**0**	**0**	
ISP-Facility A	001	A 001 1	270 Cell	50	50	0	100	II	PF	75	88	11	1	176%
		A 001 2	270 Cell	50	50	0	100	II	PF	75	100	0	0	200%
	002	A 002 1	270 Cell	50	50	0	100	II	PF	75	96	4	0	192%
		A 002 2	270 Cell	50	50	0	100	II	PF	75	99	0	1	198%
	003	A 003 1	270 Cell	50	50	0	100	II	PF	75	93	7	0	186%
		A 003 2	270 Cell	50	50	0	100	II	PF	75	98	2	0	196%
	004	A 004 1	270 Cell	50	50	0	100	II	PF	75	93	7	0	186%
		A 004 2	270 Cell	50	50	0	100	II	PF	75	98	2	0	196%
	005	A 005 1	270 Cell	50	50	0	100	NA	ASU	63	26	72	2	52%
		A 005 2	270 Cell	50	50	0	100	NA	ASU	63	21	76	3	42%
ISP-Facility A Total				**500**	**500**	**0**	**1000**			**725**	**812**	**181**	**7**	**162%**
ISP-Facility B	001	B 001 1	270 Cell	50	50	0	100	III	SNY	75	0	100	0	0%
		B 001 2	270 Cell	50	50	0	100	III	SNY	75	0	100	0	0%
	002	B 002 1	270 Cell	50	50	0	100	III	SNY	75	70	26	4	140%
		B 002 2	270 Cell	50	50	0	100	III	SNY	75	89	8	3	178%
	003	B 003 1	270 Cell	50	50	0	100	III	SNY	75	77	22	1	154%
		B 003 2	270 Cell	50	50	0	100	III	SNY	75	86	13	0	172%
	004	B 004 1	270 Cell	50	50	0	100	III	SNY	75	82	18	0	164%
		B 004 2	270 Cell	50	50	0	100	III	SNY	75	87	11	1	174%
	005	B 005 1	270 Cell	50	50	0	100	III	SNY	75	52	48	0	104%
		B 005 2	270 Cell	50	50	0	100	III	SNY	75	81	16	1	162%
ISP-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**624**	**362**	**10**	**125%**
ISP-Facility C	001	C 001 1	270 Cell	50	50	0	100	III	VAR	75	22	73	3	44%
		C 001 2	270 Cell	50	50	0	100	III	VAR	75	0	100	0	0%
	002	C 002 1	270 Cell	50	50	0	100	III	GP	75	0	100	0	0%
		C 002 2	270 Cell	50	50	0	100	III	GP	75	0	100	0	0%
	003	C 003 1	270 Cell	50	50	0	100	III	GP	75	41	57	0	82%
		C 003 2	270 Cell	50	50	0	100	III	GP	75	9	91	0	18%
	004	C 004 1	270 Cell	50	50	0	100	III	GP	75	57	43	0	114%
		C 004 2	270 Cell	50	50	0	100	III	GP	75	73	27	0	146%
	005	C 005 1	270 Cell	50	50	0	100	III	GP	75	80	20	0	160%
		C 005 2	270 Cell	50	50	0	100	III	GP	75	86	13	0	172%
ISP-Facility C Total				**500**	**500**	**0**	**1000**			**750**	**368**	**624**	**3**	**74%**
ISP-Facility D	001	D 001 1	270 Cell	50	50	0	100	III	GP	75	65	35	0	130%
		D 001 2	270 Cell	50	50	0	100	III	GP	75	69	30	0	138%
	002	D 002 1	270 Cell	50	50	0	100	III	GP	75	53	47	0	106%
		D 002 2	270 Cell	50	50	0	100	III	GP	75	69	30	1	138%
	003	D 003 1	270 Cell	50	50	0	100	III	GP	75	48	52	0	96%
		D 003 2	270 Cell	50	50	0	100	III	GP	75	53	46	1	106%
	004	D 004 1	270 Cell	50	50	0	100	III	GP	75	44	56	0	88%
		D 004 2	270 Cell	50	50	0	100	III	GP	75	62	37	0	124%
	005	D 005 1	270 Cell	50	50	0	100	III	GP	75	0	100	0	0%
		D 005 2	270 Cell	50	50	0	100	III	GP	75	0	100	0	0%
ISP-Facility D Total				**500**	**500**	**0**	**1000**			**750**	**463**	**533**	**2**	**93%**
ISP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	0	200	0	0%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	54	146	0	54%
ISP-MSF Total				**200**	**200**	**0**	**400**			**300**	**54**	**346**	**0**	**27%**
Grand Total				**2200**	**2200**	**14**	**4414**			**3275**	**2321**	**2046**	**22**	**106%**

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KVSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
KVSP-Central Service	INF	S INF 1	Cell	0	0	10	10	NA	CTC	0	10	0	0	
				0	0	12	12		MCB	0	4	8	0	
KVSP-Central Service Total				**0**	**0**	**22**	**22**			**0**	**14**	**8**	**0**	
KVSP-Facility A	001	A 001 1	180 Cell	22	22	0	44	IV	GP	33	17	25	2	77%
				10	10	0	20		VAR	15	8	11	1	80%
		A 001 2	180 Cell	22	22	0	44	IV	GP	33	19	21	4	86%
				10	10	0	20		VAR	15	8	11	1	80%
	002	A 002 1	180 Cell	32	32	0	64	IV	GP	48	57	3	4	178%
		A 002 2	180 Cell	32	32	0	64	IV	GP	48	59	4	1	184%
	003	A 003 1	180 Cell	32	32	0	64	IV	GP	48	62	2	0	194%
		A 003 2	180 Cell	32	32	0	64	IV	GP	48	61	2	1	191%
	004	A 004 1	180 Cell	32	32	0	64	IV	GP	48	47	15	2	147%
		A 004 2	180 Cell	32	32	0	64	IV	GP	48	47	13	2	147%
	005	A 005 1	180 Cell	32	32	0	64	IV	GP	48	57	6	1	178%
		A 005 2	180 Cell	32	32	0	64	IV	GP	48	59	1	4	184%
	006	A 006 1	180 Cell	32	32	0	64	IV	GP	48	54	5	5	169%
		A 006 2	180 Cell	32	32	0	64	IV	GP	48	58	1	4	181%
	007	A 007 1	180 Cell	32	32	0	64	IV	GP	48	53	8	1	166%
		A 007 2	180 Cell	32	32	0	64	IV	GP	48	59	2	1	184%
	008	A 008 1	180 Cell	32	32	0	64	IV	GP	48	59	2	3	184%
		A 008 2	180 Cell	32	32	0	64	IV	GP	48	60	0	3	188%
KVSP-Facility A Total				**512**	**512**	**0**	**1024**			**768**	**844**	**132**	**40**	**165%**
KVSP-Facility B	001	B 001 1	180 Cell	32	32	0	64	IV	GP	48	14	50	0	44%
		B 001 2	180 Cell	32	32	0	64	IV	GP	48	11	53	0	34%
	002	B 002 1	180 Cell	32	32	0	64	IV	GP	48	52	9	3	163%
		B 002 2	180 Cell	32	32	0	64	IV	GP	48	47	14	3	147%
	003	B 003 1	180 Cell	32	32	0	64	IV	GP	48	53	10	1	166%
		B 003 2	180 Cell	32	32	0	64	IV	GP	48	49	12	3	153%
	004	B 004 1	180 Cell	32	32	0	64	IV	GP	48	58	3	3	181%
		B 004 2	180 Cell	32	32	0	64	IV	GP	48	61	3	0	191%
	005	B 005 1	180 Cell	32	32	0	64	IV	GP	48	44	17	3	138%
		B 005 2	180 Cell	32	32	0	64	IV	GP	48	48	14	2	150%
	006	B 006 1	180 Cell	32	32	0	64	IV	GP	48	54	7	3	169%
		B 006 2	180 Cell	32	32	0	64	IV	GP	48	57	4	3	178%
	007	B 007 1	180 Cell	32	32	0	64	IV	GP	48	50	12	2	156%
		B 007 2	180 Cell	32	32	0	64	IV	GP	48	55	7	2	172%
	008	B 008 1	180 Cell	32	32	0	64	IV	GP	48	51	10	3	159%
		B 008 2	180 Cell	32	32	0	64	IV	GP	48	53	9	1	166%
KVSP-Facility B Total				**512**	**512**	**0**	**1024**			**768**	**757**	**234**	**32**	**148%**
KVSP-Facility C	001	C 001 1	180 Cell	32	32	0	64	IV	SNY	48	41	13	7	128%
		C 001 2	180 Cell	32	32	0	64	IV	SNY	48	34	13	17	106%
	002	C 002 1	180 Cell	32	32	0	64	IV	SNY	48	55	2	7	172%
		C 002 2	180 Cell	32	32	0	64	IV	SNY	48	53	2	9	166%
	003	C 003 1	180 Cell	32	32	0	64	IV	SNY	48	52	5	7	163%
		C 003 2	180 Cell	32	32	0	64	IV	SNY	48	53	3	6	166%
	004	C 004 1	180 Cell	32	32	0	64	IV	SNY	48	42	12	10	131%
		C 004 2	180 Cell	32	32	0	64	IV	SNY	48	45	10	8	141%
	005	C 005 1	180 Cell	32	32	0	64	IV	SNY	48	52	2	10	163%
		C 005 2	180 Cell	32	32	0	64	IV	SNY	48	55	3	6	172%
	006	C 006 1	180 Cell	32	32	0	64	IV	SNY	48	52	1	11	163%
		C 006 2	180 Cell	32	32	0	64	IV	SNY	48	59	0	5	184%
	007	C 007 1	180 Cell	32	32	0	64	IV	SNY	48	52	4	8	163%
		C 007 2	180 Cell	32	32	0	64	IV	SNY	48	54	4	6	169%
	008	C 008 1	180 Cell	32	32	0	64	IV	EOP	48	49	4	11	153%
		C 008 2	180 Cell	32	32	0	64	IV	EOP	48	42	7	15	131%
KVSP-Facility C Total				**512**	**512**	**0**	**1024**			**768**	**790**	**85**	**143**	**154%**
KVSP-Facility D	001	D 001 1	180 Cell	32	32	0	64	IV	SNY	48	50	5	9	156%
		D 001 2	180 Cell	32	32	0	64	IV	SNY	48	51	7	5	159%
	002	D 002 1	180 Cell	32	32	0	64	IV	SNY	48	52	2	10	163%
		D 002 2	180 Cell	32	32	0	64	IV	SNY	48	53	5	6	166%
	003	D 003 1	180 Cell	32	32	0	64	IV	SNY	48	56	5	2	175%
		D 003 2	180 Cell	32	32	0	64	IV	SNY	48	57	3	4	178%
	004	D 004 1	180 Cell	32	32	0	64	IV	SNY	48	47	6	11	147%
		D 004 2	180 Cell	32	32	0	64	IV	SNY	48	56	3	5	175%
	005	D 005 1	180 Cell	32	32	0	64	IV	SNY	48	51	8	5	159%
		D 005 2	180 Cell	32	32	0	64	IV	SNY	48	54	6	4	169%
	006	D 006 1	180 Cell	32	32	0	64	IV	VAR	48	28	26	6	88%
		D 006 2	180 Cell	32	32	0	64	IV	VAR	48	18	44	2	56%
	007	D 007 1	180 Cell	32	32	0	64	IV	SNY	48	42	19	3	131%
		D 007 2	180 Cell	32	32	0	64	IV	SNY	48	40	20	2	125%
	008	D 008 1	180 Cell	32	32	0	64	IV	SNY	48	47	11	6	147%
		D 008 2	180 Cell	32	32	0	64	IV	SNY	48	46	11	7	144%

Generated by :
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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
KVSP-Facility D Total				**512**	**512**	**0**	**1024**			**768**	**748**	**181**	**87**	**146%**
KVSP-Facility Z01 - STRH	001	Z01001A1	Cell	12	12	0	24	NA	SRH	15	12	11	1	100%
		Z01001B1	Cell	12	12	0	24	NA	SRH	15	14	5	5	117%
		Z01001C1	Cell	12	12	0	24	NA	SRH	15	12	5	7	100%
		Z01001D1	Cell	12	12	0	24	NA	SRH	15	19	3	2	158%
		Z01001E1	Cell	12	12	0	24	NA	SRH	15	15	6	3	125%
		Z01001F1	Cell	14	14	0	28	NA	SRH	18	22	2	4	157%
		Z01001G1	Cell	14	14	0	28	NA	SRH	18	12	11	5	86%
		Z01001H1	Cell	12	12	0	24	NA	SRH	15	9	12	3	75%
KVSP-Facility Z01 - STRH Total				**100**	**100**	**0**	**200**			**125**	**115**	**55**	**30**	**115%**
KVSP-Facility Z02	001	Z02001A1	Cell	12	12	0	24	NA	ASU	15	11	10	3	92%
		Z02001B1	Cell	12	12	0	24	NA	ASU	15	13	6	5	108%
		Z02001C1	Cell	12	12	0	24	NA	ASU	15	11	9	4	92%
		Z02001D1	Cell	12	12	0	24	NA	ASU	15	13	7	4	108%
		Z02001E1	Cell	12	12	0	24	NA	ASU	15	1	22	1	8%
		Z02001F1	Cell	14	14	0	28	NA	ASU	18	20	7	1	143%
		Z02001G1	Cell	14	14	0	28	NA	ASU	18	11	15	2	79%
		Z02001H1	Cell	12	12	0	24	NA	ASU	15	13	7	2	108%
KVSP-Facility Z02 Total				**100**	**100**	**0**	**200**			**125**	**93**	**83**	**22**	**93%**
KVSP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	71	129	0	71%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	0	200	0	0%
KVSP-MSF Total				**200**	**200**	**0**	**400**			**300**	**71**	**329**	**0**	**36%**
Grand Total				**2448**	**2448**	**22**	**4918**			**3622**	**3432**	**1107**	**354**	**140%**

Generated by :
JERRY.GOLD

LAC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
LAC-Central Service	INF	S INF 1	Cell	0	0	4	4	NA	CTC	0	2	0	0	
				0	0	12	12		MCB	0	8	4	0	
LAC-Central Service Total				**0**	**0**	**16**	**16**			**0**	**10**	**4**	**0**	
LAC-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	GP	75	66	25	7	132%
		A 001 2	270 Cell	50	50	0	100	III	GP	75	81	17	2	162%
	002	A 002 1	270 Cell	50	50	0	100	III	GP	75	79	17	4	158%
		A 002 2	270 Cell	50	50	0	100	III	GP	75	82	18	0	164%
	003	A 003 1	270 Cell	50	50	0	100	III	GP	75	67	28	4	134%
		A 003 2	270 Cell	50	50	0	100	III	GP	75	91	7	1	182%
	004	A 004 1	270 Cell	50	50	0	100	III	GP	75	50	40	10	100%
		A 004 2	270 Cell	50	50	0	100	III	GP	75	71	29	0	142%
	005	A 005 1	270 Cell	50	50	0	100	III	GP	75	71	22	6	142%
		A 005 2	270 Cell	50	50	0	100	III	GP	75	78	21	1	156%
LAC-Facility A Total				**500**	**500**	**0**	**1000**			**750**	**736**	**224**	**35**	**147%**
LAC-Facility B	001	B 001 1	270 Cell	50	50	0	100	IV	GP	75	70	19	11	140%
		B 001 2	270 Cell	50	50	0	100	IV	GP	75	84	13	3	168%
	002	B 002 1	270 Cell	50	50	0	100	IV	VAR	75	6	93	1	12%
		B 002 2	270 Cell	50	50	0	100	IV	VAR	75	5	95	0	10%
	003	B 003 1	270 Cell	50	50	0	100	IV	GP	75	76	18	5	152%
		B 003 2	270 Cell	50	50	0	100	IV	GP	75	88	7	5	176%
	004	B 004 1	270 Cell	50	50	0	100	IV	GP	75	75	15	10	150%
		B 004 2	270 Cell	50	50	0	100	IV	GP	75	85	9	6	170%
	005	B 005 1	270 Cell	50	50	0	100	IV	GP	75	84	13	3	168%
		B 005 2	270 Cell	50	50	0	100	IV	GP	75	85	13	2	170%
LAC-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**658**	**295**	**46**	**132%**
LAC-Facility C	001	C 001 1	270 Cell	50	50	0	100	IV	SNY	75	66	22	11	132%
		C 001 2	270 Cell	50	50	0	100	IV	SNY	75	78	14	8	156%
	002	C 002 1	270 Cell	50	50	0	100	IV	SNY	75	69	22	9	138%
		C 002 2	270 Cell	50	50	0	100	IV	SNY	75	69	22	9	138%
	003	C 003 1	270 Cell	50	50	0	100	IV	SNY	75	60	34	5	120%
		C 003 2	270 Cell	50	50	0	100	IV	SNY	75	69	26	5	138%
	004	C 004 1	270 Cell	50	50	0	100	IV	SNY	75	63	29	8	126%
		C 004 2	270 Cell	50	50	0	100	IV	SNY	75	78	19	3	156%
	005	C 005 1	270 Cell	50	50	0	100	IV	VAR	75	16	82	2	32%
		C 005 2	270 Cell	50	50	0	100	IV	VAR	75	0	100	0	0%
LAC-Facility C Total				**500**	**500**	**0**	**1000**			**750**	**568**	**370**	**60**	**114%**
LAC-Facility D	001	D 001 1	270 Cell	50	50	0	100	IV	EOP	75	53	32	14	106%
		D 001 2	270 Cell	50	50	0	100	IV	EOP	75	60	23	17	120%
	002	D 002 1	270 Cell	50	50	0	100	IV	EOP	75	53	35	11	106%
		D 002 2	270 Cell	50	50	0	100	IV	EOP	75	57	25	17	114%
	003	D 003 1	270 Cell	50	50	0	100	IV	EOP	75	54	38	8	108%
		D 003 2	270 Cell	50	50	0	100	IV	EOP	75	66	28	6	132%
	004	D 004 1	270 Cell	50	50	0	100	IV	EOP	75	50	39	11	100%
		D 004 2	270 Cell	50	50	0	100	IV	EOP	75	57	33	10	114%
	005	D 005 1	270 Cell	50	50	0	100	NA	ASU	63	49	42	9	98%
		D 005 2	270 Cell	50	50	0	100	NA	ASU	63	53	35	12	106%
LAC-Facility D Total				**500**	**500**	**0**	**1000**			**725**	**552**	**330**	**115**	**110%**
LAC-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	24	40	0	24%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	22	42	0	22%
LAC-MSF Total				**200**	**200**	**0**	**400**			**300**	**46**	**82**	**0**	**23%**
LAC-STRH	001	Z 001 1	Cell	101	99	0	200	NA	SRH	126	107	68	25	106%
LAC-STRH Total				**101**	**99**	**0**	**200**			**126**	**107**	**68**	**25**	**106%**
Grand Total				**2301**	**2299**	**16**	**4616**			**3401**	**2677**	**1373**	**281**	**116%**

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MCSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
MCSP-Central Service	INF	S INF 1	Cell	0	0	2	2	NA	CTC	0	2	0	0	
				0	0	8	8		MCB	0	8	0	0	
MCSP-Central Service Total				**0**	**0**	**10**	**10**			**0**	**10**	**0**	**0**	
MCSP-Facility A	001	A 001 1	270 Cell	50	50	0	100	IV	SNY	75	80	7	13	160%
		A 001 2	270 Cell	50	50	0	100	IV	SNY	75	83	6	11	166%
	002	A 002 1	270 Cell	50	50	0	100	IV	VAR	75	3	94	1	6%
		A 002 2	270 Cell	50	50	0	100	IV	VAR	75	14	79	3	28%
	003	A 003 1	270 Cell	50	50	0	100	IV	SNY	75	83	11	6	166%
		A 003 2	270 Cell	50	50	0	100	IV	SNY	75	94	3	3	188%
	004	A 004 1	270 Cell	50	50	0	100	IV	SNY	75	88	7	5	176%
		A 004 2	270 Cell	50	50	0	100	IV	SNY	75	79	11	8	158%
	005	A 005 1	270 Cell	52	48	0	100	IV	EOP	78	81	10	7	156%
		A 005 2	270 Cell	50	50	0	100	IV	EOP	75	66	22	12	132%
MCSP-Facility A Total				**502**	**498**	**0**	**1000**			**753**	**671**	**250**	**69**	**134%**
MCSP-Facility B	006	B 006 1	270 Cell	50	50	0	100	III	EOP	75	65	24	11	130%
		B 006 2	270 Cell	50	50	0	100	III	EOP	75	73	15	11	146%
	007	B 007 1	270 Cell	50	50	0	100	III	EOP	75	60	32	8	120%
		B 007 2	270 Cell	50	50	0	100	III	EOP	75	69	20	10	138%
	008	B 008 1	270 Cell	50	50	0	100	III	SNY	75	77	18	4	154%
		B 008 2	270 Cell	50	50	0	100	III	SNY	75	84	12	4	168%
	009	B 009 1	270 Cell	50	50	0	100	III	SNY	75	84	14	2	168%
		B 009 2	270 Cell	50	50	0	100	III	SNY	75	79	13	8	158%
	010	B 010 1	270 Cell	50	50	0	100	III	SNY	75	83	12	5	166%
		B 010 2	270 Cell	50	50	0	100	III	SNY	75	90	5	4	180%
MCSP-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**764**	**165**	**67**	**153%**
MCSP-Facility C	011	C 011 1	270 Cell	50	50	0	100	III	SNY	75	87	9	4	174%
		C 011 2	270 Cell	50	50	0	100	III	SNY	75	91	6	3	182%
	012	C 012 1	270 Cell	50	50	0	100	NA	ASU	63	46	46	8	92%
		C 012 2	270 Cell	50	50	0	100	NA	ASU	63	52	36	12	104%
	013	C 013 1	270 Cell	50	50	0	100	III	SNY	75	66	26	7	132%
		C 013 2	270 Cell	50	50	0	100	III	SNY	75	85	10	5	170%
	014	C 014 1	270 Cell	50	50	0	100	III	SNY	75	88	10	2	176%
		C 014 2	270 Cell	50	50	0	100	III	SNY	75	94	4	2	188%
	015	C 015 1	270 Cell	50	50	0	100	III	SNY	75	89	10	1	178%
		C 015 2	270 Cell	50	50	0	100	III	SNY	75	86	8	6	172%
MCSP-Facility C Total				**500**	**500**	**0**	**1000**			**725**	**784**	**165**	**50**	**157%**
MCSP-Facility D	016A	D 016A1	Dorm	30	0	0	30	II	PF	30	29	0	0	97%
		D 016A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	016B	D 016B1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		D 016B2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	016C	D 016C1	Dorm	30	0	0	30	II	PF	30	28	1	0	93%
		D 016C2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	016D	D 016D1	Dorm	30	0	0	30	II	PF	30	29	1	0	97%
		D 016D2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	017A	D 017A1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		D 017A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	017B	D 017B1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		D 017B2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	017C	D 017C1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		D 017C2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	017D	D 017D1	Dorm	30	0	0	30	II	PF	30	29	1	0	97%
		D 017D2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	018A	D 018A1	Dorm	30	0	0	30	II	EOP	30	18	12	0	60%
		D 018A2	Dorm	36	0	0	36	II	EOP	36	33	3	0	92%
	018B	D 018B1	Dorm	30	0	0	30	II	EOP	30	29	1	0	97%
		D 018B2	Dorm	36	0	0	36	II	EOP	36	34	2	0	94%
	018C	D 018C1	Dorm	30	0	0	30	II	EOP	30	27	3	0	90%
		D 018C2	Dorm	36	0	0	36	II	EOP	36	33	3	0	92%
	018D	D 018D1	Dorm	30	0	0	30	II	EOP	30	27	3	0	90%
		D 018D2	Dorm	36	0	0	36	II	EOP	36	32	4	0	89%
MCSP-Facility D Total				**792**	**0**	**0**	**792**			**792**	**756**	**34**	**0**	**95%**
MCSP-Facility E	019A	E 019A1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 019A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	019B	E 019B1	Dorm	30	0	0	30	II	PF	30	29	0	0	97%
		E 019B2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	019C	E 019C1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 019C2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	019D	E 019D1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 019D2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	020A	E 020A1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 020A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	020B	E 020B1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
MCSP-Facility E	020B	E 020B2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	020C	E 020C1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 020C2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	020D	E 020D1	Dorm	30	0	0	30	II	PF	30	29	0	0	97%
		E 020D2	Dorm	36	0	0	36	II	PF	36	35	1	0	97%
	021A	E 021A1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 021A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	021B	E 021B1	Dorm	30	0	0	30	II	PF	30	29	1	0	97%
		E 021B2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	021C	E 021C1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 021C2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	021D	E 021D1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 021D2	Dorm	36	0	0	36	II	PF	36	35	0	0	97%
MCSP-Facility E Total				**792**	**0**	**0**	**792**			**792**	**787**	**2**	**0**	**99%**
MCSP-MSF	001	M 001A1	Dorm	12	12	0	24	I	WC	18	3	21	0	25%
		M 001B1	Dorm	12	12	0	24	I	WC	18	2	22	0	17%
		M 001C1	Dorm	12	12	0	24	I	WC	18	3	21	0	25%
		M 001D1	Dorm	12	12	0	24	I	WC	18	2	22	0	17%
		M 001E1	Dorm	12	12	0	24	I	WC	18	4	20	0	33%
		M 001F1	Dorm	12	12	0	24	I	WC	18	3	21	0	25%
		M 001G1	Dorm	12	12	0	24	I	WC	18	3	21	0	25%
		M 001H1	Dorm	12	12	0	24	I	WC	18	3	21	0	25%
	002	M 002A1	Dorm	12	12	0	24	I	WC	18	5	19	0	42%
		M 002B1	Dorm	12	12	0	24	I	WC	18	4	20	0	33%
		M 002C1	Dorm	12	12	0	24	I	WC	18	4	20	0	33%
		M 002D1	Dorm	12	12	0	24	I	WC	18	5	19	0	42%
		M 002E1	Dorm	12	12	0	24	I	WC	18	0	24	0	0%
		M 002F1	Dorm	12	12	0	24	I	WC	18	5	19	0	42%
		M 002G1	Dorm	12	12	0	24	I	WC	18	5	19	0	42%
		M 002H1	Dorm	12	12	0	24	I	WC	18	0	24	0	0%
	FIR	M FIR 1	Dorm	8	0	0	8	I	FH	8	5	3	0	63%
MCSP-MSF Total				**200**	**192**	**0**	**392**			**296**	**56**	**336**	**0**	**28%**
Grand Total				**3286**	**1690**	**10**	**4986**			**4108**	**3828**	**952**	**186**	**116%**

Generated by :
JERRY.GOLD

NKSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
NKSP-Central Service	INF	S INF 1	Cell	0	0	6	6	NA	CTC	0	6	0	0	
				0	0	10	10		MCB	0	4	6	0	
NKSP-Central Service Total				**0**	**0**	**16**	**16**			**0**	**10**	**6**	**0**	
NKSP-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	GP	75	86	9	1	172%
		A 001 2	270 Cell	50	50	0	100	III	GP	75	89	10	1	178%
	002	A 002 1	270 Cell	50	50	0	100	III	GP	75	89	6	1	178%
		A 002 2	270 Cell	50	50	0	100	III	GP	75	90	8	2	180%
	003	A 003 1	270 Cell	50	50	0	100	III	GP	75	82	7	7	164%
		A 003 2	270 Cell	50	50	0	100	III	GP	75	91	7	1	182%
	004	A 004 1	270 Cell	50	45	0	95	III	GP	75	16	79	0	32%
		A 004 2	270 Cell	50	50	0	100	III	GP	75	21	79	0	42%
	005	A 005 1	270 Cell	50	50	0	100	III	GP	75	89	7	0	178%
		A 005 2	270 Cell	50	50	0	100	III	GP	75	86	13	1	172%
NKSP-Facility A Total				**500**	**495**	**0**	**995**			**750**	**739**	**225**	**14**	**148%**
NKSP-Facility B	001	B 001 1	Cell	46	46	0	92	NA	RC	69	9	82	1	20%
		B 001 2	Cell	54	54	0	108	NA	RC	81	24	84	0	44%
	002	B 002 1	Cell	46	46	0	92	NA	RC	69	81	11	0	176%
		B 002 2	Cell	54	54	0	108	NA	RC	81	89	18	1	165%
	003	B 003 1	Cell	46	46	0	92	NA	RC	69	81	11	0	176%
		B 003 2	Cell	54	54	0	108	NA	RC	81	96	11	1	178%
	004	B 004 1	Cell	48	46	0	94	NA	RC	72	76	17	1	158%
		B 004 2	Cell	54	54	0	108	NA	RC	81	87	21	0	161%
	005	B 005 1	Cell	46	46	0	92	NA	RC	69	68	24	0	148%
		B 005 2	Cell	54	54	0	108	NA	RC	81	46	62	0	85%
	006	B 006 1	Cell	46	46	0	92	NA	RC	69	77	14	1	167%
		B 006 2	Cell	54	54	0	108	NA	RC	81	83	23	2	154%
NKSP-Facility B Total				**602**	**600**	**0**	**1202**			**903**	**817**	**378**	**7**	**136%**
NKSP-Facility C	001	C 001 1	Dorm	80	79	0	159	NA	RC	120	112	47	0	140%
		C 001 2	Dorm	66	66	0	132	NA	RC	99	75	57	0	114%
	002	C 002 1	Dorm	80	79	0	159	NA	RC	120	49	110	0	61%
		C 002 2	Dorm	66	66	0	132	NA	RC	99	103	29	0	156%
	003	C 003 1	Dorm	80	79	0	159	NA	RC	120	140	18	0	175%
		C 003 2	Dorm	66	66	0	132	NA	RC	99	125	7	0	189%
	004	C 004 1	Dorm	80	79	0	159	NA	RC	120	133	26	0	166%
		C 004 2	Dorm	66	66	0	132	NA	RC	99	116	16	0	176%
	East	C E 1	Dorm	100	100	0	200	NA	RC	150	125	75	0	125%
	West	C W 1	Dorm	100	100	0	200	NA	RC	150	131	69	0	131%
NKSP-Facility C Total				**784**	**780**	**0**	**1564**			**1176**	**1109**	**454**	**0**	**141%**
NKSP-Facility D	001	D 001 1	Cell	46	46	0	92	NA	RC	69	77	13	2	167%
		D 001 2	Cell	54	54	0	108	NA	RC	81	90	18	0	167%
	002	D 002 1	Cell	46	46	0	92	NA	RC	69	86	5	1	187%
		D 002 2	Cell	54	54	0	108	NA	RC	81	86	21	1	159%
	003	D 003 1	Cell	48	46	0	94	NA	VAR	72	25	68	1	52%
		D 003 2	Cell	54	54	0	108	NA	VAR	81	21	85	2	39%
	004	D 004 1	Cell	46	46	0	92	NA	RC	69	75	15	2	163%
		D 004 2	Cell	54	54	0	108	NA	RC	81	77	26	5	143%
	005	D 005 1	Cell	46	46	0	92	NA	RC	69	78	11	3	170%
		D 005 2	Cell	54	54	0	108	NA	RC	81	103	4	1	191%
	006	D 006 1	Cell	46	46	0	92	NA	ASU	58	37	40	15	80%
		D 006 2	Cell	54	54	0	108	NA	ASU	68	67	23	18	124%
NKSP-Facility D Total				**602**	**600**	**0**	**1202**			**878**	**822**	**329**	**51**	**137%**
NKSP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	64	136	0	64%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	63	136	0	63%
	FIR	M FIR 1	Dorm	10	0	0	10	I	FH	10	6	4	0	60%
NKSP-MSF Total				**210**	**200**	**0**	**410**			**310**	**133**	**276**	**0**	**63%**
Grand Total				**2698**	**2675**	**16**	**5389**			**4017**	**3630**	**1668**	**72**	**135%**

Generated by :
JERRY.GOLD

PBSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
PBSP-Central Service	INF	S INF 1	Cell	0	0	10	10	NA	CTC	0	3	7	0	
				0	0	10	10		MCB	0	4	6	0	
PBSP-Central Service Total				**0**	**0**	**20**	**20**			**0**	**7**	**13**	**0**	
PBSP-Facility A	001	A 001 1	180 Cell	32	32	0	64	IV	VAR	48	2	62	0	6%
		A 001 2	180 Cell	32	32	0	64	IV	VAR	48	0	64	0	0%
	002	A 002 1	180 Cell	32	32	0	64	IV	GP	48	26	35	2	81%
		A 002 2	180 Cell	32	32	0	64	IV	GP	48	24	40	0	75%
	003	A 003 1	180 Cell	32	32	0	64	IV	GP	48	24	40	0	75%
		A 003 2	180 Cell	32	32	0	64	IV	GP	48	20	44	0	63%
	004	A 004 1	180 Cell	32	32	0	64	IV	GP	48	59	2	3	184%
		A 004 2	180 Cell	32	32	0	64	IV	GP	48	62	1	1	194%
	005	A 005 1	180 Cell	32	32	0	64	IV	GP	48	58	2	4	181%
		A 005 2	180 Cell	32	32	0	64	IV	GP	48	59	2	3	184%
	006	A 006 1	180 Cell	32	32	0	64	IV	GP	48	62	2	0	194%
		A 006 2	180 Cell	33	31	0	64	IV	GP	50	59	2	3	179%
	007	A 007 1	180 Cell	32	32	0	64	IV	GP	48	63	0	1	197%
		A 007 2	180 Cell	32	32	0	64	IV	GP	48	59	4	1	184%
	008	A 008 1	180 Cell	32	32	0	64	IV	GP	48	52	11	1	163%
		A 008 2	180 Cell	32	32	0	64	IV	GP	48	56	7	1	175%
PBSP-Facility A Total				**513**	**511**	**0**	**1024**			**770**	**685**	**318**	**20**	**134%**
PBSP-Facility B	001	B 001 1	180 Cell	32	32	0	64	NA	RGP	48	22	36	5	69%
		B 001 2	180 Cell	32	32	0	64	NA	RGP	48	21	40	3	66%
	002	B 002 1	180 Cell	32	10	0	42	NA	RGP	32	14	23	5	44%
		B 002 2	180 Cell	32	10	0	42	NA	RGP	32	9	30	3	28%
	003	B 003 1	180 Cell	32	32	0	64	IV	GP	48	45	18	1	141%
		B 003 2	180 Cell	32	32	0	64	IV	GP	48	35	29	0	109%
	004	B 004 1	180 Cell	32	32	0	64	IV	GP	48	43	20	1	134%
		B 004 2	180 Cell	32	32	0	64	IV	GP	48	47	17	0	147%
	005	B 005 1	180 Cell	32	32	0	64	IV	GP	48	51	10	3	159%
		B 005 2	180 Cell	32	32	0	64	IV	GP	48	49	12	3	153%
	006	B 006 1	180 Cell	32	32	0	64	IV	GP	48	48	16	0	150%
		B 006 2	180 Cell	32	32	0	64	IV	GP	48	43	18	3	134%
	007	B 007 1	180 Cell	32	32	0	64	IV	GP	48	37	27	0	116%
		B 007 2	180 Cell	32	32	0	64	IV	GP	48	44	20	0	138%
	008	B 008 1	180 Cell	32	32	0	64	IV	GP	48	57	5	2	178%
		B 008 2	180 Cell	32	32	0	64	IV	GP	48	57	5	2	178%
PBSP-Facility B Total				**512**	**468**	**0**	**980**			**736**	**622**	**326**	**31**	**121%**
PBSP-Facility C	001	C 001 1	Cell	24	24	0	48	NA	VAR	36	21	27	0	88%
		C 001 2	Cell	24	24	0	48	NA	VAR	36	13	32	1	54%
	002	C 002 1	Cell	24	24	0	48	NA	ASU	30	24	23	1	100%
		C 002 2	Cell	24	24	0	48	NA	ASU	30	15	30	3	63%
	003	C 003 1	Cell	24	24	0	48	NA	ASU	30	32	16	0	133%
		C 003 2	Cell	24	24	0	48	NA	ASU	30	18	28	2	75%
	004	C 004 1	Cell	24	24	0	48	NA	ASU	30	0	48	0	0%
		C 004 2	Cell	24	24	0	48	NA	ASU	30	0	48	0	0%
	005	C 005 1	Cell	24	24	0	48	NA	ASU	30	29	19	0	121%
		C 005 2	Cell	24	24	0	48	NA	ASU	30	22	23	1	92%
	006	C 006 1	Cell	24	24	0	48	NA	ASU	30	0	48	0	0%
		C 006 2	Cell	24	24	0	48	NA	ASU	30	0	48	0	0%
	007	C 007 1	Cell	24	24	0	48	NA	SHU	29	29	18	1	121%
		C 007 2	Cell	24	24	0	48	NA	SHU	29	14	30	4	58%
	008	C 008 1	Cell	24	24	0	48	NA	SHU	29	27	19	2	113%
		C 008 2	Cell	24	24	0	48	NA	SHU	29	11	35	2	46%
	009	C 009 1	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
		C 009 2	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
	010	C 010 1	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
		C 010 2	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
	011	C 011 1	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
		C 011 2	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
	012	C 012 1	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
		C 012 2	Cell	24	24	0	48	NA	SHU	29	0	48	0	0%
PBSP-Facility C Total				**576**	**576**	**0**	**1152**			**718**	**255**	**876**	**17**	**44%**
PBSP-Facility D	001	D 001 1	Cell	24	0	0	24	II	PF	36	20	4	0	83%
		D 001 2	Cell	24	0	0	24	II	PF	36	20	4	0	83%
	002	D 002 1	Cell	24	0	0	24	II	PF	36	24	0	0	100%
		D 002 2	Cell	24	0	0	24	II	PF	36	23	1	0	96%
	003	D 003 1	Cell	24	0	0	24	II	PF	36	24	0	0	100%
		D 003 2	Cell	24	0	0	24	II	PF	36	24	0	0	100%
	004	D 004 1	Cell	24	0	0	24	II	PF	36	24	0	0	100%
		D 004 2	Cell	24	0	0	24	II	PF	36	24	0	0	100%
	005	D 005 1	Cell	24	1	0	25	II	PF	36	19	5	0	79%
		D 005 2	Cell	24	0	0	24	II	PF	36	23	1	0	96%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
PBSP-Facility D	006	D 006 1	Cell	24	0	0	24	II	PF	36	23	1	0	96%
		D 006 2	Cell	24	0	0	24	II	PF	36	24	0	0	100%
	007	D 007 1	Cell	24	0	0	24	II	PF	36	23	1	0	96%
		D 007 2	Cell	24	0	0	24	II	PF	36	20	4	0	83%
	008	D 008 1	Cell	24	0	0	24	II	PF	36	21	3	0	88%
		D 008 2	Cell	24	0	0	24	II	PF	36	22	2	0	92%
	009	D 009 1	Cell	24	0	0	24	II	PF	36	24	0	0	100%
		D 009 2	Cell	24	0	0	24	II	PF	36	22	2	0	92%
	010	D 010 1	Cell	24	0	0	24	II	PF	36	22	2	0	92%
		D 010 2	Cell	24	0	0	24	II	PF	36	21	3	0	88%
PBSP-Facility D Total				**480**	**1**	**0**	**481**			**720**	**447**	**33**	**0**	**93%**
PBSP-MSF	001	M 001 1	Dorm	48	48	0	96	I	WC	72	15	81	0	31%
		M 001 2	Dorm	48	48	0	96	I	WC	72	14	82	0	29%
	002	M 002 1	Dorm	48	48	0	96	I	WC	72	0	96	0	0%
		M 002 2	Dorm	48	48	0	96	I	WC	72	0	96	0	0%
	FIR	M FIR 1	Dorm	8	8	0	16	I	FH	8	1	15	0	13%
PBSP-MSF Total				**200**	**200**	**0**	**400**			**296**	**30**	**370**	**0**	**15%**
PBSP-STRH	001	Z 001 1	Cell	100	100	0	200	NA	SRH	125	65	123	12	65%
PBSP-STRH Total				**100**	**100**	**0**	**200**			**125**	**65**	**123**	**12**	**65%**
Grand Total				**2381**	**1856**	**20**	**4257**			**3364**	**2111**	**2059**	**80**	**89%**

Generated by :
JERRY.GOLD

PVSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
PVSP-Central Service	INF	S INF 1	Cell	0	0	9	9	NA	CTC	0	0	0	0	
				0	0	6	6		MCB	0	0	0	0	
PVSP-Central Service Total				**0**	**0**	**15**	**15**			**0**	**0**	**0**	**0**	
PVSP-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	SNY	75	59	41	0	118%
		A 001 2	270 Cell	50	50	0	100	III	SNY	75	73	27	0	146%
	002	A 002 1	270 Cell	50	50	0	100	III	SNY	75	67	32	1	134%
		A 002 2	270 Cell	50	50	0	100	III	SNY	75	74	25	1	148%
	003	A 003 1	270 Cell	50	50	0	100	III	SNY	75	65	34	1	130%
		A 003 2	270 Cell	50	50	0	100	III	SNY	75	73	27	0	146%
	004	A 004 1	270 Cell	50	50	0	100	III	SNY	75	66	33	1	132%
		A 004 2	270 Cell	50	50	0	100	III	SNY	75	69	30	1	138%
	005	A 005 1	270 Cell	50	50	0	100	III	SNY	75	68	29	3	136%
		A 005 2	270 Cell	50	50	0	100	III	SNY	75	70	29	1	140%
PVSP-Facility A Total				**500**	**500**	**0**	**1000**			**750**	**684**	**307**	**9**	**137%**
PVSP-Facility B	001	B 001 1	270 Cell	50	50	0	100	III	GP	75	64	35	1	128%
		B 001 2	270 Cell	50	50	0	100	III	GP	75	72	28	0	144%
	002	B 002 1	270 Cell	50	50	0	100	III	GP	75	65	34	0	130%
		B 002 2	270 Cell	50	50	0	100	III	GP	75	70	30	0	140%
	003	B 003 1	270 Cell	50	50	0	100	III	GP	75	69	31	0	138%
		B 003 2	270 Cell	50	50	0	100	III	GP	75	68	32	0	136%
	004	B 004 1	270 Cell	50	50	0	100	III	GP	75	68	31	1	136%
		B 004 2	270 Cell	50	50	0	100	III	GP	75	66	34	0	132%
	005	B 005 1	270 Cell	50	50	0	100	III	GP	75	75	25	0	150%
		B 005 2	270 Cell	50	50	0	100	III	GP	75	54	45	1	108%
PVSP-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**671**	**325**	**3**	**134%**
PVSP-Facility C	001	C 001 1	270 Cell	50	50	0	100	III	GP	75	43	56	1	86%
		C 001 2	270 Cell	50	50	0	100	III	GP	75	44	56	0	88%
	002	C 002 1	270 Cell	50	50	0	100	III	GP	75	62	38	0	124%
		C 002 2	270 Cell	50	50	0	100	III	GP	75	64	34	0	128%
	003	C 003 1	270 Cell	50	50	0	100	III	GP	75	66	34	0	132%
		C 003 2	270 Cell	50	50	0	100	III	GP	75	64	36	0	128%
	004	C 004 1	270 Cell	50	50	0	100	III	GP	75	55	45	0	110%
		C 004 2	270 Cell	50	50	0	100	III	GP	75	65	35	0	130%
	005	C 005 1	270 Cell	50	50	0	100	III	GP	75	58	40	1	116%
		C 005 2	270 Cell	50	50	0	100	III	GP	75	66	34	0	132%
PVSP-Facility C Total				**500**	**500**	**0**	**1000**			**750**	**587**	**408**	**2**	**117%**
PVSP-Facility D	001	D 001 1	270 Cell	50	50	0	100	III	SNY	75	84	12	4	168%
		D 001 2	270 Cell	50	50	0	100	III	SNY	75	86	14	0	172%
	002	D 002 1	270 Cell	50	50	0	100	III	SNY	75	84	13	3	168%
		D 002 2	270 Cell	50	50	0	100	III	SNY	75	86	11	2	172%
	003	D 003 1	270 Cell	50	50	0	100	III	SNY	75	1	99	0	2%
		D 003 2	270 Cell	50	50	0	100	III	SNY	75	0	100	0	0%
	004	D 004 1	270 Cell	50	50	0	100	III	SNY	75	36	64	0	72%
		D 004 2	270 Cell	50	50	0	100	III	SNY	75	84	13	3	168%
	005	D 005 1	270 Cell	50	50	0	100	III	VAR	75	44	55	1	88%
		D 005 2	270 Cell	50	50	0	100	III	VAR	75	15	84	1	30%
PVSP-Facility D Total				**500**	**500**	**0**	**1000**			**750**	**520**	**465**	**14**	**104%**
PVSP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	56	144	0	56%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	54	146	0	54%
	FIR	M FIR 1	Dorm	8	0	0	8	I	FH	8	7	1	0	88%
PVSP-MSF Total				**208**	**200**	**0**	**408**			**308**	**117**	**291**	**0**	**56%**
PVSP-STRH	001	Z 001 1	Cell	100	100	0	200	NA	SRH	125	82	115	3	82%
PVSP-STRH Total				**100**	**100**	**0**	**200**			**125**	**82**	**115**	**3**	**82%**
Grand Total				**2308**	**2300**	**15**	**4623**			**3433**	**2661**	**1911**	**31**	**115%**

Generated by :
JERRY.GOLD

RJD Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
RJD-Central Service	INF	S INF 1	Cell	0	0	14	14	NA	CTC	0	11	1	0	
				0	0	14	14		MCB	0	13	1	0	
RJD-Central Service Total				**0**	**0**	**28**	**28**			**0**	**24**	**2**	**0**	
RJD-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	EOP	75	63	14	10	126%
		A 001 2	270 Cell	50	50	0	100	III	EOP	75	67	13	13	134%
	002	A 002 1	270 Cell	50	50	0	100	III	EOP	75	72	21	7	144%
		A 002 2	270 Cell	50	50	0	100	III	EOP	75	71	22	7	142%
	003	A 003 1	270 Cell	50	50	0	100	III	SNY	75	81	18	1	162%
		A 003 2	270 Cell	50	50	0	100	III	SNY	75	86	8	6	172%
	004	A 004 1	270 Cell	50	50	0	100	III	SNY	75	70	20	8	140%
		A 004 2	270 Cell	50	50	0	100	III	SNY	75	85	6	9	170%
	005	A 005 1	270 Cell	50	50	0	100	III	SNY	75	79	16	5	158%
		A 005 2	270 Cell	50	50	0	100	III	SNY	75	94	1	5	188%
RJD-Facility A Total				**500**	**500**	**0**	**1000**			**750**	**768**	**139**	**71**	**154%**
RJD-Facility B	006	B 006 1	270 Cell	50	50	0	100	NA	ASU	63	24	58	8	48%
		B 006 2	270 Cell	50	50	0	100	NA	ASU	63	26	60	6	52%
	007	B 007 1	270 Cell	50	50	0	100	NA	ASU	63	20	61	3	40%
		B 007 2	270 Cell	50	50	0	100	NA	ASU	63	24	69	0	48%
	008	B 008 1	270 Cell	50	50	0	100	III	GP	75	48	50	2	96%
		B 008 2	270 Cell	50	50	0	100	III	GP	75	60	40	0	120%
	009	B 009 1	270 Cell	50	50	0	100	III	GP	75	50	44	6	100%
		B 009 2	270 Cell	50	50	0	100	III	GP	75	43	56	1	86%
	010	B 010 1	270 Cell	50	50	0	100	III	GP	75	51	47	2	102%
		B 010 2	270 Cell	50	50	0	100	III	GP	75	50	49	1	100%
RJD-Facility B Total				**500**	**500**	**0**	**1000**			**700**	**396**	**534**	**29**	**79%**
RJD-Facility C	011	C 011 1	270 Cell	50	50	0	100	IV	SNY	75	56	32	11	112%
		C 011 2	270 Cell	50	50	0	100	IV	SNY	75	79	16	5	158%
	012	C 012 1	270 Cell	50	50	0	100	IV	SNY	75	67	26	7	134%
		C 012 2	270 Cell	50	50	0	100	IV	SNY	75	79	13	8	158%
	013	C 013 1	270 Cell	50	50	0	100	IV	SNY	75	62	29	9	124%
		C 013 2	270 Cell	50	50	0	100	IV	SNY	75	78	16	6	156%
	014	C 014 1	270 Cell	50	50	0	100	IV	EOP	75	67	22	10	134%
		C 014 2	270 Cell	50	50	0	100	IV	EOP	75	63	23	14	126%
	015	C 015 1	270 Cell	50	50	0	100	IV	EOP	75	50	25	11	100%
		C 015 2	270 Cell	50	50	0	100	IV	EOP	75	63	23	14	126%
RJD-Facility C Total				**500**	**500**	**0**	**1000**			**750**	**664**	**225**	**95**	**133%**
RJD-Facility D	016	D 016 1	270 Cell	50	50	0	100	III	SNY	75	87	9	3	174%
		D 016 2	270 Cell	50	50	0	100	III	SNY	75	90	4	6	180%
	017	D 017 1	270 Cell	50	50	0	100	III	SNY	75	93	5	2	186%
		D 017 2	270 Cell	50	50	0	100	III	SNY	75	95	2	3	190%
	018	D 018 1	270 Cell	50	50	0	100	III	SNY	75	44	31	0	88%
		D 018 2	270 Cell	50	50	0	100	III	SNY	75	47	38	2	94%
	019	D 019 1	270 Cell	50	50	0	100	III	SNY	75	90	6	4	180%
		D 019 2	270 Cell	50	50	0	100	III	SNY	75	94	2	4	188%
	020	D 020 1	270 Cell	50	50	0	100	III	VAR	75	11	84	1	22%
		D 020 2	270 Cell	50	50	0	100	III	VAR	75	3	97	0	6%
RJD-Facility D Total				**500**	**500**	**0**	**1000**			**750**	**654**	**278**	**25**	**131%**
RJD-Facility E	023A	E 023A1	Dorm	30	0	0	30	II	EOP	30	28	1	0	93%
		E 023A2	Dorm	36	0	0	36	II	EOP	36	33	3	0	92%
	023B	E 023B1	Dorm	30	0	0	30	II	EOP	30	27	3	0	90%
		E 023B2	Dorm	36	0	0	36	II	EOP	36	36	0	0	100%
	023C	E 023C1	Dorm	30	0	0	30	II	EOP	30	27	3	0	90%
		E 023C2	Dorm	36	0	0	36	II	EOP	36	28	7	0	78%
	023D	E 023D1	Dorm	30	0	0	30	II	EOP	30	29	1	0	97%
		E 023D2	Dorm	36	0	0	36	II	EOP	36	32	4	0	89%
	024A	E 024A1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 024A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	024B	E 024B1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 024B2	Dorm	36	0	0	36	II	PF	36	35	1	0	97%
	024C	E 024C1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 024C2	Dorm	36	0	0	36	II	PF	36	31	5	0	86%
	024D	E 024D1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 024D2	Dorm	36	0	0	36	II	PF	36	35	1	0	97%
	025A	E 025A1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 025A2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	025B	E 025B1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 025B2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	025C	E 025C1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 025C2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
	025D	E 025D1	Dorm	30	0	0	30	II	PF	30	30	0	0	100%
		E 025D2	Dorm	36	0	0	36	II	PF	36	36	0	0	100%
RJD-Facility E Total				**792**	**0**	**0**	**792**			**792**	**761**	**29**	**0**	**96%**

Generated by :
JERRY.GOLD

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
RJD-MSF	021	M 021 1	Dorm	48	48	0	96	I	WC	72	9	87	0	19%
		M 021 2	Dorm	48	48	0	96	I	WC	72	6	90	0	13%
	022	M 022 1	Dorm	48	48	0	96	I	WC	72	9	87	0	19%
		M 022 2	Dorm	48	48	0	96	I	WC	72	4	92	0	8%
	FIR	M FIR 1	Dorm	8	0	0	8	I	FH	8	5	3	0	63%
RJD-MSF Total				**200**	**192**	**0**	**392**			**296**	**33**	**359**	**0**	**17%**
Grand Total				**2992**	**2192**	**28**	**5212**			**4038**	**3300**	**1566**	**220**	**110%**

Generated by :
JERRY.GOLD

SAC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SAC-Central Service	CTC 1	S CT1 1	Cell	0	0	2	2	NA	CTC	0	2	0	0	
				0	0	13	13		MCB	0	11	0	0	
	CTC 2	S CT2 1	Cell	0	0	11	11	NA	MCB	0	9	1	0	
SAC-Central Service Total				**0**	**0**	**26**	**26**			**0**	**22**	**1**	**0**	
SAC-Facility A	001	A 001 1	180 Cell	32	0	0	32	NA	PSU	32	31	1	0	97%
		A 001 2	180 Cell	32	0	0	32	NA	PSU	32	31	1	0	97%
	002	A 002 1	180 Cell	22	0	0	22	NA	PSU	22	21	1	0	95%
				10	0	0	10		VAR	10	5	5	0	50%
		A 002 2	180 Cell	22	0	0	22	NA	PSU	22	22	0	0	100%
				10	0	0	10		VAR	10	3	7	0	30%
	003	A 003 1	180 Cell	32	32	0	64	IV	EOP	48	43	11	10	134%
		A 003 2	180 Cell	32	32	0	64	IV	EOP	48	47	6	11	147%
	004	A 004 1	180 Cell	32	32	0	64	IV	EOP	48	53	5	6	166%
		A 004 2	180 Cell	32	32	0	64	IV	EOP	48	47	3	14	147%
	005	A 005 1	180 Cell	33	10	0	43	NA	ASU	41	34	6	2	103%
		A 005 2	180 Cell	32	0	0	32	NA	ASU	32	31	1	0	97%
	006	A 006 1	180 Cell	32	32	0	64	IV	EOP	48	48	9	7	150%
		A 006 2	180 Cell	32	32	0	64	IV	EOP	48	47	9	8	147%
	007	A 007 1	180 Cell	32	32	0	64	IV	EOP	48	48	8	8	150%
		A 007 2	180 Cell	32	32	0	64	IV	EOP	48	49	9	6	153%
	008	A 008 1	180 Cell	32	32	0	64	IV	GP	48	27	29	8	84%
		A 008 2	180 Cell	32	32	0	64	IV	GP	48	32	24	8	100%
SAC-Facility A Total				**513**	**330**	**0**	**843**			**681**	**619**	**135**	**88**	**121%**
SAC-Facility B	001	B 001 1	180 Cell	22	22	0	44	IV	EOP	33	29	4	11	132%
				10	0	0	10	NA	MCB	10	0	10	0	0%
		B 001 2	180 Cell	10	10	0	20	IV	EOP	15	15	0	5	150%
				12	12	0	24		VAR	18	13	5	6	108%
				10	0	0	10	NA	MCB	10	0	10	0	0%
	002	B 002 1	180 Cell	32	32	0	64	IV	GP	48	41	21	2	128%
		B 002 2	180 Cell	32	32	0	64	IV	GP	48	39	25	0	122%
	003	B 003 1	180 Cell	32	32	0	64	IV	GP	48	48	15	1	150%
		B 003 2	180 Cell	32	32	0	64	IV	GP	48	42	22	0	131%
	004	B 004 1	180 Cell	32	24	0	56	IV	GP	48	40	16	0	125%
		B 004 2	180 Cell	32	32	0	64	IV	GP	48	49	15	0	153%
	005	B 005 1	180 Cell	32	32	0	64	IV	EOP	48	46	10	8	144%
		B 005 2	180 Cell	32	32	0	64	IV	EOP	48	47	0	17	147%
	006	B 006 1	180 Cell	32	32	0	64	IV	EOP	48	48	4	12	150%
		B 006 2	180 Cell	32	32	0	64	IV	EOP	48	49	3	12	153%
	007	B 007 1	180 Cell	10	0	0	10	NA	NDS	10	0	10	0	0%
				22	0	0	22		PSU	22	21	1	0	95%
		B 007 2	180 Cell	10	0	0	10	NA	NDS	10	0	10	0	0%
				22	0	0	22		PSU	22	18	4	0	82%
	008	B 008 1	180 Cell	32	0	0	32	NA	LRH	38	19	13	0	59%
		B 008 2	180 Cell	32	0	0	32	NA	LRH	38	1	31	0	3%
SAC-Facility B Total				**512**	**356**	**0**	**868**			**707**	**565**	**229**	**74**	**110%**
SAC-Facility C	001	C 001 1	180 Cell	32	32	0	64	IV	GP	48	57	4	3	178%
		C 001 2	180 Cell	32	32	0	64	IV	GP	48	53	10	1	166%
	002	C 002 1	180 Cell	32	32	0	64	IV	GP	48	48	15	1	150%
		C 002 2	180 Cell	32	32	0	64	IV	GP	48	51	7	6	159%
	003	C 003 1	180 Cell	32	32	0	64	IV	GP	48	54	8	2	169%
		C 003 2	180 Cell	32	32	0	64	IV	GP	48	54	8	2	169%
	004	C 004 1	180 Cell	32	32	0	64	IV	GP	48	56	5	3	175%
		C 004 2	180 Cell	32	32	0	64	IV	GP	48	48	14	2	150%
	005	C 005 1	180 Cell	32	32	0	64	IV	GP	48	57	4	2	178%
		C 005 2	180 Cell	32	32	0	64	IV	GP	48	55	6	3	172%
	006	C 006 1	180 Cell	33	31	0	64	IV	GP	50	50	10	2	152%
		C 006 2	180 Cell	32	32	0	64	IV	GP	48	58	6	0	181%
	007	C 007 1	180 Cell	32	32	0	64	IV	GP	48	34	29	1	106%
		C 007 2	180 Cell	32	32	0	64	IV	GP	48	30	32	2	94%
	008	C 008 1	180 Cell	32	32	0	64	IV	VAR	48	4	60	0	13%
		C 008 2	180 Cell	32	32	0	64	IV	VAR	48	0	64	0	0%
SAC-Facility C Total				**513**	**511**	**0**	**1024**			**770**	**709**	**282**	**30**	**138%**
SAC-MSF	001	M 001A1	Dorm	12	11	0	23	I	WC	18	1	6	0	8%
		M 001B1	Dorm	12	11	0	23	I	WC	18	3	4	0	25%
		M 001C1	Dorm	12	11	0	23	I	WC	18	1	6	0	8%
		M 001D1	Dorm	12	11	0	23	I	WC	18	3	4	0	25%
		M 001E1	Dorm	12	11	0	23	I	WC	18	6	1	0	50%
		M 001F1	Dorm	12	11	0	23	I	WC	18	5	2	0	42%
		M 001G1	Dorm	12	11	0	23	I	WC	18	4	3	0	33%
		M 001H1	Dorm	12	11	0	23	I	WC	18	3	5	0	25%
	002	M 002I1	Dorm	12	11	0	23	I	WC	18	4	3	0	33%
		M 002J1	Dorm	12	11	0	23	I	WC	18	4	3	0	33%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SAC-MSF	002	M 002K1	Dorm	12	11	0	23	I	WC	18	4	4	0	33%
		M 002L1	Dorm	12	11	0	23	I	WC	18	3	4	0	25%
		M 002M1	Dorm	12	11	0	23	I	WC	18	4	3	0	33%
		M 002N1	Dorm	12	11	0	23	I	WC	18	2	5	0	17%
		M 002O1	Dorm	12	11	0	23	I	WC	18	3	4	0	25%
		M 002P1	Dorm	12	11	0	23	I	WC	18	2	5	0	17%
SAC-MSF Total				**192**	**176**	**0**	**368**			**288**	**52**	**62**	**0**	**27%**
SAC-STRH	001	Z 001A1	Cell	12	12	0	24	NA	SRH	15	7	15	2	58%
		Z 001B1	Cell	12	12	0	24	NA	SRH	15	14	4	6	117%
		Z 001C1	Cell	12	12	0	24	NA	SRH	15	13	6	5	108%
		Z 001D1	Cell	12	12	0	24	NA	SRH	15	4	19	1	33%
		Z 001E1	Cell	12	12	0	24	NA	SRH	15	12	1	10	100%
		Z 001F1	Cell	14	14	0	28	NA	SRH	18	14	6	8	100%
		Z 001G1	Cell	14	14	0	28	NA	SRH	18	17	5	6	121%
		Z 001H1	Cell	12	12	0	24	NA	SRH	15	15	5	4	125%
SAC-STRH Total				**100**	**100**	**0**	**200**			**125**	**96**	**61**	**42**	**96%**
Grand Total				**1830**	**1473**	**26**	**3329**			**2571**	**2063**	**770**	**234**	**113%**

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SATF Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SATF-Central Service	CTC	S INF 1	Cell	0	0	18	18	NA	CTC	0	17	1	0	
				0	0	20	20		MCB	0	8	12	0	
SATF-Central Service Total				**0**	**0**	**38**	**38**			**0**	**25**	**13**	**0**	
SATF-Facility A	001	A 001 1	Dorm	63	63	0	126	II	SNY	95	108	18	0	171%
		A 001 2	Dorm	63	63	0	126	II	SNY	95	111	14	0	176%
	002	A 002 1	Dorm	63	63	0	126	II	SNY	95	98	28	0	156%
		A 002 2	Dorm	63	63	0	126	II	SNY	95	119	7	0	189%
	003	A 003 1	Dorm	63	63	0	126	II	SNY	95	93	33	0	148%
		A 003 2	Dorm	63	63	0	126	II	SNY	95	102	24	0	162%
SATF-Facility A Total				**378**	**378**	**0**	**756**			**567**	**631**	**124**	**0**	**167%**
SATF-Facility B	001	B 001 1	Dorm	63	63	0	126	II	GP	95	94	32	0	149%
		B 001 2	Dorm	63	63	0	126	II	GP	95	117	8	0	186%
	002	B 002 1	Dorm	63	63	0	126	II	GP	95	100	26	0	159%
		B 002 2	Dorm	63	63	0	126	II	GP	95	120	6	0	190%
	003	B 003 1	Dorm	63	63	0	126	II	GP	95	104	22	0	165%
		B 003 2	Dorm	63	63	0	126	II	GP	95	123	3	0	195%
SATF-Facility B Total				**378**	**378**	**0**	**756**			**567**	**658**	**97**	**0**	**174%**
SATF-Facility C	001	C 001 1	180 Cell	32	32	0	64	IV	GP	48	37	24	3	116%
		C 001 2	180 Cell	32	32	0	64	IV	GP	48	40	23	1	125%
	002	C 002 1	180 Cell	32	32	0	64	IV	GP	48	48	14	2	150%
		C 002 2	180 Cell	32	32	0	64	IV	GP	48	50	12	1	156%
	003	C 003 1	180 Cell	32	32	0	64	IV	VAR	48	14	48	0	44%
		C 003 2	180 Cell	32	32	0	64	IV	VAR	48	3	59	0	9%
	004	C 004 1	180 Cell	10	10	0	20	IV	GP	15	0	20	0	0%
				22	22	0	44		VAR	33	0	42	0	0%
		C 004 2	180 Cell	11	11	0	22	IV	GP	17	7	14	1	64%
				21	21	0	42		VAR	32	0	42	0	0%
	005	C 005 1	180 Cell	32	32	0	64	IV	GP	48	48	14	2	150%
		C 005 2	180 Cell	32	32	0	64	IV	GP	48	50	11	3	156%
	006	C 006 1	180 Cell	32	32	0	64	IV	GP	48	47	14	3	147%
		C 006 2	180 Cell	32	32	0	64	IV	GP	48	44	15	5	138%
	007	C 007 1	180 Cell	32	32	0	64	IV	GP	48	46	15	3	144%
		C 007 2	180 Cell	32	32	0	64	IV	GP	48	54	7	3	169%
	008	C 008 1	180 Cell	32	32	0	64	IV	GP	48	54	9	1	169%
		C 008 2	180 Cell	32	32	0	64	IV	GP	48	57	7	0	178%
SATF-Facility C Total				**512**	**512**	**0**	**1024**			**768**	**599**	**390**	**28**	**117%**
SATF-Facility D	001	D 001 1	270 Cell	50	50	0	100	IV	SNY	75	81	15	4	162%
		D 001 2	270 Cell	50	50	0	100	IV	SNY	75	90	7	3	180%
	002	D 002 1	270 Cell	50	50	0	100	IV	SNY	75	87	7	4	174%
		D 002 2	270 Cell	50	50	0	100	IV	SNY	75	88	4	8	176%
	003	D 003 1	270 Cell	50	50	0	100	IV	SNY	75	75	13	8	150%
		D 003 2	270 Cell	50	50	0	100	IV	SNY	75	75	14	11	150%
	004	D 004 1	270 Cell	50	50	0	100	IV	SNY	75	85	5	10	170%
		D 004 2	270 Cell	50	50	0	100	IV	SNY	75	93	2	5	186%
	005	D 005 1	270 Cell	50	50	0	100	IV	SNY	75	93	2	4	186%
		D 005 2	270 Cell	50	50	0	100	IV	SNY	75	100	0	0	200%
SATF-Facility D Total				**500**	**500**	**0**	**1000**			**750**	**867**	**69**	**57**	**173%**
SATF-Facility E	001	E 001 1	270 Cell	50	50	0	100	III	SNY	75	62	26	9	124%
		E 001 2	270 Cell	50	50	0	100	III	SNY	75	80	12	8	160%
	002	E 002 1	270 Cell	50	50	0	100	III	VAR	75	14	79	1	28%
		E 002 2	270 Cell	50	50	0	100	III	VAR	75	2	98	0	4%
	003	E 003 1	270 Cell	50	50	0	100	III	SNY	75	80	3	16	160%
		E 003 2	270 Cell	50	50	0	100	III	SNY	75	93	1	6	186%
	004	E 004 1	270 Cell	50	50	0	100	III	SNY	75	84	5	11	168%
		E 004 2	270 Cell	50	50	0	100	III	SNY	75	91	3	6	182%
	005	E 005 1	270 Cell	50	50	0	100	III	SNY	75	82	5	13	164%
		E 005 2	270 Cell	50	50	0	100	III	SNY	75	93	2	5	186%
SATF-Facility E Total				**500**	**500**	**0**	**1000**			**750**	**681**	**234**	**75**	**136%**
SATF-Facility F	001	F 001 1	Dorm	60	60	0	120	II	PF	90	77	43	0	128%
				20	20	0	40		VAR	30	2	38	0	10%
		F 001 2	Dorm	72	72	0	144	II	PF	108	95	49	0	132%
				24	24	0	48		VAR	36	0	47	0	0%
	002	F 002 1	Dorm	80	80	0	160	II	PF	120	160	0	0	200%
		F 002 2	Dorm	96	96	0	192	II	PF	144	191	0	0	199%
	003	F 003 1	Dorm	80	40	0	120	II	EOP	120	100	20	0	125%
		F 003 2	Dorm	96	48	0	144	II	EOP	144	114	30	0	119%
SATF-Facility F Total				**528**	**440**	**0**	**968**			**792**	**739**	**227**	**0**	**140%**
SATF-Facility G	001	G 001 1	Dorm	80	40	0	120	II	EOP	120	65	55	0	81%
		G 001 2	Dorm	96	48	0	144	II	EOP	144	95	49	0	99%
	002	G 002 1	Dorm	80	80	0	160	II	PF	120	153	7	0	191%
		G 002 2	Dorm	96	96	0	192	II	PF	144	181	11	0	189%
	003	G 003 1	Dorm	40	20	0	60	II	EOP	60	34	26	0	85%

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SATF-Facility G	003	G 003 1	Dorm	40	40	0	80	II	PF	60	72	8	0	180%
		G 003 2	Dorm	48	24	0	72	II	EOP	72	35	37	0	73%
				48	48	0	96		PF	72	85	11	0	177%
SATF-Facility G Total				**528**	**396**	**0**	**924**			**792**	**720**	**204**	**0**	**136%**
SATF-STRH	001	Z 001 1	Cell	100	100	0	200	NA	SRH	125	108	45	46	108%
SATF-STRH Total				**100**	**100**	**0**	**200**			**125**	**108**	**45**	**46**	**108%**
Grand Total				**3424**	**3204**	**38**	**6666**			**5111**	**5028**	**1403**	**206**	**147%**

Generated by :
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SCC Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SCC-CAMPS	Acton	X11001 1	Dorm	80	8	0	88	I	CMP	80	48	40	0	60%
	Bautista	X36001 1	Dorm	120	12	0	132	I	CMP	120	52	80	0	43%
	Fenner Canyon	X41001 1	Dorm	120	12	0	132	I	CMP	120	51	81	0	43%
	Francisquito	X04001 1	Dorm	80	8	0	88	I	CMP	80	46	42	0	57%
	Gabilan	X38001 1	Dorm	120	12	0	132	I	CMP	120	46	86	0	38%
	Growlersburg	X33001 1	Dorm	120	12	0	132	I	CMP	120	76	56	0	63%
	Holton	X16001 1	Dorm	100	10	0	110	I	CMP	100	53	57	0	53%
	Julius Klein	X19001 1	Dorm	120	12	0	132	I	CMP	120	54	78	0	45%
	La Cima	X42001 1	Dorm	80	8	0	88	I	CMP	80	52	36	0	65%
	Miramonte	X05001 1	Dorm	80	8	0	88	I	CMP	80	40	48	0	50%
	Mountain Home	X10001 1	Dorm	100	10	0	110	I	CMP	100	48	62	0	48%
	Mt. Bullion	X39001 1	Dorm	100	10	0	110	I	CMP	100	57	53	0	57%
	Oak Glen	X35001 1	Dorm	160	0	0	160	I	CMP	160	68	92	0	43%
	Owens Valley	X26001 1	Dorm	120	12	0	132	I	CMP	120	51	81	0	43%
	Prado	X28001 1	Dorm	80	11	0	91	I	CMP	80	61	30	0	76%
	Vallecito	X01001 1	Dorm	114	0	0	114	I	CMP	114	57	57	0	50%
SCC-CAMPS Total				**1694**	**145**	**0**	**1839**			**1694**	**860**	**979**	**0**	**51%**
SCC-Central Service	FIR	S FIR 1	Dorm	10	0	0	10	I	FH	10	9	1	0	90%
	HOS	S HOS 1	Cell	0	0	10	10	NA	OHU	0	0	0	0	
SCC-Central Service Total				**10**	**0**	**10**	**20**			**10**	**9**	**1**	**0**	**90%**
SCC-Devils Garden Camp	Devils Garden	X40001 1	Dorm	1	0	0	1	I	CMP	1	0	1	0	0%
SCC-Devils Garden Camp Total				**1**	**0**	**0**	**1**			**1**	**0**	**1**	**0**	**0%**
SCC-Facility A	Calaveras	A 001A1	Dorm	96	96	0	192	I	PF	144	117	75	0	122%
		A 001A2	Dorm	96	96	0	192	I	PF	144	154	38	0	160%
		A 001B1	Dorm	112	112	0	224	I	PF	168	84	140	0	75%
		A 001B2	Dorm	112	112	0	224	I	PF	168	145	79	0	129%
		A 001C1	Dorm	94	98	0	192	I	PF	141	87	105	0	93%
		A 001C2	Dorm	96	96	0	192	I	PF	144	135	57	0	141%
SCC-Facility A Total				**606**	**610**	**0**	**1216**			**909**	**722**	**494**	**0**	**119%**
SCC-Facility B	Mariposa	B 001D1	Dorm	96	96	0	192	II	PF	144	155	37	0	161%
		B 001D2	Dorm	96	96	0	192	II	PF	144	158	34	0	165%
		B 001E1	Dorm	112	112	0	224	II	PF	168	201	23	0	179%
		B 001E2	Dorm	112	112	0	224	II	PF	168	200	24	0	179%
		B 001F1	Dorm	94	94	0	188	II	PF	141	123	65	0	131%
		B 001F2	Dorm	96	96	0	192	II	PF	144	162	29	0	169%
SCC-Facility B Total				**606**	**606**	**0**	**1212**			**909**	**999**	**212**	**0**	**165%**
SCC-Facility C	Tuolumne	C 001 1	270 Cell	50	50	0	100	III	PF	75	64	36	0	128%
		C 001 2	270 Cell	50	50	0	100	III	PF	75	71	28	1	142%
		C 002 1	270 Cell	50	50	0	100	NA	ASU	63	44	54	2	88%
		C 002 2	270 Cell	50	50	0	100	NA	ASU	63	51	49	0	102%
		C 003 1	270 Cell	50	50	0	100	III	PF	75	31	69	0	62%
		C 003 2	270 Cell	50	50	0	100	III	PF	75	39	61	0	78%
		C 004 1	270 Cell	50	50	0	100	III	PF	75	87	7	6	174%
		C 004 2	270 Cell	50	50	0	100	III	PF	75	87	11	2	174%
		C 005 1	270 Cell	50	50	0	100	III	PF	75	83	15	2	166%
		C 005 2	270 Cell	50	50	0	100	III	PF	75	90	6	4	180%
SCC-Facility C Total				**500**	**500**	**0**	**1000**			**725**	**647**	**336**	**17**	**129%**
SCC-High Rock Camp	High Rock	X32001 1	Dorm	1	0	0	1	I	CMP	1	0	1	0	0%
SCC-High Rock Camp Total				**1**	**0**	**0**	**1**			**1**	**0**	**1**	**0**	**0%**
SCC-Valley View Camp	Valley View	X34001 1	Dorm	1	0	0	1	I	CMP	1	0	1	0	0%
SCC-Valley View Camp Total				**1**	**0**	**0**	**1**			**1**	**0**	**1**	**0**	**0%**
Grand Total				**3419**	**1861**	**10**	**5290**			**4250**	**3237**	**2025**	**17**	**95%**

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SOL Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SOL-Central Service	INF	S INF 1	Cell	3	0	0	3	NA	CTC	3	3	0	0	100%
				9	0	0	9		MCB	9	5	2	0	56%
			Dorm	3	0	0	3	NA	CTC	3	2	0	0	67%
SOL-Central Service Total				**15**	**0**	**0**	**15**			**15**	**10**	**2**	**0**	**67%**
SOL-Facility A	001	A 001 1	270 Cell	34	34	0	68	III	GP	51	25	39	2	74%
		A 001 2	270 Cell	50	50	0	100	III	GP	75	41	57	0	82%
	002	A 002 1	270 Cell	50	50	0	100	III	GP	75	86	11	3	172%
		A 002 2	270 Cell	50	50	0	100	III	GP	75	95	5	0	190%
	003	A 003 1	270 Cell	50	50	0	100	III	GP	75	76	24	0	152%
		A 003 2	270 Cell	50	50	0	100	III	GP	75	80	16	2	160%
	004	A 004 1	270 Cell	50	50	0	100	III	GP	75	85	10	5	170%
		A 004 2	270 Cell	50	50	0	100	III	GP	75	97	3	0	194%
	005	A 005 1	270 Cell	50	50	0	100	III	GP	75	82	16	2	164%
		A 005 2	270 Cell	50	50	0	100	III	GP	75	85	13	2	170%
	006	A 006 1	270 Cell	50	50	0	100	III	GP	75	75	20	5	150%
		A 006 2	270 Cell	50	50	0	100	III	GP	75	90	9	1	180%
SOL-Facility A Total				**584**	**584**	**0**	**1168**			**876**	**917**	**223**	**22**	**157%**
SOL-Facility B	007	B 007 1	270 Cell	50	50	0	100	III	VAR	75	20	74	0	40%
		B 007 2	270 Cell	50	50	0	100	III	VAR	75	20	76	0	40%
	008	B 008 1	270 Cell	50	50	0	100	III	GP	75	87	8	5	174%
		B 008 2	270 Cell	50	50	0	100	III	GP	75	96	3	1	192%
	009	B 009 1	270 Cell	50	50	0	100	III	VAR	75	6	89	0	12%
		B 009 2	270 Cell	50	50	0	100	III	VAR	75	18	82	0	36%
	010	B 010 1	270 Cell	50	50	0	100	NA	ASU	63	30	64	4	60%
		B 010 2	270 Cell	50	50	0	100	NA	ASU	63	52	39	9	104%
	011	B 011 1	270 Cell	50	50	0	100	III	GP	75	56	43	1	112%
		B 011 2	270 Cell	50	50	0	100	III	GP	75	63	37	0	126%
	012	B 012 1	270 Cell	50	50	0	100	III	GP	75	88	9	1	176%
		B 012 2	270 Cell	50	50	0	100	III	GP	75	93	6	1	186%
SOL-Facility B Total				**600**	**600**	**0**	**1200**			**875**	**629**	**530**	**22**	**105%**
SOL-Facility C	013	C 013 1	270 Dorm	68	68	0	136	II	GP	102	89	47	0	131%
		C 013 2	270 Dorm	62	62	0	124	II	GP	93	82	42	0	132%
	014	C 014 1	270 Dorm	68	68	0	136	II	GP	102	91	44	0	134%
		C 014 2	270 Dorm	62	62	0	124	II	GP	93	86	38	0	139%
	015	C 015 1	270 Dorm	68	68	0	136	II	GP	102	89	47	0	131%
		C 015 2	270 Dorm	62	62	0	124	II	GP	93	83	41	0	134%
	016	C 016 1	Dorm	100	100	0	200	II	GP	150	97	103	0	97%
	017	C 017 1	Dorm	100	100	0	200	II	GP	150	103	97	0	103%
	018	C 018 1	Dorm	100	100	0	200	II	GP	150	98	102	0	98%
SOL-Facility C Total				**690**	**690**	**0**	**1380**			**1035**	**818**	**561**	**0**	**119%**
SOL-Facility D	019	D 019 1	Dorm	100	100	0	200	II	GP	150	102	98	0	102%
	020	D 020 1	270 Dorm	68	68	0	136	II	GP	102	93	43	0	137%
		D 020 2	270 Dorm	62	62	0	124	II	GP	93	84	40	0	135%
	021	D 021 1	270 Dorm	68	68	0	136	II	GP	102	100	36	0	147%
		D 021 2	270 Dorm	62	62	0	124	II	GP	93	94	30	0	152%
	022	D 022 1	270 Dorm	68	68	0	136	II	GP	102	81	55	0	119%
		D 022 2	270 Dorm	62	62	0	124	II	GP	93	72	52	0	116%
	023	D 023 1	270 Dorm	68	68	0	136	II	GP	102	88	47	0	129%
		D 023 2	270 Dorm	62	62	0	124	II	GP	93	90	34	0	145%
	024	D 024 1	Dorm	100	100	0	200	II	GP	150	97	103	0	97%
SOL-Facility D Total				**720**	**720**	**0**	**1440**			**1080**	**901**	**538**	**0**	**125%**
Grand Total				**2609**	**2594**	**0**	**5203**			**3881**	**3275**	**1854**	**44**	**126%**

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SQ Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SQ-Central Service	FIR	S FIR 1	Dorm	15	0	0	15	I	FH	15	9	6	0	60%
	INF	S INF 1	Cell	4	0	6	10	NA	CTC	4	8	2	0	200%
				41	0	0	41		PIP	41	18	22	0	44%
SQ-Central Service Total				**60**	**0**	**6**	**66**			**60**	**35**	**30**	**0**	**58%**
SQ-Facility A	Adjustment Center	A AC 1	Cell	17	0	0	17	NA	ASU	17	7	10	0	41%
				17	0	0	17		DR	17	17	0	0	100%
		A AC 2	Cell	16	0	0	16	NA	ASU	16	16	0	0	100%
				18	0	0	18		DR	18	17	1	0	94%
		A AC 3	Cell	17	0	0	17	NA	ASU	17	17	0	0	100%
				17	0	0	17		DR	17	17	0	0	100%
	Alpine Unit	A SB A1	Cell	47	47	0	94	II	PF	71	54	36	4	115%
		A SB A2	Cell	50	50	0	100	II	PF	75	65	35	0	130%
		A SB A3	Cell	50	50	0	100	II	PF	75	73	27	0	146%
		A SB A4	Cell	50	50	0	100	II	PF	75	63	37	0	126%
		A SB A5	Cell	50	50	0	100	II	PF	75	72	25	3	144%
	Badger Unit	A SB B1	Cell	47	47	0	94	II	PF	71	0	94	0	0%
		A SB B2	Cell	50	50	0	100	II	PF	75	0	100	0	0%
		A SB B3	Cell	50	50	0	100	II	PF	75	0	100	0	0%
		A SB B4	Cell	50	50	0	100	II	PF	75	0	100	0	0%
		A SB B5	Cell	50	50	0	100	II	PF	75	0	100	0	0%
	Carson Unit	A SB C1	Cell	41	0	0	41	NA	ASU	41	7	34	0	17%
		A SB C2	Cell	48	0	0	48	NA	ASU	48	8	40	0	17%
		A SB C3	Cell	48	0	0	48	NA	ASU	48	0	48	0	0%
		A SB C4	Cell	48	0	0	48	NA	ASU	48	0	48	0	0%
		A SB C5	Cell	48	0	0	48	II	PF	48	0	48	0	0%
	Donner Unit	A SB D1	Cell	47	0	0	47	NA	DR	47	2	45	0	4%
		A SB D2	Cell	50	0	0	50	NA	DR	50	18	32	0	36%
		A SB D3	Cell	48	48	0	96	II	PF	72	0	96	0	0%
		A SB D4	Cell	48	48	0	96	II	PF	72	0	96	0	0%
		A SB D5	Cell	48	48	0	96	II	PF	72	0	96	0	0%
	East Block	A EB 1	Cell	97	0	0	97	NA	DR	97	89	8	0	92%
		A EB 2	Cell	108	0	0	108	NA	DR	108	98	10	0	91%
		A EB 3	Cell	108	0	0	108	NA	DR	108	98	10	0	91%
		A EB 4	Cell	108	0	0	108	NA	DR	108	106	2	0	98%
		A EB 5	Cell	108	0	0	108	NA	DR	108	104	4	0	96%
	NORTH SEG	A NB N6	Cell	34	0	0	34	NA	DR	34	27	7	0	79%
		A NB S6	Cell	34	0	0	34	NA	DR	34	31	3	0	91%
	North Block	A NB 1	Cell	82	82	0	164	II	PF	123	108	53	2	132%
		A NB 2	Cell	83	83	0	166	II	PF	125	127	38	1	153%
		A NB 3	Cell	83	83	0	166	II	PF	125	119	47	0	143%
		A NB 4	Cell	83	83	0	166	II	PF	125	117	48	0	141%
		A NB 5	Cell	83	83	0	166	II	PF	125	122	41	2	147%
	West Block	A WB 1	Cell	89	89	0	178	II	PF	134	122	53	2	137%
		A WB 2	Cell	90	90	0	180	II	PF	135	123	55	2	137%
		A WB 3	Cell	90	90	0	180	II	PF	135	136	43	1	151%
		A WB 4	Cell	90	90	0	180	II	PF	135	126	52	2	140%
		A WB 5	Cell	90	90	0	180	II	PF	135	128	52	0	142%
SQ-Facility A Total				**2530**	**1501**	**0**	**4031**			**3281**	**2234**	**1774**	**19**	**88%**
SQ-Facility B	H Unit 1	B 001 1	Dorm	100	0	0	100	II	EOP	100	50	49	0	50%
	H Unit 2	B 002 1	Dorm	100	0	0	100	II	EOP	100	53	47	0	53%
	H Unit 3	B 003 1	Dorm	100	100	0	200	II	PF	150	96	104	0	96%
	H Unit 4	B 004 1	Dorm	100	100	0	200	II	PF	150	92	108	0	92%
	H Unit 5	B 005 1	Dorm	100	100	0	200	II	PF	150	88	111	0	88%
SQ-Facility B Total				**500**	**300**	**0**	**800**			**650**	**379**	**419**	**0**	**76%**
Grand Total				**3090**	**1801**	**6**	**4897**			**3991**	**2648**	**2223**	**19**	**86%**

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SVSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SVSP-Central Service	CTC	S CTC 1	Cell	0	0	12	12	NA	CTC	0	11	0	0	
				0	0	10	10		MCB	0	9	0	0	
SVSP-Central Service Total				**0**	**0**	**22**	**22**			**0**	**20**	**0**	**0**	
SVSP-Facility A	001	A 001 1	270 Cell	51	49	0	100	III	SNY	77	77	16	6	151%
		A 001 2	270 Cell	50	50	0	100	III	SNY	75	95	2	2	190%
	002	A 002 1	270 Cell	50	50	0	100	III	SNY	75	78	5	6	156%
		A 002 2	270 Cell	50	50	0	100	III	SNY	75	93	4	1	186%
	003	A 003 1	270 Cell	50	50	0	100	III	SNY	75	80	10	8	160%
		A 003 2	270 Cell	50	50	0	100	III	SNY	75	87	8	3	174%
	004	A 004 1	270 Cell	50	50	0	100	III	EOP	75	51	40	8	102%
		A 004 2	270 Cell	50	50	0	100	III	EOP	75	56	30	14	112%
	005	A 005 1	270 Cell	50	50	0	100	III	EOP	75	51	36	11	102%
		A 005 2	270 Cell	50	50	0	100	III	EOP	75	53	32	14	106%
SVSP-Facility A Total				**501**	**499**	**0**	**1000**			**752**	**721**	**183**	**73**	**144%**
SVSP-Facility B	001	B 001 1	270 Cell	50	50	0	100	IV	GP	75	71	21	8	142%
		B 001 2	270 Cell	50	50	0	100	IV	GP	75	73	22	4	146%
	002	B 002 1	270 Cell	50	50	0	100	IV	GP	75	69	22	9	138%
		B 002 2	270 Cell	50	50	0	100	IV	GP	75	84	15	1	168%
	003	B 003 1	270 Cell	50	50	0	100	IV	GP	75	80	15	5	160%
		B 003 2	270 Cell	50	50	0	100	IV	GP	75	77	23	0	154%
	004	B 004 1	270 Cell	50	50	0	100	IV	GP	75	72	22	6	144%
		B 004 2	270 Cell	50	50	0	100	IV	GP	75	73	24	3	146%
	005	B 005 1	270 Cell	50	50	0	100	IV	GP	75	77	20	2	154%
		B 005 2	270 Cell	50	50	0	100	IV	GP	75	67	31	2	134%
SVSP-Facility B Total				**500**	**500**	**0**	**1000**			**750**	**743**	**215**	**40**	**149%**
SVSP-Facility C	001	C 001 1	180 Cell	32	32	0	64	IV	GP	48	46	14	4	144%
		C 001 2	180 Cell	32	32	0	64	IV	GP	48	44	17	3	138%
	002	C 002 1	180 Cell	32	32	0	64	IV	GP	48	55	7	2	172%
		C 002 2	180 Cell	32	32	0	64	IV	GP	48	50	12	2	156%
	003	C 003 1	180 Cell	32	32	0	64	IV	GP	48	47	14	3	147%
		C 003 2	180 Cell	32	32	0	64	IV	GP	48	47	13	4	147%
	004	C 004 1	180 Cell	32	32	0	64	IV	GP	48	54	9	1	169%
		C 004 2	180 Cell	32	32	0	64	IV	GP	48	44	18	2	138%
	005	C 005 1	180 Cell	24	0	0	24	NA	ICF	24	18	0	0	75%
				8	0	0	8		PIP	8	7	1	0	88%
		C 005 2	180 Cell	22	0	0	22	NA	ICF	22	22	0	0	100%
				10	0	0	10		PIP	10	6	4	0	60%
	006	C 006 1	180 Cell	32	0	0	32	NA	ICF	32	23	3	0	72%
		C 006 2	180 Cell	32	0	0	32	NA	ICF	32	31	1	0	97%
	007	C 007 1	180 Cell	32	32	0	64	IV	VAR	48	7	57	0	22%
		C 007 2	180 Cell	32	32	0	64	IV	VAR	48	1	61	0	3%
	008	C 008 1	180 Cell	32	32	0	64	IV	GP	48	57	4	2	178%
		C 008 2	180 Cell	32	32	0	64	IV	GP	48	54	8	2	169%
SVSP-Facility C Total				**512**	**384**	**0**	**896**			**704**	**613**	**243**	**25**	**120%**
SVSP-Facility D	001	D 001 1	180 Cell	32	32	0	64	NA	ASU	40	36	19	7	113%
		D 001 2	180 Cell	32	32	0	64	NA	ASU	40	34	18	8	106%
	002	D 002 1	180 Cell	32	32	0	64	IV	SNY	48	14	46	3	44%
		D 002 2	180 Cell	32	32	0	64	IV	SNY	48	14	43	6	44%
	003	D 003 1	180 Cell	32	32	0	64	IV	EOP	48	37	2	23	116%
		D 003 2	180 Cell	32	32	0	64	IV	EOP	48	45	1	17	141%
	004	D 004 1	180 Cell	32	32	0	64	IV	SNY	48	45	8	11	141%
		D 004 2	180 Cell	32	32	0	64	IV	SNY	48	45	12	7	141%
	005	D 005 1	180 Cell	32	32	0	64	IV	SNY	48	50	9	5	156%
		D 005 2	180 Cell	32	32	0	64	IV	SNY	48	52	6	6	163%
	006	D 006 1	180 Cell	22	22	0	44	IV	SNY	33	32	8	4	145%
				10	10	0	20		VAR	15	10	6	2	100%
		D 006 2	180 Cell	22	22	0	44	IV	SNY	33	32	11	1	145%
				10	10	0	20		VAR	15	9	9	2	90%
	007	D 007 1	180 Cell	32	32	0	64	IV	SNY	48	45	14	5	141%
		D 007 2	180 Cell	32	32	0	64	IV	SNY	48	57	3	3	178%
	008	D 008 1	180 Cell	32	32	0	64	IV	SNY	48	49	11	4	153%
		D 008 2	180 Cell	32	32	0	64	IV	SNY	48	53	9	2	166%
SVSP-Facility D Total				**512**	**512**	**0**	**1024**			**752**	**659**	**235**	**116**	**129%**
SVSP-Facility I	001	I 001A1	Cell	12	0	0	12	NA	ICF	12	10	2	0	83%
		I 001B1	Cell	10	0	0	10	NA	ICF	10	10	0	0	100%
		I 001C1	Cell	10	0	0	10	NA	ICF	10	10	0	0	100%
		I 001D1	Dorm	24	0	0	24	NA	ICF	24	20	4	0	83%
	002	I 002A1	Cell	16	10	0	26	NA	ICF	16	22	4	0	138%
		I 002B1	Cell	16	0	0	16	NA	ICF	16	15	1	0	94%
		I 002C1	Cell	16	0	0	16	NA	ICF	16	15	1	0	94%
		I 002D1	Cell	16	0	0	16	NA	ICF	16	13	3	0	81%
SVSP-Facility I Total				**120**	**10**	**0**	**130**			**120**	**115**	**15**	**0**	**96%**

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Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
SVSP-MSF	001	M 001 1	Dorm	100	100	0	200	I	WC	150	17	183	0	17%
	002	M 002 1	Dorm	100	100	0	200	I	WC	150	17	183	0	17%
SVSP-MSF Total				**200**	**200**	**0**	**400**			**300**	**34**	**366**	**0**	**17%**
SVSP-STRH	009	Z 009 1	Cell	100	100	0	200	NA	SRH	125	95	84	16	95%
SVSP-STRH Total				**100**	**100**	**0**	**200**			**125**	**95**	**84**	**16**	**95%**
Grand Total				**2445**	**2205**	**22**	**4672**			**3503**	**3000**	**1341**	**270**	**123%**

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VSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
VSP-Central Service	INF	S INF 1	Cell	11	0	9	20	NA	OHU	11	17	1	0	155%
VSP-Central Service Total				**11**	**0**	**9**	**20**			**11**	**17**	**1**	**0**	**155%**
VSP-Facility A	001	A 001 1	Dorm	128	64	0	192	II	EOP	192	135	57	0	105%
	002	A 002 1	Dorm	119	61	0	180	II	EOP	179	142	38	0	119%
	003	A 003 1	270 Cell	50	49	0	99	II	VAR	75	24	75	0	48%
		A 003 2	270 Cell	50	50	0	100	II	VAR	75	0	100	0	0%
	004	A 004 1	270 Cell	22	22	0	44	II	VAR	33	5	39	0	23%
				22	22	0	44	NA	ASU	28	17	24	3	77%
		A 004 2	270 Cell	22	22	0	44	II	VAR	33	0	44	0	0%
				22	22	0	44	NA	ASU	28	12	30	2	55%
VSP-Facility A Total				**435**	**312**	**0**	**747**			**642**	**335**	**407**	**5**	**77%**
VSP-Facility B	001	B 001 1	Dorm	118	118	0	236	II	PF	177	209	27	0	177%
	002	B 002 1	Dorm	128	128	0	256	II	PF	192	234	22	0	183%
	003	B 003 1	Dorm	128	128	0	256	II	PF	192	245	10	0	191%
	004	B 004 1	Dorm	128	128	0	256	II	PF	192	174	82	0	136%
VSP-Facility B Total				**502**	**502**	**0**	**1004**			**753**	**862**	**141**	**0**	**172%**
VSP-Facility C	001	C 001 1	Dorm	128	128	0	256	II	PF	192	194	62	0	152%
	002	C 002 1	Dorm	128	128	0	256	II	PF	192	223	33	0	174%
	003	C 003 1	Dorm	128	128	0	256	II	PF	192	224	32	0	175%
	004	C 004 1	Dorm	128	128	0	256	II	PF	192	229	27	0	179%
VSP-Facility C Total				**512**	**512**	**0**	**1024**			**768**	**870**	**154**	**0**	**170%**
VSP-Facility D	001	D 001 1	Dorm	128	128	0	256	II	PF	192	236	20	0	184%
	002	D 002 1	Dorm	128	128	0	256	II	PF	192	219	37	0	171%
	003	D 003 1	Dorm	128	128	0	256	II	PF	192	199	57	0	155%
	004	D 004 1	Dorm	128	128	0	256	II	PF	192	227	29	0	177%
VSP-Facility D Total				**512**	**512**	**0**	**1024**			**768**	**881**	**143**	**0**	**172%**
Grand Total				**1972**	**1838**	**9**	**3819**			**2942**	**2965**	**846**	**5**	**150%**

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WSP Male Only

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Security Level	Program	BP Crowding	Occupied Count	Empty Bed Count	Single Cell	O/C %
WSP-Central Service	INF	S INF 1	Cell	0	0	10	10	NA	CTC	0	8	2	0	
				0	0	6	6		MCB	0	2	3	0	
WSP-Central Service Total				**0**	**0**	**16**	**16**			**0**	**10**	**5**	**0**	
WSP-Facility A	001	A 001 1	270 Cell	50	50	0	100	III	GP	75	60	39	1	120%
		A 001 2	270 Cell	50	50	0	100	III	GP	75	84	14	0	168%
	002	A 002 1	270 Cell	50	50	0	100	III	GP	75	78	14	0	156%
		A 002 2	270 Cell	50	50	0	100	III	GP	75	82	6	0	164%
	003	A 003 1	270 Cell	50	50	0	100	III	GP	75	76	22	0	152%
		A 003 2	270 Cell	50	50	0	100	III	GP	75	82	15	1	164%
	004	A 004 1	270 Cell	50	50	0	100	III	GP	75	50	46	0	100%
		A 004 2	270 Cell	50	50	0	100	III	GP	75	50	48	0	100%
	005	A 005 1	270 Cell	50	50	0	100	III	GP	75	74	22	0	148%
		A 005 2	270 Cell	50	50	0	100	III	GP	75	68	32	0	136%
WSP-Facility A Total				**500**	**500**	**0**	**1000**			**750**	**704**	**258**	**2**	**141%**
WSP-Facility B	001	B 001 1	Cell	46	46	0	92	NA	RC	69	46	35	1	100%
		B 001 2	Cell	50	50	0	100	NA	RC	75	58	38	0	116%
				4	4	0	8		VAR	6	0	8	0	0%
	002	B 002 1	Cell	46	46	0	92	NA	RC	69	23	68	1	50%
		B 002 2	Cell	54	54	0	108	NA	RC	81	11	97	0	20%
	003	B 003 1	Cell	46	46	0	92	NA	RC	69	72	15	3	157%
		B 003 2	Cell	54	54	0	108	NA	RC	81	76	27	4	141%
	004	B 004 1	Cell	46	46	0	92	NA	RC	69	52	36	0	113%
		B 004 2	Cell	54	54	0	108	NA	RC	81	67	37	0	124%
	005	B 005 1	Cell	46	46	0	92	NA	VAR	69	45	45	2	98%
		B 005 2	Cell	54	54	0	108	NA	VAR	81	45	60	0	83%
	006	B 006 1	Cell	46	46	0	92	NA	RC	69	35	53	1	76%
		B 006 2	Cell	54	54	0	108	NA	RC	81	39	60	3	72%
WSP-Facility B Total				**600**	**600**	**0**	**1200**			**900**	**569**	**579**	**15**	**95%**
WSP-Facility C	001	C 001 1	Dorm	80	80	0	160	NA	RC	120	76	84	0	95%
		C 001 2	Dorm	66	66	0	132	NA	RC	99	55	77	0	83%
	002	C 002 1	Dorm	80	80	0	160	NA	RC	120	92	68	0	115%
		C 002 2	Dorm	66	66	0	132	NA	RC	99	45	87	0	68%
	003	C 003 1	Dorm	80	80	0	160	NA	RC	120	142	18	0	178%
		C 003 2	Dorm	66	66	0	132	NA	RC	99	119	13	0	180%
	004	C 004 1	Dorm	80	80	0	160	NA	RC	120	141	18	0	176%
		C 004 2	Dorm	66	66	0	132	NA	RC	99	120	12	0	182%
WSP-Facility C Total				**584**	**584**	**0**	**1168**			**876**	**790**	**377**	**0**	**135%**
WSP-Facility D	001	D 001 1	Cell	46	46	0	92	NA	RC	69	37	54	1	80%
		D 001 2	Cell	54	54	0	108	NA	RC	81	38	68	0	70%
	002	D 002 1	Cell	46	46	0	92	NA	RC	69	76	15	0	165%
		D 002 2	Cell	54	54	0	108	NA	RC	81	73	35	0	135%
	003	D 003 1	Cell	46	46	0	92	NA	RC	69	78	11	0	170%
		D 003 2	Cell	54	54	0	108	NA	RC	81	88	15	1	163%
	004	D 004 1	Cell	46	46	0	92	NA	RC	69	48	43	1	104%
		D 004 2	Cell	54	54	0	108	NA	RC	81	91	15	0	169%
	005	D 005 1	Cell	46	46	0	92	NA	RC	69	70	18	2	152%
		D 005 2	Cell	54	54	0	108	NA	RC	81	74	31	1	137%
	006	D 006 1	Cell	46	45	0	91	NA	ASU	58	21	63	6	46%
		D 006 2	Cell	54	54	0	108	NA	ASU	68	24	77	5	44%
	007	D 007 1	Dorm	100	100	0	200	NA	RC	150	164	36	0	164%
WSP-Facility D Total				**700**	**699**	**0**	**1399**			**1025**	**882**	**481**	**17**	**126%**
WSP-Facility H	001	H 001 1	Dorm	100	100	0	200	NA	RC	150	178	20	0	178%
	002	H 002 1	Dorm	100	100	0	200	NA	RC	150	99	101	0	99%
	003	H 003 1	Dorm	100	100	0	200	NA	RC	150	129	71	0	129%
	004	H 004 1	Dorm	100	100	0	200	NA	RC	150	136	64	0	136%
WSP-Facility H Total				**400**	**400**	**0**	**800**			**600**	**542**	**256**	**0**	**136%**
WSP-MSF	001	M 001 1	Dorm	48	48	0	96	I	WC	72	0	96	0	0%
		M 001 2	Dorm	48	38	0	86	I	WC	72	0	86	0	0%
	002	M 002 1	Dorm	48	57	0	105	I	WC	72	23	82	0	48%
		M 002 2	Dorm	48	45	0	93	I	WC	72	32	61	0	67%
	FIR	M FIR 1	Dorm	8	0	0	8	I	FH	8	4	4	0	50%
WSP-MSF Total				**200**	**188**	**0**	**388**			**296**	**59**	**329**	**0**	**30%**
Grand Total				**2984**	**2971**	**16**	**5971**			**4447**	**3556**	**2285**	**34**	**119%**

This report is based on SOMS Bed Data, utilizing the bed status and bed program use. "Empty beds" takes into consideration Single-Celled inmates, and therefore only reflects "vacant" status beds.

EXHIBIT 4

Selected Institution(s): ASP, CAC, CAL, CCC, CCI, CCWF, CCWF-RC, CEN, CHCF, CIM, CIM-RC, CIW, CMC, CMF, COR, CPMP, CRC, CTF, CVSP, FCRF, FOL, HDSP, ISP, KVSP, LAC, MCSP, NKSP, NKSP-RC, PBSP, PRCCF, PUCCF, PVSP, RJD, SAC, SACCO, SATF, SCC, SHS, SOL, SQ, SQ-RC, SVSP, VSP, WSP, WSP-RC

CCWF	[redacted]	[redacted]	B 506[redacted]	DPM,DNH,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture - Acrylic, Partial Upper Denture - Acrylic, Therapeutic Shoes/Orthotics, Walkers, Wrist Support Brace	Accommodation Chrono: rail room, Durable Medical Equipment: Round Pillow Perm., DPP Verification: rail room, MCC: See CDCR 7410 and 1845 on file,bilat wrist brace, flat insole,diabetic shoes,cane. Needs grab bars			N
CCWF	[redacted]	[redacted]	S INF[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Heel/Foot Protector, Other (Include in Comments), Pressure Reducing Support Services-Groups 1,2 & 3 (Mattress), Wheelchair	Accommodation Chrono: Pt has severe skin and lower extremity medical problems that require special restraints, Durable Medical Equipment: pillows to lift feet from bed, w/c gel cusion, neck pillow, and mattress, DPP Verification: Pt has severe skin and lower extremity medical problems that require special restraints,			

CCWF	[redacted]	[redacted]	S INF [redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Full Upper Denture, Heel/Foot Protector, Incontinence Supplies, Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - Bi-Pap Machine, Other (Include in Comments), Partial Lower Denture, Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Accommodation Chrono: Medical condition, Durable Medical Equipment: WEDGE PILLOW , wheelchair seat cushion, DPP Verification: Medical condition,			
CHCF	[redacted]	[redacted]	A 304 [redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only		Accommodation Chrono: no lifting > 10 lbs., DPP Verification: no lifting > 10 lbs.			
CHCF	[redacted]	[redacted]	A 304 [redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Therapeutic Shoes/Orthotics	Accommodation Chrono: low bunk due to dialysis access site and TEMPORARY low tier due to reports of difficulty climbing stairs. Pending further eval., DPP Verification: low bunk due to dialysis access site and TEMPORARY low tier due to reports of difficulty climbing stairs. Pending further eval.,			

CHCF	[redacted]	[redacted]	A 304[redacted]	DPS,DKD	Lower/Bottom Bunk Only	Other (Include in Comments), Partial Upper Denture, Therapeutic Shoes/Orthotics	Accommodation Chrono: Needs low bunk because reaching, climbing, and pulling himself up risks damage to AVF. He also reports lightheadedness post-dialysis, which predisposes to falling and injury himself., Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2019-06-28 20:15:46, DPP Verification: Needs low bunk because reaching, climbing, and pulling himself up risks damage to AVF. He also reports lightheadedness post-dialysis, which predisposes to falling and injury himself.,			N
CHCF	[redacted]	[redacted]	C 301A1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Diabetic Supplies/Monitors, Eyeglass Frames, Full Lower Denture, Full Upper Denture, Knee Braces, Mobility Impaired Disability Vest, Therapeutic Shoes/Orthotics, Walkers	Accommodation Chrono: n.a, Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2021-03-25 16:19:22, DPP Verification: n.a,			
CHCF	[redacted]	[redacted]	C 301A1[redacted]	DPO,DNV,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture - Acrylic, Partial Upper Denture - Acrylic, Therapeutic Shoes/Orthotics, Walkers, Wheelchair, Wound Care Dressings	Durable Medical Equipment: Wheelchair seat cushion and wheelchair gloves.,			

CHCF	[redacted]	[redacted]	C 301A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Upper Denture - Acrylic, Therapeutic Shoes/Orthotics, Walkers, Wheelchair, Wrist Support Brace	Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2020-11-18 17:51:48,			
CHCF	[redacted]	[redacted]	C 301A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: Wedge Pillow,			
CHCF	[redacted]	[redacted]	C 301A1[redacted]	DKD	Lower/Bottom Bunk Only		Accommodation Chrono: IP on long term hemodialysis. He does not produce urine, urine drug testing is not possible, DPP Verification: on long term hemodialysis, on renal dietdoes not produce urine, urine drug testing is not possible,			
CHCF	[redacted]	[redacted]	C 301A1[redacted]	DNM,DNH,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture - Acrylic, Partial Upper Denture - Acrylic, Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2017-11-20 19:58:04,			N

CHCF	[redacted]	[redacted]	C 301B1[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Eyeglass Frames, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers	Accommodation Chrono: patient with CHF and dialysis, Durable Medical Equipment: dentures, shoes, DPP Verification: patient with CHF and dialysis,			
CHCF	[redacted]	[redacted]	C 301B1[redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments)	Accommodation Chrono: Due to her chronic medical condition the patient cannot stand for prolonged periods of time. He cannot stand for longer than 15 minutes at a time without taking a 15 minute break to sit and rest., Durable Medical Equipment: CPAP Supplies, DPP Verification: Due to her chronic medical condition the patient cannot stand for prolonged periods of time. He cannot stand for longer than 15 minutes at a time without taking a 15 minute break to sit and rest.,			
CHCF	[redacted]	[redacted]	C 302A1[redacted]	DPO,DNH,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: 1 pair Post OP Boots, XL, MCC: no lifting more than 10 lbs, but pt can work in areas where there is no heavy lifting, w/c			N

CHCF	[redacted]	[redacted]	C 302A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Commode Chair, Compression Stocking, Eyeglass Frames, Full Upper Denture, Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Partial Lower Denture, Therapeutic Shoes/Orthotics, Toilet Seat Lift (Erector), Walkers, Wheelchair	Accommodation Chrono: Due to severe obesity, neuropathy and mobility restrictions., Durable Medical Equipment: Distilled Water, CPAP MASK, Wedge pillow, foam squeeze ballWheelchair gloves, elbow pads., DPP Verification: Due to severe obesity, neuropathy and mobility restrictions.,			
CHCF	[redacted]	[redacted]	C 302B1[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Reading Glasses, Wound Care Dressings, Wrist Support Brace	Accommodation Chrono: cane, Durable Medical Equipment: 12 Large bandaid, DPP Verification: lower tier, lower bunk,			
CHCF	[redacted]	[redacted]	C 303A1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Walkers, Wheelchair	Accommodation Chrono: Severe weakness, Hypotension after dialysis, Durable Medical Equipment: 3 transparent dressings, 6 alcohol pads and 10 pieces gauze every week (Saturdays); Wedge pillow, wheelchair seat cushion 20" and a pair of XL wheelchair gloves. Drive anti-tippers w/wheels. 7/14/2021 issued an abdominal binder LG, DPP Verification: Severe weakness, Hypotension after dialysis,			

CHCF	[redacted]	[redacted]	C 304A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Knee Braces, Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Therapeutic Shoes/Orthotics, Wheelchair	Durable Medical Equipment: 1 ocular prothesis for the left eye, wheelchair cushion, wheelchair gloves, MCC: Patient is working as a porter and is full duty.			
CHCF	[redacted]	[redacted]	C 304A1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Other (Include in Comments), Truss Hernia Support	Accommodation Chrono: No heavy exercise. No lifting >5-10 lb., Durable Medical Equipment: cervial pillow,			
CHCF	[redacted]	[redacted]	C 304A1[redacted]	DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames	Accommodation Chrono: inclusion criteria met for lower bunk, DPP Verification: inclusion criteria met for lower bunk			
CHCF	[redacted]	[redacted]	C 304A1[redacted]	DNH,DKD		Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest				N
CHCF	[redacted]	[redacted]	C 304A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Knee Braces, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair, Wrist Support Brace	Durable Medical Equipment: Foam cushion, gloves, size large , Diabetic socks, 1 RIGHT wrist support given, MCC: Low bunk. No working at heights or with sharp tools.			
CHCF	[redacted]	[redacted]	C 304A1[redacted]	DKD		Eyeglass Frames, Other (Include in Comments), Therapeutic Shoes/Orthotics	Durable Medical Equipment: MDI spacer,			
CHCF	[redacted]	[redacted]	C 304B1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest, Therapeutic Shoes/Orthotics, Walkers				

CHCF	[redacted]	[redacted]	C 304B1[redacted]	DPO,DNH,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Back Braces, Canes, Eyeglass Frames, Foot Orthoses, Hearing Aid, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Wheelchair	Durable Medical Equipment: Wheel Chair Gloves, Dentures, Wheel chair cushion., Hearing aid batteries, MCC: Renal diet, Cane, Mobility vest, Sitting work only, Wheel chair and Cane as needed.			N
CHCF	[redacted]	[redacted]	C 304B1[redacted]	DPO,DNH,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Back Braces, Canes, Eyeglass Frames, Foot Orthoses, Full Lower Denture, Full Upper Denture, Hearing Aid, Mobility Impaired Disability	Durable Medical Equipment: tens unit, gel foam cushion 18x16x2, MCC: needs wheelchair for long distances			N
CHCF	[redacted]	[redacted]	C 304B1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Truss Hernia Support, Walkers, Wrist Support Brace	Accommodation Chrono: Patient meets inclusion criteria, Durable Medical Equipment: Propet Shoes, eye glasses, DPP Verification: Patient meets inclusion criteria,			
CHCF	[redacted]	[redacted]	C 304B1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Back Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: Wedge pillow, Wheelchair seat cushion, XL Wheelchair gloves.,			
CHCF	[redacted]	[redacted]	C 304B1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Back Braces, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: Wheel Chair Cushion, MCC: LBLT, Wheel chair, Renal diet, cane			

CHCF	[redacted]	[redacted]	C 305A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Accommodation Chrono: dialysis shunt in arm, Durable Medical Equipment: Wheelchair gloves (full fingered), DPP Verification: dialysis shunt in arm,			
CHCF	[redacted]	[redacted]	C 305A1[redacted]	DPM,DNV,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Eyeglasses for Aphakia, Mobility Impaired Disability Vest, Therapeutic Shoes/Orthotics, Vision Impaired Disability Vest, Walkers	Accommodation Chrono: Patient meets inclusion criteria for LB chrono., DPP Verification: Patient meets inclusion criteria for LB chrono.,			
CHCF	[redacted]	[redacted]	C 305A1[redacted]	DKD	Lower/Bottom Bunk Only	Ankle Foot Orthoses/Knee Ankle Foot Orthoses (AFO/KAFO), Compression Stocking, Eyeglass Frames, Partial Lower Denture - Acrylic, Therapeutic Shoes/Orthotics	Accommodation Chrono: post traumatic djd, Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2019-01-31 18:53:13, DPP Verification: post traumatic djd, MCC: N/A			
CHCF	[redacted]	[redacted]	C 305A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Foot Orthoses, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Walkers	Durable Medical Equipment: tens unit, MCC: 1845			
CHCF	[redacted]	[redacted]	C 305A1[redacted]	DKD		Eyeglass Frames, Other (Include in Comments), Therapeutic Shoes/Orthotics	Durable Medical Equipment: Left ASO ankle brace, MCC: RENAL DIET			

CHCF	[redacted]	[redacted]	C 305A1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Therapeutic Shoes/Orthotics, Walkers	Accommodation Chrono: needed lower bunk accommodation with chronic low back and bone pain due to ESRD and gout., DPP Verification: needed lower bunk accommodation with chronic low back and bone pain due to ESRD			
CHCF	[redacted]	[redacted]	C 305A1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames	Accommodation Chrono: ON HEMODYALYSIS, DPP Verification: ON HEMODYALYSIS, MCC: Bottom bunk, no lifting > 19 lbs			
CHCF	[redacted]	[redacted]	C 305B1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames	Accommodation Chrono: Due to medical necessity, DPP Verification: Due to medical necessity,			
CHCF	[redacted]	[redacted]	C 305B1[redacted]	DLT,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Mobility Impaired Disability Vest, Therapeutic Shoes/Orthotics, Walkers	Accommodation Chrono: lower bunkno rooftop worklifting restriction no more than 19lbs., DPP Verification: lower bunkno rooftop worklifting restriction no more than 19lbs.,			
CHCF	[redacted]	[redacted]	C 305B1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Incontinence Supplies, Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Walkers	Accommodation Chrono: Meets inclusion criteria, Durable Medical Equipment: ., DPP Verification: Meets inclusion criteria,			N

CHCF	[redacted]	[redacted]	C 306A1[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics	Accommodation Chrono: lower bunk, lifting restriction., Durable Medical Equipment: Wedge pillow, DPP Verification: lower bunk, lifting restriction.,			
CHCF	[redacted]	[redacted]	C 306A1[redacted]	DPM,DNH,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Truss Hernia Support, Walkers	Durable Medical Equipment: Hearing aid filter,			N
CHCF	[redacted]	[redacted]	C 306A1[redacted]	DKD		Compression Stocking	MCC: RENAL DIET			
CHCF	[redacted]	[redacted]	C 306A1-[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Full Upper Denture, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture, Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: gv 03/04/19 gave pt a roho cushion. (4) AA batteries., MCC: Per Dr. Sagireddy Renal die changed to regular diet.LB/LT, No llifting >10lbs, independent, no nursing assisit needed. Goes to dialysis.			
CHCF	[redacted]	[redacted]	C 306A1[redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Back Braces, Compression Stocking, Eyeglass Frames, Other (Include in Comments), Therapeutic	Durable Medical Equipment: Orthotic inserts. Wedge pillow, MCC: no sharp tool			

CHCF	[redacted]	[redacted]	C 306B1[redacted]	DKD	Lower/Bottom Bunk Only	Full Lower Denture	Accommodation Chrono: Initiating hemodialysis, need to protect shunts and caths until mature., Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2020-11-18 17:48:17, DPP Verification: Initiating hemodialysis, need to protect shunts and caths until mature., MCC: Bottom bunk.			
CHCF	[redacted]	[redacted]	D 301A1[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Full Lower Denture, Full Upper Denture, Other (Include in Comments), Prosthetic Limbs - Lower Extremity, Therapeutic Shoes/Orthotics, Wheelchair	Durable Medical Equipment: Wheelchair gloves, Wheelchair ROHO cushion. 8/21/19 PCP K SINGH ORDERED A GRABBER. 8/22/19 GRABBER DISPENSED TO I/P.,			
CHCF	[redacted]	[redacted]	D 302A1[redacted]	DPO,DNH,DPS,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Durable Medical Equipment: Dentures. Wheelchair seat cushion.,			N
CHCF	[redacted]	[redacted]	D 302B1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Diabetic Supplies/Monitors, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Accommodation Chrono: deconditioning, Durable Medical Equipment: carrying case for diabetic supplies, DPP Verification: deconditioning,			
CHCF	[redacted]	[redacted]	D 303A1[redacted]	DKD		Eyeglass Frames, Therapeutic Shoes/Orthotics				
CHCF	[redacted]	[redacted]	D 303B1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Hearing Aid, Hearing Impaired	MCC: Prescription eyeglasses			

CHCF	[redacted]	[redacted]	D 303B1[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Wheelchair	Accommodation Chrono: Patient has recent open heart surgery, DPP Verification: Patient has recent open heart surgery,			
CHCF	[redacted]	[redacted]	D 304A1[redacted]	DPW,DNH,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Hearing Aid, Hearing Impaired Disability Vest, Other (Include in Comments), Pressure Reducing Support Services-Groups 1,2 & 3 (Mattress), Therapeutic Shoes/Orthotics, Wheelchair	Accommodation Chrono: medically necessary, Durable Medical Equipment: Right Post Op Shoe, Wheelchair seat cushion, XL wheelchair gloves, DPP Verification: medically necessary,			N
CHCF	[redacted]	[redacted]	D 304B1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Walkers, Wheelchair	Durable Medical Equipment: Wheelchair seat cushion, A pair of XL wheelchair gloves, MCC: DPO			
CHCF	[redacted]	[redacted]	D 304B1[redacted]	DPO,DNH,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair, Wrist Support Brace	Durable Medical Equipment: walker-temp. MDI spacer, temporary stabilization boot, wheelchair gloves, wheelchair cushion,			N
CHCF	[redacted]	[redacted]	D 304B1[redacted]	DPV,DKD	Lower/Bottom Bunk Only	Compression Stocking, Other (Include in Comments), Vision Impaired Disability Vest	Accommodation Chrono: no mobility impairment, Durable Medical Equipment: Tapping Cane,, DPP Verification: no mobility impairment,			
CHCF	[redacted]	[redacted]	D 305A1[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Knee Braces, Other (Include in Comments), Wheelchair, Wrist Support Brace	Durable Medical Equipment: Foam cushion , Wheelchair Gloves XL, Grabber,			

CHCF	[redacted]	[redacted]	D 305A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Helmet, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Wheelchair	Durable Medical Equipment: W/C GLOVES (L), W/C CUSHION, MCC: DPO, DKD			
CHCF	[redacted]	[redacted]	D 305A1[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair, Wrist Support Brace	Durable Medical Equipment: Wheelchair supply gloves, cushion,			
CHCF	[redacted]	[redacted]	D 305A1[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Incontinence Supplies, Other (Include in Comments), Wheelchair	Accommodation Chrono: Wheelchair bound. Unsteady gait and at risk for fall, Durable Medical Equipment: WATER PITCHER, wheelchair cushion foam , XL Wheelchair gloves, Foot rest, DPP Verification: Wheelchair bound. Unsteady gait and at risk for fall,			
CHCF	[redacted]	[redacted]	D 306A1[redacted]	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Mobility Impaired Disability Vest, Other (Include in Comments), Oxygen Concentrators, Walkers, Wheelchair	Durable Medical Equipment: W/C Gloves.,			
CHCF	[redacted]	[redacted]	D 306A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Full Upper Denture, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture - Acrylic, Wheelchair	Durable Medical Equipment: WHEELCHAIR GLOVES LG/XLG,WHEELCHAIR FOAM SEAT CUSHION 18 "			

CHCF	[redacted]	[redacted]	D 306A1[redacted]	DPW,DNH,DNV,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Air Cell Cushion - High Profile (Roho), Air Cushion (for Wheelchair Seat), Back Braces, Compression Stocking, Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Incontinence Supplies, Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Oxygen Concentrators, Pressure Reducing Support Services-Groups 1,2 & 3 (Mattress), Therapeutic Shoes/Orthotics, Vision Impaired Disability Vest, Wheelchair, Wrist Support Brace	Accommodation Chrono: See previous 7410., Durable Medical Equipment: 7 chux, 1 leg bag, 1ext.tube, 14 pair gloves, 1roll tape, 1 pack of wipes, 14 condoms caths. 1 - Oxy. nasal canula tubing, Grabber . high profile roho cushion, B/L hand resting splint ,wedge pillow, DPP Verification: See previous 7410.,			N
CHCF	[redacted]	[redacted]	D 306B1[redacted]	DPO,DPV,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Vision Impaired Disability Vest, Wheelchair	Accommodation Chrono: r/l to medical condition, Durable Medical Equipment: W/C Gloves, Foam seat cushion, Collapsible tapping cane, DPP Verification: r/l to medical condition, MCC: see 7410. vision impaired vest. pt has tapping cane. inmate assistance as needed			
CHCF	[redacted]	[redacted]	E 301B1[redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Therapeutic Shoes/Orthotics	Accommodation Chrono: Dialysis patient, DPP Verification: Dialysis patient, MCC: 1/2/18: Low bunk low tier chrono			

CHCF	[redacted]	[redacted]	E 301B1[redacted]	DNH,DKD	Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Hearing Aid, Hearing Impaired Disability Vest, Other (Include in Comments)	Accommodation Chrono: left hand AV fistula, Durable Medical Equipment: HEARING AID SUPPLY, DPP Verification: left hand AV fistula, MCC: SEE 7410			N
CHCF	[redacted]	[redacted]	E 301B1[redacted]	DKD		Therapeutic Shoes/Orthotics	MCC: renal diet			
CHCF	[redacted]	[redacted]	E 301B1[redacted]	DKD	Lower/Bottom Bunk Only	Other (Include in Comments), Therapeutic Shoes/Orthotics, Wheelchair	Accommodation Chrono: On hemodialysis, Durable Medical Equipment: thera bandpost op shoe, DPP Verification: On hemodialysis, MCC: Lower bunk, lower tier			
CHCF	[redacted]	[redacted]	E 301E[redacted]	DKD	Lower/Bottom Bunk Only	Compression Stocking, Diabetic Supplies/Monitors, Eyeglass Frames, Foot Orthoses, Other (Include in Comments), Therapeutic Shoes/Orthotics	Accommodation Chrono: Due to medical condition., Durable Medical Equipment: wedge pillows, DPP Verification: Due to medical condition.,			
CHCF	[redacted]	[redacted]	E 301C[redacted]	DPM,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Full Lower Denture, Full Upper Denture, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Walkers	Accommodation Chrono: ESRD on HD, vitreous hemorrhage of left eye, tophaceous gout, hypertension, unsteady gait, Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2020-03-04 19:18:15, DPP Verification: Newly maturated fistula,			

CHCF	[redacted]	[redacted]	E 301F1[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers	Accommodation Chrono: Inmate is a dialysis patient and requires lifting restrictions, housing restrictions and DLT status due to medical diagnosis, Durable Medical Equipment: cpap bag, mask and hose replaced, DPP Verification: Inmate is a dialysis patient and requires lifting restrictions, housing restrictions and DLT status due to medical diagnosis,			
CHCF	[redacted]	[redacted]	E 302A1[redacted]	DKD		Eyeglass Frames				
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Eyeglass Frames, Foot Orthoses, Mobility Impaired Disability Vest				
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest, Walkers	Accommodation Chrono: old fragile IP with spine arthritis., DPP Verification: old fragile IP with spine arthritis., MCC: multiple medical conditions NOT CANDIDATE FOR MRCP			
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Eyeglass Frames, Incontinence Supplies, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Walkers, Wheelchair	Durable Medical Equipment: ARM SLEEVE, wheelchair cushion,			
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DKD	Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames	Accommodation Chrono: Patient on HD., DPP Verification: Patient on HD..			
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DKD		Eyeglass Frames, Therapeutic	MCC: Needs immediate dialysis.			

CHCF	[redacted]	[redacted]	E 302B1[redacted]	DKD	Lower/Bottom Bunk Only	Night Guard	Accommodation Chrono: HD patient feels weak after HD, Durable Medical Equipment: Inmate shall be allowed to retain possession of the following prescribed health care appliance until a health care evaluation is performed providing that safety and security of the institution/facility will not be compromised., DPP Verification: bottom bunk, MCC: Bottom bunk.			
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Helmet	DPP Verification: medical condition,			
CHCF	[redacted]	[redacted]	E 302B1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Partial Lower Denture, Wrist Support Brace	Accommodation Chrono: lower bunk due to weakness and dizziness after dialysis session., Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2018-04-06 15:42:42, DPP Verification: DKD,chronic medical condition, MCC: No heavy lifing, more than 15 lbs; No repetitive use of hands or wrists.			
CHCF	[redacted]	[redacted]	E 303A[redacted]	DPH,DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Foot Orthoses, Full Lower Denture, Full Upper Denture, Hearing Aid, Hearing Impaired Disability Vest, Therapeutic Shoes/Orthotics	Accommodation Chrono: For Medical Condition, DPP Verification: For Medical Condition, MCC: DPH, HEARING AIDS/VEST			Y

CHCF	[redacted]	[redacted]	E 303A1[redacted]	DKD	Lower/Bottom Bunk Only		Accommodation Chrono: Meets inclusion criteria for permanent chronos, DPP Verification: LB/LT. Medical necessity for a medical condition,			
CHCF	[redacted]	[redacted]	E 303A1[redacted]	DKD	Lower/Bottom Bunk Only	Compression Stocking, Diabetic Supplies/Monitors, Eyeglass Frames, Knee Braces, Other (Include in Comments), Partial Lower Denture - Acrylic, Therapeutic Shoes/Orthotics	Accommodation Chrono: Medical, Durable Medical Equipment: Prostetic eye wash, DPP Verification: Medical, MCC: see 7410,			
CHCF	[redacted]	[redacted]	E 303A1[redacted]	DKD	Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Foot Orthoses, Full Upper Denture, Knee Braces, Other (Include in Comments), Partial Lower Denture, Therapeutic Shoes/Orthotics	Accommodation Chrono: No prolonged standing > 30 minutes without 15 minutes sitting break., Durable Medical Equipment: A & D, Ace wrap 3", DPP Verification: RIGHT HIP PAIN,			
CHCF	[redacted]	[redacted]	E 303B1[redacted]	DNH,DKD	Lower/Bottom Bunk Only	Back Braces, Hearing Aid, Hearing Impaired Disability Vest, Truss Hernia Support, Wound Care Dressings	Accommodation Chrono: Meets inclusion criteria, DPP Verification: HD pt,			N

CHCF	[redacted]	[redacted]	E 303B1[redacted]	DPO,DPS,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Knee Braces, Mobility Impaired Disability Vest, Non-invasive Airway Assistive Devices - C-Pap Machine, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers, Wheelchair	Accommodation Chrono: significant upper extremity risk of harm with cuffing, Durable Medical Equipment: tens unit and 2" paper tape 2 rolls, elbow, knee, back brace, orthopedic shoes, wedge pillow, special embolism stockings-Pumo-Aide Nebulizer. Air cushion, DPP Verification: significant upper extremity risk of harm with cuffing, MCC: WC, walker, cane, CPAP machine, cervical collar, back brace, ankle brace and elbow brace, 3 tier shelf (temporary)			N
CHCF	[redacted]	[redacted]	E 303B1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest, Partial Upper Denture - Acrylic, Walkers	Accommodation Chrono: On dialysis MWF, Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2020-11-18 22:46:42, DPP Verification: On dialysis MWF,			
CHCF	[redacted]	[redacted]	E 304A1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Foot Orthoses	Accommodation Chrono: ESRD on HD, DPP Verification: ESRD on HD,			

CHCF	[redacted]	[redacted]	E 304A1[redacted]	DPO,DNV,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Back Braces, Canes, Mobility Impaired Disability Vest, Other (Include in Comments), Wheelchair	Accommodation Chrono: No Rooftop Work/Hazardous Restriction * Lifting Restriction * Special Cuffing * Limited Wheelchair User * Bottom Bunk * Ground Floor- No Stairs, Durable Medical Equipment: Wheelchair gloves, cushion, DPP Verification: No Rooftop Work/Hazardous Restriction * Lifting Restriction * Special Cuffing * Limited Wheelchair User * Bottom Bunk * Ground Floor- No Stairs, MCC: wheelchair, cane, renal diet.			N
CHCF	[redacted]	[redacted]	E 304A1[redacted]	DNM,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Wound Care Dressings	Accommodation Chrono: Severe postdialysis vertigo. Requires permanent cane chrono., DPP Verification: Severe postdialysis vertigo. Requires permanent cane chrono.,			
CHCF	[redacted]	[redacted]	E 304A1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Mobility Impaired Disability Vest, Partial Lower Denture - Acrylic, Partial Upper Denture - Acrylic, Therapeutic Shoes/Orthotics, Walkers				

CHCF	[redacted]	[redacted]	E 304B1[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Foot Orthoses, Incontinence Supplies, Mobility Impaired Disability Vest, Therapeutic Shoes/Orthotics, Walkers				
CHCF	[redacted]	[redacted]	E 304B1[redacted]	DKD	Lower/Bottom Bunk Only	Wound Care Dressings	Accommodation Chrono: ESRD on HD with aVF, DPP Verification: ESRD on HD with aVF,			
CHCF	[redacted]	[redacted]	E 304B1[redacted]	DNM,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics, Walkers	Accommodation Chrono: Lower bunk. Pt. cannot stand for > 20 minutes or push, pull or lift any object > 15 lbs for prolonged period., Durable Medical Equipment: wedge pillow D/C, DPP Verification: Lower bunk. Pt. cannot stand for > 20 minutes or push, pull or lift any object > 15 lbs for prolonged period.,			

CHCF	[redacted]	[redacted]	E 304B1[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Night Guard, Partial Upper Denture - Acrylic	Accommodation Chrono: Bottom bunk accommodation to avoid repetitive use of left upper extremity for climbing, pullling as has left arm fistula for hemodialysis, Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2019-07-12 18:39:29, DPP Verification: Bottom bunk accommodation to avoid repetitive use of left upper extremity for climbing, pullling as has left arm fistula for hemodialysis,			
CHCF	[redacted]	[redacted]	E 304B1[redacted]	DKD	Lower/Bottom Bunk Only	Mobility Impaired Disability Vest, Therapeutic Shoes/Orthotics	Accommodation Chrono: Medical, DPP Verification: Medical,			
CHCF	[redacted]	[redacted]	E 304B1[redacted]	DKD	Lower/Bottom Bunk Only	Foot Orthoses	Accommodation Chrono: ESRD, DPP Verification: ESRD, MCC: Patient with right arm AV fistula. Do not put handcuffs over the fistula.			
CHCF	[redacted]	[redacted]	E 305A1[redacted]	DKD	Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Other (Include in Comments)	Accommodation Chrono: HD patient feels weak and tired after HD, Durable Medical Equipment: carrying case for diabetic supplies, Meter Battery, DPP Verification: No lifting > 20 lbsNo vigorous activity No kitchen work, MCC: Renal Diet			

CHCF	[redacted]	[redacted]	E 305A1[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture, Partial Upper Denture, Therapeutic Shoes/Orthotics, Wheelchair	Accommodation Chrono: Elderly patient with multiple medical comorbidities need wheelchair for assistant and also need lower bunk., Durable Medical Equipment: Wheelchair seat cushion and XL wheelchair gloves, wedge pillow, DPP Verification: Elderly patient with multiple medical comorbidities need wheelchair for assistant and also need lower bunk., MCC: lower bunk			
CHCF	[redacted]	[redacted]	E 305B1[redacted]	DPO,DPV,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Mobility Impaired Disability Vest, Other (Include in Comments), Vision Impaired Disability Vest, Walkers, Wheelchair	Durable Medical Equipment: Wheelchair seat cushion and XL wheelchair gloves.,			
CHCF	[redacted]	[redacted]	E 305B1[redacted]	DKD	Lower/Bottom Bunk Only	Canes	Accommodation Chrono: Lower bunk Chrono, DPP Verification: Patient has end-stage renal disease on hemodialysis, MCC: see 1845/7410			
CHCF	[redacted]	[redacted]	E 305B1[redacted]	DKD	Lower/Bottom Bunk Only	Other (Include in Comments)	Accommodation Chrono: medical reasons, Durable Medical Equipment: wedge pillow, pitcher and measuring cup (I/P on dialysis), DPP Verification: medical reasons, MCC: renal diet			
CHCF	[redacted]	[redacted]	E 305B1[redacted]	DKD						
CHCF	[redacted]	[redacted]	UNK-UNK	DLT,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Knee Braces	Accommodation Chrono: Knee sprain, DPP Verification: Knee sprain, MCC: DKD			

CHCF	[redacted]	[redacted]	UNK-UNK	DKD		Eyeglass Frames	Accommodation Chrono: heart condition, DPP Verification: heart condition,			
CIM	[redacted]	[redacted]	C DEL [redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Foot Orthoses, Therapeutic Shoes/Orthotics	Accommodation Chrono: unfit for duty due to medical condition., DPP Verification: dialysis,			
CMC	[redacted]	[redacted]	E 010 [redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Therapeutic Shoes/Orthotics	Accommodation Chrono: Chronic Kidney Disease needs hemodialysis (not available at CMC), DPP Verification: Chronic Kidney Disease needs hemodialysis (not available at CMC),			
KVSP	[redacted]	[redacted]	A 007 [redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Knee Braces, Other (Include in Comments), Partial Lower Denture - Acrylic, Partial Upper Denture - Acrylic, Wheelchair	Accommodation Chrono: LBO and allow IP to shower - risk for fall due to healing injury, Durable Medical Equipment: Front Wheel Walker., DPP Verification: need LB due to ESRD on dialysis,			
KVSP	[redacted]	[redacted]	B 002 [redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Other (Include in Comments)	Accommodation Chrono: ., Durable Medical Equipment: 1 knee immobilizerwheelcahir gloves- 6/30/20right arm sling-blue, DPP Verification: Due to medical information on intake eval,			
KVSP	[redacted]	[redacted]	B 007 [redacted]	DKD		Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments)	Durable Medical Equipment: 6 sterile 4x4 gauze6 alcohol prep pads6 band aids			
KVSP	[redacted]	[redacted]	C 002 [redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Mobility Impaired Disability Vest				

KVSP	[redacted]	[redacted]	C 005[redacted]	DPM,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Other (Include in Comments), Partial Lower Denture, Therapeutic Shoes/Orthotics, Wrist Support Brace	Accommodation Chrono: recovered well on his left hip surgery but unable to climb stair yetremove wheel chair, maintain the walker, Durable Medical Equipment: gauze, tape, lancet drums, lancet pen, test strips, alcohol prep pads, and AAA-batteries, DPP Verification: recovered well on his left hip surgery but unable to climb stair yetremove wheel chair, maintain the walker,			
KVSP	[redacted]	[redacted]	C 007[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames	Accommodation Chrono: dialysis vascular access,			
KVSP	[redacted]	[redacted]	D 001[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Foot Orthoses, Non-invasive Airway Assistive Devices - Bi-Pap Machine, Reading Glasses, Therapeutic Shoes/Orthotics	Accommodation Chrono: Low bunk due to medical necessity, DPP Verification: Low bunk due to medical necessity, MCC: Hemodialysis			
SAC	[redacted]	[redacted]	B 004[redacted]	DKD		Back Braces, Eyeglass Frames	MCC: Renal diet. Back brace, glasses.			
SAC	[redacted]	[redacted]	B 006[redacted]	DKD		Compression Stocking, Eyeglass Frames, Foot	MCC: Renal diet, permanent LB.			
SAC	[redacted]	[redacted]	C 004[redacted]	DKD		Eyeglass Frames, Other (Include in Comments)	Durable Medical Equipment: elbow brace, compression sleve for dialysis coverage,			
SACCO	[redacted]	[redacted]	UNK-UNK	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Canes, Egg Crate Mattress, Eyeglass Frames, Pressure Reducing Support Services-Groups 1,2 & 3 (Mattress), Wheelchair				N

SACCO	[redacted]	[redacted]	UNK-UNK	DPW,DKD	Barrier Free/Wheelchair Accessible, Ground Floor-No Stairs, Lower/Bottom Bunk Only	Compression Stocking, Eyeglass Frames, Other (Include in Comments), Partial Upper Denture, Therapeutic Shoes/Orthotics, Wheelchair	Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2018-09-12 18:29:28,			
SATF	[redacted]	[redacted]	A 002 [redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Therapeutic Shoes/Orthotics	Accommodation Chrono: DKD, Chronic medical condition, DPP Verification: DKD, Chronic medical condition			
SATF	[redacted]	[redacted]	B 003 [redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Ankle Foot Orthoses/Knee Ankle Foot Orthoses (AFO/KAFO), Canes, Eyeglass Frames, Mobility Impaired Disability Vest, Partial Lower Denture - Acrylic, Partial Upper Denture - Acrylic, Reading Glasses, Therapeutic Shoes/Orthotics, Wheelchair, Wound Care Dressings, Wrist Support Brace	Accommodation Chrono: ., DPP Verification: ., MCC: DNM. No strenuous activity, no prolonged walking or standing. 2 AFO brace. Low bunk, Low tier. Mobility impaired vest. Renal diet, Right Arm Fistula, wheel chair gloves, glasses, orthotic boots, back brace,			
SOL	[redacted]	[redacted]	B 007 [redacted]	DNM,DKD	Lower/Bottom Bunk Only	Ankle Foot Orthoses/Knee Ankle Foot Orthoses (AFO/KAFO), Canes, Compression Stocking, Eyeglass Frames, Other (Include in Comments), Therapeutic Shoes/Orthotics	Durable Medical Equipment: bilateral elbow sleeves,			
SQ	[redacted]	[redacted]	A AC [redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames, Other (Include in Comments)	Durable Medical Equipment: dialysis peritonealBlack TherabandSilver Theraband			
SQ	[redacted]	[redacted]	A EB [redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Eyeglass Frames, Wheelchair				

SQ	[redacted]	[redacted]	A SB[redacted]	DPO,DKD	Ground Floor-No Stairs, Lower/Bottom Bunk Only	Ankle Foot Orthoses/Knee Ankle Foot Orthoses (AFO/KAFO), Canes, Compression Stocking, Eyeglass Frames, Knee Braces, Mobility Impaired Disability Vest, Other (Include in Comments), Partial Lower Denture - Metal, Partial Upper Denture - Metal, Therapeutic Shoes/Orthotics, Wheelchair	Durable Medical Equipment: Athletic support; therabands7/3/19-Spirometer exp 7/31/19,			
SQ	[redacted]	[redacted]	A WB [redacted]	DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only					
WSP	[redacted]	[redacted]	A 001[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Mobility Impaired Disability Vest, Other (Include in Comments), Therapeutic Shoes/Orthotics	Accommodation Chrono: LB/LT . TEMPORARY WHEELCHAIR, Durable Medical Equipment: 6" ACE wrap, DPP Verification: LB/LT,			
WSP	[redacted]	[redacted]	A 002[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Eyeglass Frames, Hearing Aid, Mobility Impaired Disability Vest, Other (Include in Comments)	Durable Medical Equipment: Patient was given one small mobility vest permanent and one brown wooden cane permanent.,			
WSP	[redacted]	[redacted]	A 002[redacted]	DLT,DKD	Ground Floor-Limited Stairs, Lower/Bottom Bunk Only	Canes, Compression Stocking, Eyeglass Frames, Knee Braces, Therapeutic Shoes/Orthotics				
WSP	[redacted]	[redacted]	A 003[redacted]	DKD			Durable Medical Equipment: Built by datafix for defect CIT 9796 on 05/04/2015 18:13:31 - original signed time: 07:21:52			N
WSP	[redacted]	[redacted]	A 003[redacted]	DKD		Eyeglass Frames				
WSP	[redacted]	[redacted]	A 003[redacted]	DKD						

WSP	[redacted]	[redacted]	A 005[redacted]	DKD	Lower/Bottom Bunk Only	Foot Orthoses, Therapeutic Shoes/Orthotics	Accommodation Chrono: HD patient feels weak after dialysis., Durable Medical Equipment: Dental DME Conversion, Original Order Date and Time 2018-02-08 22:20:07, DPP Verification: dialysis patient,			
WSP-RC	[redacted]	[redacted]	B 002[redacted]	DKD	Lower/Bottom Bunk Only		Accommodation Chrono: medical accommodation, DPP Verification: medical accommodation,			
WSP-RC	[redacted]	[redacted]	B 003[redacted]	DKD	Lower/Bottom Bunk Only	Compression Stocking, Diabetic Supplies/Monitors, Eyeglass Frames, Therapeutic Shoes/Orthotics	Accommodation Chrono: No lifting> 19 lb, DPP Verification: No lifting> 19 lb, MCC: temporary single cell for 2 months			
WSP-RC	[redacted]	[redacted]	B 003[redacted]	DKD	Lower/Bottom Bunk Only	Diabetic Supplies/Monitors, Eyeglass Frames, Therapeutic Shoes/Orthotics	Accommodation Chrono: disability, DPP Verification: disability, MCC: Permanent low bunk. Orthopedic shoes.			
WSP-RC	[redacted]	[redacted]	D 005[redacted]	DKD	Lower/Bottom Bunk Only	Crutches, Eyeglass Frames, Mobility Impaired Disability Vest	Accommodation Chrono: LB/LT,			
WSP-RC	[redacted]	[redacted]	D 005[redacted]	DKD	Lower/Bottom Bunk Only	Eyeglass Frames	Accommodation Chrono: ESRD ON HD, DPP Verification: ESRD ON HD.			

EXHIBIT 5

DASHBOARD STATEWIDE COMPARISON

All Institutions

January 2020

Report Range:	*Current Month Selected*
Selected Domain(s):	*All*

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Scheduling & Access to Care	SW	ASP	CAC	CAL	CCC	CCI	CCWF	CEN	CHCF	CIM	CIW	CMC	CMF	COR	CRC
Patient Requested Exam 90 Days	91%	98%	98%	85%	99%	56%	85%	100%	99%	99%	100%	99%	97%	88%	23%
Notice of Exam	98%	100%	100%	99%	100%	91%	94%	99%	100%	99%	99%	98%	98%	99%	98%
Appts Cancelled due to Custody- Medical	**0.7%**	**0.0%**	**0.0%**	**0.3%**	**0.0%**	**0.1%**	**0.1%**	**0.0%**	**0.0%**	**0.2%**	**0.6%**	**0.1%**	**1.2%**	**0.8%**	**0.1%**
Seen as Scheduled- Medical	**84%**	**93%**	**91%**	**87%**	**89%**	**86%**	**79%**	**91%**	**83%**	**84%**	**83%**	**89%**	**78%**	**85%**	**82%**
Effective Communication Provided	**97%**	**100%**	**99%**	**99%**	**99%**	**97%**	**96%**	**96%**	**97%**	**98%**	**96%**	**95%**	**96%**	**94%**	**95%**
Medical Services	98%	100%	100%	99%	100%	99%	98%	100%	97%	99%	94%	99%	97%	86%	100%
Dental Services	95%	100%	96%	98%	96%	93%	94%	89%	98%	98%	96%	89%	95%	97%	85%
Sign Language Interpreter (SLI) Provided	**88%**	-	-	-	-	-	**94%**	-	**88%**	**92%**	-	-	**71%**	-	-
Medical Backlog*	**75.8**	**12.8**	**6.0**	**56.7**	**31.9**	**9.4**	**183.4**	**54.8**	**48.6**	**42.0**	**69.5**	**116.4**	**88.4**	**41.8**	**95.4**
Allied Health Backlog*	1.4	0.0	0.0	0.0	0.0	0.0	1.7	0.3	14.2	3.2	0.6	0.3	2.4	1.0	0.3
Laboratory Backlog*	6.3	0.5	0.0	0.0	22.1	2.2	0.3	25.3	3.1	4.0	3.0	0.0	1.2	2.3	0.0
LVN Backlog*	4.5	3.1	1.4	13.6	0.5	0.3	0.7	5.1	0.7	1.8	9.1	1.3	9.1	2.6	0.8
PCP Backlog*	22.7	1.2	0.9	4.1	6.1	0.5	79.6	3.1	0.0	5.3	8.5	81.3	19.4	4.2	79.8
Radiology Backlog*	4.9	1.4	0.0	0.0	0.0	0.3	26.5	0.0	2.1	5.3	4.8	1.1	13.5	10.4	0.8
RN Backlog*	5.7	2.8	0.0	1.3	0.5	0.3	6.3	0.9	1.0	4.2	21.1	4.5	7.9	1.9	1.6
Specialty Backlog*	30.3	3.8	3.7	37.7	2.7	5.9	68.1	20.1	27.4	18.2	22.4	28.0	34.9	19.5	12.2

Population Health Management	SW	ASP	CAC	CAL	CCC	CCI	CCWF	CEN	CHCF	CIM	CIW	CMC	CMF	COR	CRC
Adult Immunizations	**36%**	**31%**	**28%**	**39%**	**64%**	**36%**	**36%**	**23%**	**40%**	**32%**	**46%**	**34%**	**43%**	**32%**	**51%**
Tdap/Td	61%	68%	38%	58%	95%	42%	63%	68%	70%	55%	80%	61%	71%	62%	70%
Hepatitis B	30%	42%	18%	34%	53%	28%	22%	29%	36%	27%	28%	29%	41%	29%	29%
Pneumococcal	62%	-	-	-	100%	77%	65%	0%	64%	68%	55%	53%	77%	58%	100%

** Rate Per 1,000 Inmates*

Please direct questions or feedback to QMstaff@cdcr.ca.gov

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DASHBOARD STATEWIDE COMPARISON

All Institutions

January 2020

Report Range:	*Current Month Selected*
Selected Domain(s):	*All*

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Scheduling & Access to Care	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP	RJD	SAC	SATF
Patient Requested Exam 90 Days	100%	85%	100%	99%	82%	91%	99%	89%	78%	88%	100%	99%	99%	99%	96%
Notice of Exam	99%	99%	93%	99%	96%	99%	99%	99%	100%	84%	100%	100%	92%	99%	100%
Appts Cancelled due to Custody- Medical	**0.0%**	**0.0%**	**0.1%**	**0.1%**	**0.1%**	**1.2%**	**0.2%**	**0.4%**	**3.9%**	**2.2%**	**0.0%**	**0.1%**	**1.7%**	**0.7%**	**0.2%**
Seen as Scheduled- Medical	**80%**	**86%**	**82%**	**92%**	**83%**	**83%**	**88%**	**85%**	**82%**	**77%**	**80%**	**91%**	**80%**	**88%**	**86%**
Effective Communication Provided	**98%**	**96%**	**98%**	**96%**	**96%**	**99%**	**98%**	**98%**	**98%**	**97%**	**97%**	**96%**	**95%**	**98%**	**96%**
Medical Services	99%	100%	99%	100%	100%	99%	99%	99%	99%	98%	98%	99%	99%	99%	97%
Dental Services	95%	89%	95%	88%	90%	98%	98%	97%	98%	97%	96%	94%	92%	95%	96%
Sign Language Interpreter (SLI) Provided	-	-	**92%**	-	-	-	-	**92%**	-	-	-	-	**86%**	-	**93%**
Medical Backlog*	**24.7**	**146.7**	**60.0**	**12.7**	**96.2**	**29.1**	**102.6**	**121.0**	**40.8**	**182.5**	**20.3**	**19.6**	**199.5**	**25.6**	**109.8**
Allied Health Backlog*	0.2	0.4	0.9	0.3	0.0	0.7	0.6	0.0	1.0	0.2	0.0	0.0	2.1	0.0	12.2
Laboratory Backlog*	3.1	16.9	0.5	0.3	4.7	2.7	2.5	11.1	3.0	0.0	0.0	1.6	3.1	0.4	2.6
LVN Backlog*	0.0	0.0	16.5	0.0	20.1	5.1	1.1	3.1	1.2	12.2	0.8	3.2	4.4	0.4	6.0
PCP Backlog*	0.0	51.4	8.0	1.5	9.1	8.2	85.3	12.6	1.7	111.9	1.9	0.3	27.7	5.0	6.7
Radiology Backlog*	0.6	6.5	0.9	1.5	0.9	0.7	1.4	0.9	4.2	0.2	1.5	0.0	40.1	0.0	4.3
RN Backlog*	0.0	4.0	13.7	2.7	1.3	3.1	2.0	8.0	1.2	46.3	1.5	0.6	3.1	0.8	3.9
Specialty Backlog*	20.8	67.6	19.4	6.3	60.1	8.6	9.8	85.4	28.4	11.7	14.7	13.9	119.2	18.9	74.1

Population Health Management	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP	RJD	SAC	SATF
Adult Immunizations	**27%**	**29%**	**49%**	**25%**	**43%**	**32%**	**31%**	**38%**	**45%**	**25%**	**42%**	**36%**	**45%**	**31%**	**23%**
Tdap/Td	53%	45%	71%	45%	66%	61%	47%	57%	82%	43%	81%	60%	85%	61%	42%
Hepatitis B	18%	27%	54%	30%	33%	47%	36%	32%	29%	17%	50%	45%	39%	43%	22%
Pneumococcal	55%	57%	100%	32%	100%	-	62%	69%	79%	33%	53%	-	67%	33%	43%

** Rate Per 1,000 Inmates*

Please direct questions or feedback to QMstaff@cdcr.ca.gov

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DASHBOARD STATEWIDE COMPARISON

All Institutions

January 2020

Report Range:	*Current Month Selected*
Selected Domain(s):	*All*

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Subcommittee View | Dashboard Glossary

Scheduling & Access to Care	SCC	SOL	SQ	SVSP	VSP	WSP
Patient Requested Exam 90 Days	100%	95%	100%	100%	99%	83%
Notice of Exam	99%	99%	99%	99%	100%	91%
Appts Cancelled due to Custody- Medical	**0.5%**	**4.6%**	**0.8%**	**0.1%**	**0.1%**	**0.0%**
Seen as Scheduled- Medical	**93%**	**75%**	**83%**	**79%**	**86%**	**88%**
Effective Communication Provided	**96%**	**96%**	**96%**	**96%**	**97%**	**99%**
Medical Services	97%	98%	98%	98%	100%	100%
Dental Services	96%	91%	93%	95%	98%	98%
Sign Language Interpreter (SLI) Provided	-	-	-	-	-	-
Medical Backlog*	**62.6**	**144.5**	**127.9**	**89.7**	**74.4**	**35.9**
Allied Health Backlog*	0.5	0.0	0.2	2.7	0.0	0.4
Laboratory Backlog*	8.1	16.5	45.0	0.0	5.6	8.8
LVN Backlog*	2.5	17.0	3.9	0.7	2.0	9.2
PCP Backlog*	9.3	38.1	21.0	7.1	57.2	5.3
Radiology Backlog*	1.4	21.1	8.9	5.7	0.0	1.5
RN Backlog*	21.7	13.1	3.9	6.1	1.7	1.7
Specialty Backlog*	19.2	38.6	45.0	67.4	7.9	9.0
Population Health Management	**SCC**	**SOL**	**SQ**	**SVSP**	**VSP**	**WSP**
Adult Immunizations	**37%**	**38%**	**34%**	**33%**	**36%**	**31%**
Tdap/Td	50%	66%	60%	61%	61%	20%
Hepatitis B	21%	36%	25%	35%	28%	11%
Pneumococcal	86%	50%	48%	58%	65%	100%

** Rate Per 1,000 Inmates*

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EXHIBIT 6

DASHBOARD

Specifications

Domain	Scheduling & Access to Care
Measure	Medical Backlog (Composite)

Definition	Sum of the numerators divided by the sum of the denominators of the following 7 types of orders: 1) Allied Health; 2) Laboratory; 3) LVN; 4) PCP; 5) Radiology; 6) RN; and 7) Specialty.
Denominator	Sum of the denominators of the component measures in the composite.
Numerator	Sum of the numerators of each component measure.
Rate Calculation	Composite measure rate is the numerator divided by the denominator.
Data Source(s)	Census and Discharge Data Information System Strategic Offender Management System(SOMS) Electronic Health Record System (EHRS)
Reporting Frequency	Monthly
Background	
Goal/Ranking	High =< 70.05 Moderate 70.06 – 140.05 Low > 140.05
Comments	Reported as a rate per 1,000 inmates.
Last Revised	20210629 JK
Component Measures	*Click on any link below to see component measure specifications:*

1	Allied Health
2	Laboratory
3	LVN
4	PCP
5	Radiology
6	RN

DASHBOARD

Specifications

Domain	Scheduling & Access to Care
Measure	Medical Backlog (Composite)
	7 Specialty

Click Here to:
Return to Home

DASHBOARD

Specifications

Domain	Scheduling & Access to Care
Measure	Medical Backlog - Laboratory

Definition	The rate of Laboratory backlog per 1,000 inmates during the reporting period.
Denominator	Inmate population on the last day of the reporting month.
Numerator	Total Laboratory backlog. The number of appointments with a due date (order due date or due date per policy, whichever is earlier) prior to the reporting date that are either scheduled past their due date or pending orders not yet scheduled with a due date that has passed.
Rate Calculation	**Statewide:** Rate is the sum of the numerators divided by the total inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Institution:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Care Team:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates).
Data Source(s)	Strategic Offender Management System (SOMS) Electronic Health Record System (EHRS)
Reporting Frequency	Monthly
Background	
Goal/Ranking	High =< 10.05 Moderate 10.06 – 20.05 Low > 20.05
Comments	Reported as a rate per 1,000 inmates.
Last Revised	20190110 SAE

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DASHBOARD

Specifications

Domain	Scheduling & Access to Care
Measure	Medical Backlog - PCP

Definition	The rate of PCP backlog per 1,000 inmates during the reporting period.
Denominator	Inmate population on the last day of the reporting month.
Numerator	Total PCP backlog. The number of appointments with a due date (order due date or due date per policy, whichever is earlier) prior to the reporting date that are either scheduled past their due date or pending orders not yet scheduled with a due date that has passed.
Rate Calculation	**Statewide:** Rate is the sum of the numerators divided by the total inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Institution:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Care Team:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates).
Data Source(s)	Strategic Offender Management System (SOMS) Electronic Health Record System (EHRS)
Reporting Frequency	Monthly
Background	
Goal/Ranking	High =< 10.05 Moderate 10.06 – 20.05 Low > 20.05
Comments	Reported as a rate per 1,000 inmates.
Last Revised	20190110 SAE

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DASHBOARD

Specifications

Domain	Scheduling & Access to Care
Measure	Medical Backlog - RN

Definition	The rate of RN backlog per 1,000 inmates during the reporting period.
Denominator	Inmate population on the last day of the reporting month.
Numerator	Total RN backlog. The number of appointments with a due date (order due date or due date per policy, whichever is earlier) prior to the reporting date that are either scheduled past their due date or pending orders not yet scheduled with a due date that has passed.
Rate Calculation	**Statewide:** Rate is the sum of the numerators divided by the total inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Institution:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Care Team:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates).
Data Source(s)	Strategic Offender Management System (SOMS) Electronic Health Record System (EHRS)
Reporting Frequency	Monthly
Background	
Goal/Ranking	High =< 10.05 Moderate 10.06 – 20.05 Low > 20.05
Comments	Reported as a rate per 1,000 inmates.
Last Revised	20190110 SAE

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DASHBOARD

Specifications

Domain	Scheduling & Access to Care
Measure	Medical Backlog - Specialty

Definition	The rate of Specialty backlog per 1,000 inmates during the reporting period.
Denominator	Inmate population on the last day of the reporting month.
Numerator	Total specialty backlog. The number of appointments with a due date (order due date or due date per policy, whichever is earlier) prior to the reporting date that are either scheduled past their due date or pending orders not yet scheduled with a due date that has passed.
Rate Calculation	**Statewide:** Rate is the sum of the numerators divided by the total inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Institution:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates). **Care Team:** Rate is the numerator divided by the inmate population on the last day of the reporting month times 1,000 (to create a monthly rate per 1,000 inmates).
Data Source(s)	Strategic Offender Management System (SOMS) Electronic Health Record System (EHRS)
Reporting Frequency	Monthly
Background	
Goal/Ranking	High =< 10.05 Moderate 10.06 – 20.05 Low > 20.05
Comments	Reported as a rate per 1,000 inmates.
Last Revised	20190110 SAE

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DASHBOARD

Specifications

Domain	Institution & Population Characteristics
Measure	Inmates 50 Years of Age or Older

Definition	Percentage of patients who are age 50 or older.
Denominator	Institution population on the last day of the reporting month.
Numerator	Number of patients on the last day of the reporting month who are 50 years of age or older.
Rate Calculation	**Statewide**: Percentage is the sum of the numerators divided by the sum of the denominators times 100. **Institution**: Percentage is the numerator divided by the denominator times 100.
Data Source(s)	Strategic Offender Management System Electronic Health Records System (EHRS)
Reporting Frequency	Monthly
Background	
Goal/Ranking	This measure is included for monitoring purposes and has no specified benchmark or goal.
Comments	
Last Revised	20170128 JD
Component Measures	

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EXHIBIT 7

PCP STAFFING & BACKLOG REPORT

June 1, 2021 thru June 15, 2021

***** Backlog may be affected by COVID-19**

	Institution	Months Since EHRS Go-Live	HR PCP Data							Daily Backlog								QM Tool Usage	PCP Orders					Chronic Care Patients With Out Pending PCP Appointment
			Total Position Authority	Civil Service		Registry Coverage	Telemed Coverage	**Adjusted Coverage	**Staffing +/-	Current as of 06/15/2021	Backlog Per 100 Inmates	Backlog Older than 30 Days	Backlog Older than 90 Days	Minimum	Maximum	Average	Average Backlog Between 03/15/21 to 06/15/21	Medical Scheduling Registry	Total PCP Orders	Total PCP Orders Canceled	Orders Cancelled And Not Re-Ordered	Orders Cancelled and Re-Ordered	Percent Cancelled and Re-Ordered	
				Actual Vacancies	*Functional Vacancies																			
Delegated Institutions	CMC	53	12.5	0	-	1	0	-	-	414	13.8	249	94	414	494	461	697	-	1,294	22	9	13	1%	183
	COR	44	10	3	-	1	2	-	-	234	7.3	105	14	234	340	291	365	-	2,028	75	40	35	2%	150
	KVSP	50	9.5	2.5	-	0	2.6	-	-	162	4.6	114	39	162	329	239	470	-	1,787	39	23	16	1%	124
	SQ	51	11.5	1.1	-	0.8	2	-	-	82	3.4	12	3	57	96	75	92	-	1,167	18	9	9	1%	63
	CEN	52	6.5	2.5	-	0	1	-	-	39	1.3	4	4	13	39	26	14	-	897	4	-	4	0%	113
	CVSP	53	5	1.5	-	0	1	-	-	35	1.8	1	0	4	41	24	8	-	701	-	-	0	0%	9
	ASP	52	8	1	-	0	0	-	-	34	1.1	22	12	34	63	49	46	-	1,110	6	1	5	0%	243
	VSP	50	9.5	3.5	-	2.6	1	-	-	29	1.0	6	4	29	67	52	246	-	1,255	7	3	4	0%	246
	CIM	46	12	-6	-	0	0	-	-	12	0.5	1	0	2	14	6	5	-	1,522	1	1	0	0%	38
	CIW	68	8	0	-	0	0	-	-	6	0.7	0	0	5	20	7	10	-	848	11	6	5	1%	20
	CAL	48	6	0.5	-	0.5	1	-	-	4	0.1	0	0	2	10	6	19	-	844	5	2	3	0%	43
	CCI	55	8.5	1	-	0.5	2	-	-	4	0.1	0	0	2	10	6	11	-	1,738	13	6	7	0%	18
	SCC	55	6.5	0.5	-	0	1	-	-	4	0.1	0	0	4	13	9	18	-	922	9	2	7	1%	68
	CTF	57	12	2	-	1.4	2	-	-	3	0.1	0	0	2	6	3	2	-	1,325	2	1	1	0%	538
	PVSP	49	6	1	-	0	2.3	-	-	2	0.1	1	0	2	14	12	15	-	1,246	9	4	5	0%	120
	FSP	68	7	-2	-	0	0	-	-	2	0.1	1	1	2	11	8	8	-	1,053	1	-	1	0%	54
	CAC	56	4	0	-	0	0	-	-	2	0.1	0	0	2	6	4	3	-	574	-	-	0	0%	191
	CCC	55	4.5	2.5	-	1.1	1	-	-	1	0.0	0	0	1	8	3	4	-	779	1	-	1	0%	42
	PBSP	57	5.5	2.5	-	1	1.4	-	-	0	0.0	0	0	1	3	2	8	-	509	2	2	0	0%	147
Non-Delegated Institutions	CCWF	68	9.5	-2	-	1	0	-	-	989	41.2	379	72	906	1,042	968	612	-	2,200	27	22	5	0%	39
	HDSP	53	8.5	4.5	-	1.25	2	-	-	663	20.1	414	108	663	723	686	730	-	1,403	35	29	6	0%	140
	LAC	44	10	0	-	0	0	-	-	475	17.6	14	0	181	479	353	103	-	1,129	16	10	6	1%	31
	NKSP	48	8.5	-2.5	-	0	0	-	-	443	13.0	1	1	267	531	398	182	-	2,276	16	4	12	1%	27
	CHCF	47	37	3	-	2.5	0	-	-	398	15.9	224	0	391	429	410	336	-	1,429	9	5	4	0%	518
	SAC	49	8	3	-	1.8	1	-	-	370	16.8	300	134	370	450	403	398	-	2,033	28	18	10	0%	45
	RJD	44	16	-1	-	0	0	-	-	288	8.7	96	43	288	359	322	298	-	3,199	68	37	31	1%	140
	SATF	46	14	3	-	0.5	3	-	-	263	5.4	68	1	237	272	254	387	-	3,294	74	57	17	1%	65
	MCSP	44	17.5	1.5	-	1	0	-	-	112	2.9	30	3	110	224	153	260	-	2,031	99	38	61	3%	142
	SOL	58	10.5	1.5	-	0	1	-	-	108	3.4	14	2	108	159	133	152	-	1,041	7	1	6	1%	105
	CMF	45	17	3.2	-	0	0	-	-	78	3.9	9	3	78	117	99	82	-	1,182	23	16	7	1%	143
	CRC	56	5.5	-1.5	-	0	0	-	-	13	0.6	4	3	13	22	17	13	-	751	2	2	0	0%	13
	WSP	44	9	-2	-	0	1	-	-	10	0.3	2	2	10	26	19	73	-	2,301	15	5	10	0%	328
	ISP	51	6	4	-	1.75	2	-	-	5	0.2	2	0	5	15	9	100	-	903	6	-	6	1%	6
	DVI	51	4	-2	-	0	0	-	-	2	0.7	1	1	2	3	2	10	-	195	1	1	0	0%	37
	SVSP	45	12	6	-	3.8	1	-	-	1	0.0	1	0	1	5	2	3	-	2,214	5	2	3	0%	13
SW	SW Total	-	345.5	35.8	-	23.5	31.3	-	-	5,287	-	2,075	544	4,602	6,440	5,513	5,780	0	49,180	656	356	300	-	4,202
	SW Average	-	9.9	1.0	-	0.7	0.9	-	-	151	5.3	59	16	131	184	158	165	0	1,405	19	10	9	0.5%	120

** Functional Vacancies methodology is currently under revision*

*** Adjusted Coverage and Staffing +/- cannot be calculated due to the dependency on Functional Vacancies*

*** Backlog may be affected by COVID-19

Calculations for vacancy rates are currently under revision. Until new methodology is defined, the columns "Functional Vacancies", "Adjusted Coverage" and "Staffing +/-" will not be calculated.

EXHIBIT 8

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date : July 26, 2021

To : Steven Fama, Prison Law Office

Subject : **PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO SPECIALTY SERVICES**

California Correctional Health Care Services (CCHCS) is providing the italicized information below in response to your e-mail inquiry dated July 8, 2021.

1. Please provide updated spreadsheets regarding overdue specialty services for an identified date on or after July 15.
   Please refer to Attachment A.

2. Please provide an update on whether Medical Imaging Services has provided the prisons with updated lists of backlogged ultrasound exams for ESLD (and if so, when those lists were provided), as referenced in Response #3 of the attached 6/17/21 CCHCS memorandum?
   In July 2021, Medical Services provided institutions with updated lists of pending ultrasounds for End-Stage Liver Disease (ESLD) patients. The number of overdue exams has steadily decreased over the last few months, and the expectation is for institutions to monitor their patients via the Quality Management Advanced Liver Disease patient registry.

3. Can you please also tell us the number of backlogged (overdue) ultrasound exams for ESLD patients as an identified date on or after July 15?
   As of July 15, 2021, there were 876 overdue ultrasound exams for ESLD patients.

4. Can you tell us the number of optometry appointments that CHCF currently completes each week and whether and to what extent that number is expected to change in the coming weeks?
   The number of optometry appointments has varied in recent weeks, and there is no way to predict if this number is expected to change in coming weeks.

Week	***CHCF Optometry Appointments Completed***
June 28 – July 3, 2021	73
July 4 – July 10, 2021	19
July 10 – July 17, 2021 (as of July 15, 2021)	35

MEMORANDUM

Re: Specialty Services

5. Given those numbers [of optometry appointments] and other factors, when is it anticipated that the optometry backlog at CHCF will be eliminated?
Given the wide range of appointments completed and new orders placed recently, it is difficult to anticipate the elimination of the current overdue optometry appointments. However, CHCF will continue to work diligently to schedule the overdue appointments in a timely manner.

6. Can and will CCHCS contract with a mobile optometry clinic to come on-site at CHCF, and perhaps other institutions to supplement the on-site clinic and thus increase the number of patients who can be seen?
CCHCS is willing to explore mobile optometry clinics; however, at this time it is the availability of registry optometrists that is contributing to the number of overdue appointments.

7. Can and will patients be provided optometry services locally off-site, on a same-day return basis, such that no quarantine would be required?
Yes, CCHCS did not shut down access to all specialty services during the COVID-19 pandemic, and institutions were advised to use off-site services as necessary to reduce overdue appointments, as well as when on-site and telehealth specialists were not available. None of the optometry appointments have required patients to take overnight trips, and per the COVID-19 Screening and Testing Matrix for Patient Movement, patients sent off-site wear N95 masks during transfer, are screened upon return, and are tested five days after their appointments. Quarantine practices are only utilized if patients refuse to test.

8. What are the plans at CMC, FSP, HDSP, MCSP, and SOL to reduce and eliminate the optometry backlogs and when is it anticipated that the backlogs will be eliminated?
All institutions were asked to review their pending order queues to screen for requests related to reading glasses, which are available in the canteen and for patients who have received eyeglass prescriptions within the past two years, as they are able to receive a new pair of glasses after an order is placed without seeing a specialist.

California Men's Colony (CMC):
While for many months it was difficult to obtain a registry optometrist, CMC has an optometrist scheduled to start in August 2021, and is willing to go on-site five days a week to address overdue appointments. CMC's goal is to eliminate all overdue appointments within the next two months.

Folsom State Prison (FSP):
FSP is managing their overdue appointments well and only have six appointments on their overdue report (three had order entry errors and one is an encounter mismatch; all are being addressed). FSP has 173 orders due between July 20 and November 30, 2021, and they have no concerns with completing these appointments on time.

High Desert State Prison (HDSP):
Currently, HDSP has one optometrist available to come on-site two times per month. There is an ongoing search for additional optometrists, including for after-hours and weekend coverage. Staff will be assigned to review the overdue appointments to ensure accuracy, eliminate duplicate orders, and close out appointments for patients that were already seen. HDSP will train staff on the process related to ordering replacement glasses for those with recent exams.

MEMORANDUM

Re: Specialty Services

Mule Creek State Prison (MCSP):
MCSP was able to decrease their optometry overdue orders by 100 last month and as of July 20, 2021, have 333 overdue orders. The optometrist is providing weekend clinics as well as working every Wednesday through Friday (full days) and one Tuesday (full day) a month. Scheduling staff anticipate the overdue orders should be eliminated in three to four months if the current trends continue.

California State Prison, Solano (SOL):
Currently, SOL has only one optometrist working two times per week. An active search is in progress for an additional optometrist and SOL is willing to accommodate after-hours and weekend clinics. The institution Utilization Management (UM) Committee, specialty subcommittee and optometry Licensed Vocational Nurse actively monitor the current overdue orders, and the UM Registered Nurse is tasked with removing any duplicate orders, and closing out orders where the patient was already seen.

Thank you.

cc: Clark Kelso, Receiver
Directors, CCHCS
CCHCS Office of Legal Affairs
Office of Legal Affairs, CDCR
Office of the Attorney General
Hanson Bridgett, LLP
Jackie Clark, Deputy Director (A), Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Renee Kanan, Deputy Director, Medical Services, CCHCS
Erin Hoppin, Associate Director, Risk Management Branch, CCHCS
Regional Deputy Medical Executive, Regions I-II, CCHCS
Regional Health Care Executive, Regions I-II, CCHCS
Regional Nursing Executive, Regions I-II, CCHCS
Chief Executive Officers, CHCF, CMC, FSP, HDSP, MCSP, SOL

EXHIBIT 9

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

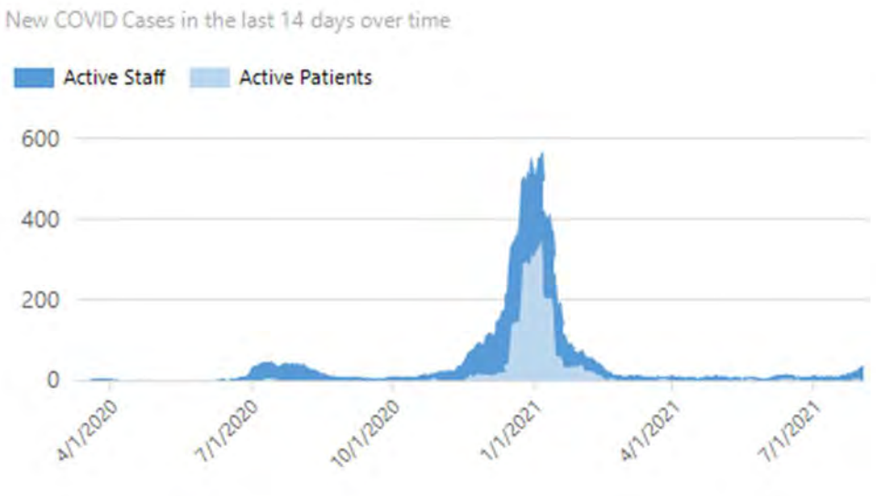
Recent Changes

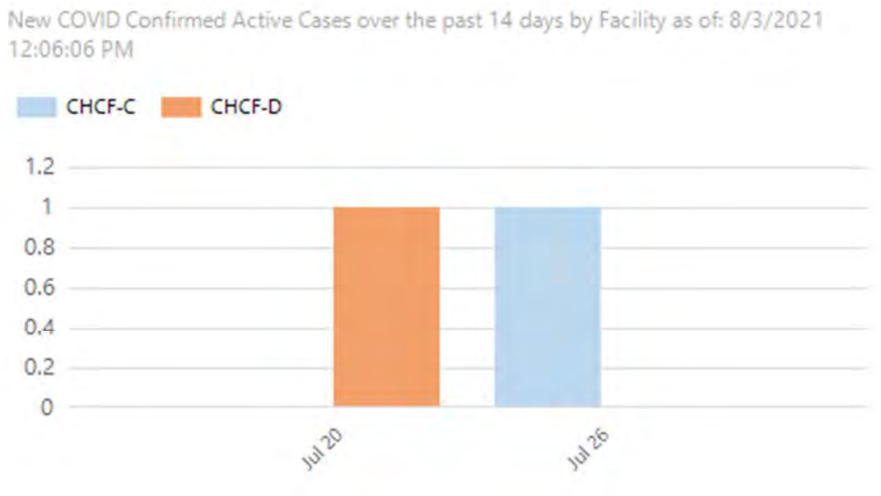
Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined





COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
31	31	3	2

Facility	CHCF-A	CHCF-B	CHCF-C	CHCF-D	CHCF-E	Offsite	Total
Confirmed Active	0	0	1	2	0	0	3
Isolation	0	0	6	3	0	0	9
Quarantine	65	267	140	215	29	3	719
Susceptible	233	438	551	397	798	0	2417

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing, cont.

2. Isolation and Quarantine Housing

r r r d r d r r r r D M r R r d d r D r r r d d

Isolation Housing

DATA PULLED @8/3/2021 12:05:47 PM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
C3B (AIIR)	2	1	1	0	N	Single Cell, Solid Door
D2A (AIIR)	2	1	1	0	N	Single Cell, Solid Door
D5A (AIIR)	2	1	1	0	N	Single Cell, Solid Door

Are any patients refusing to move to designated ISO areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new COVID positive cases since last report?	0	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Yes, all new positive cases have been moved to the appropriate housing units within the appropriate timeframe.

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Quarantine Housing

DATA PULLED @8/3/2021 12:05:47 PM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients
Quarantine Description:	**CHCF Count** **117** Patients from outside institutions, Out-to-court, Out-to-medical, and county jail intakes will be isolated on droplet precautions for 14 days and COVID-19 quarantine surveillance will be conducted at least twice daily for 14 days. **605** Patients quarantined for either high risk exposure to Covid positive patients and or staff.

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
A1A	30	4	26	3 post transfers	N	Single Cell, Solid Door
A1B	30	10	20	3 post transfers 7 post Covid positive exposure-staff	N	Single Cell, Solid Door
A2A	39	31	8	1 pre transfer 1 post transfer 29 post Covid positive exposure-staff	N	Single Cell, Solid Door
A2B	38	18	20	2 post transfers 16 post Covid positive exposure-staff	N	Single Cell, Solid Door

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

A4A	94	1	93	3 pre transfers 2 post transfers	N	Single Cell, Solid Door
B1A	30	7	23	1 post transfer	N	Single Cell, Solid Door
B1B	25	2	23	0	N	Single Cell, Solid Door
B2A	30	27	3	2 post transfers 25 post Covid positive exposure-staff	N	Single Cell, Solid Door
B2B	30	26	4	1 post transfer 25 post Covid positive exposure-staff	N	Single Cell, Solid Door
B3A	30	25	5	5 post transfers	N	Single Cell, Solid Door
B3B	30	27	3	3 post transfers	N	Single Cell, Solid Door
B4A	30	25	5	3 post transfers 22 post Covid positive exposure-staff	N	Single Cell, Solid Door
B4B	30	28	2	3 post transfers 25 post Covid positive exposure-staff	N	Single Cell, Solid Door
B5A	30	1	29	3 post transfers	N	Single Cell, Solid Door
B5B	30	5	25	2 post transfers	N	Single Cell, Solid Door
B6A	30	27	3	1 post transfer 26 post Covid positive exposure-staff	N	Single Cell, Solid Door
B6B	30	29	1	2 post transfers 27 post Covid positive exposure-staff	N	Single Cell, Solid Door
B7A	30	3	27	3 post transfers	N	Single Cell, Solid Door

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

B7B	30	1	29	2 pre transfers 1 post transfer	N	Single Cell, Solid Door
B8A	30	1	29	2 post transfers	N	Single Cell, Solid Door
B8B	30	0	30	1 post transfer	N	Single Cell, Solid Door
C1A	50	1	49	1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C1B	50	0	50	1 pre transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C2A	48	0	48	1 post transfer	N	Single Cell, Solid Door
C2B	48	0	48	1 post transfer	N	Single Cell, Solid Door
C3A	48	44	4	1 pre transfer 2 post transfers 40 post Covid positive exposure-staff	N	Single Cell, Solid Door
C3B	48	41	7	1 post transfer 40 post Covid positive exposure-staff	N	Single Cell, Solid Door
C4A	50	1	49	1 pre transfer 1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C4B	48	24	24	1 pre transfer 4 post transfers 19 post Covid positive exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C5A	50	2	48	2 post transfers	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C5B	50	1	49	1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C6A	50	3	47	0	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C6B	50	2	48	1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

D1A	30	2	28	4 post transfers 24 post Covid exposure-staff	N	Single Cell, Solid Door
D1B	30	1	29	2 post transfers	N	Single Cell, Solid Door
D2A	30	29	1	1 pre transfer 5 post transfers 23 post Covid positive I/P exposure	N	Single Cell, Solid Door
D2B	30	28	2	2 post transfers 26 post Covid positive I/P exposure	N	Single Cell, Solid Door
D3A	30	30	0	30 post Covid positive exposure-staff	N	Single Cell, Solid Door
D3B	30	1	29	0	N	Single Cell, Solid Door
D4A	30	3	27	3 post transfers	N	Single Cell, Solid Door
D4B	30	2	28	0	N	Single Cell, Solid Door
D5A	30	29	1	3 post transfers 26 post Covid positive exposure-staff	N	Single Cell, Solid Door
D5B	30	29	1	2 post transfers 27 post Covid positive exposure-staff	N	Single Cell, Solid Door
D6A	30	29	1	1 pre transfer 29 post Covid positive I/P exposure	N	Single Cell, Solid Door
D6B	30	30	0	30 post Covid positive I/P exposure	N	Single Cell, Solid Door

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

D7A	30	1	29	2 post transfers	N	Single Cell, Solid Door
D7B	30	22	8	1 post transfer 21 post Covid positive exposure-staff	N	Single Cell, Solid Door
E1A-2	25	0	25	1 post transfer	N	Single Cell, Solid Door
E1B-1	50	17	33	1 post transfer	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1B-2	50	10	40	11 post transfers	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1C-1	42	0	42	1 post transfer	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1D-2	50	0	50	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1E-1	50	0	50	1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1E-2	50	0	50	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E2B DORM	89	0	89	2 pre transfers 2 post transfers	Y	Precautionary post transfer quarantine completed prior to housing them into the dorm. Pre transfer precautionary quarantine are transferred to E1B and are segregated in a 2 man cell behind a solid door within a shared housing unit.
E3A DORM	88	0	88	1 pre transfer	Y	Pre transfer precautionary quarantine are transferred to E1B and are segregated in a 2 man cell behind a solid door within a shared housing unit.

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

E4A DORM	88	0	88	1 pre transfer 2 post transfers	Y	Precautionary post transfer quarantine completed prior to housing them into the dorm. Pre transfer precautionary quarantine are transferred to E1B and are segregated in a 2 man cell behind a solid door within a shared housing unit.
E5A DORM	88	0	88	2 post transfers	Y	Precautionary post transfer quarantine completed prior to housing them into the dorm. Pre transfer precautionary quarantine are transferred to E1B and are segregated in a 2 man cell behind a solid door within a shared housing unit.
E5B DORM	89	0	89	4 post transfers	Y	Precautionary post transfer quarantine completed prior to housing them into the dorm. Pre transfer precautionary quarantine are transferred to E1B and are segregated in a 2 man cell behind a solid door within a shared housing unit.

Are any patients refusing to move to designated Quarantine areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new Quarantine cases since last report?	319	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Yes, all new positive cases have been moved to the appropriate housing units within the appropriate timeframe.
ADA Accommodations			
Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	No	If so, where are they housed? (Location & # of patients)	N/A

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	N/A

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
924	278	550	184

3. Clinical Management of COVID Patients - d r d d r D M r R r d r d r

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	63	0

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0	N/A	18

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	6.10.2021 EMS COVID Hospitalization Press Release Good afternoon, Please see the attached press release regarding the latest San Joaquin County COVID-19 hospitalization data. **This will be the final COVID press release distributed on a daily basis.** Future press releases may be distributed as the need arises

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Testing and Movement Plan

5. Vaccination of Patients and Staff d r d d r r d r

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
3844	108	2327		2470	36	2120	320

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)

Per Memo dated July 28, 2021:

During May, June and July, CDCR and CCHCS exempted fully vaccinated staff and inmates from routine surveillance testing for COVID. This action was taken based upon the finding that fully vaccinated individuals appear to be less likely to transmit the virus to others.

We continue to monitor the spread of newer more transmissible COVID variants, some of which have been shown to be more likely to lead to hospitalization and death. The Delta strain is now the most common variant among recently infected CDCR/CCHCS staff. This variant is much easier to transmit, and more likely to result in hospitalization. We encourage those of you who are not yet vaccinated to request one now so that you, your families, and all of those around you are protected going forward.

CDCR and CCHCS are at this time extending the hiatus from routine surveillance testing for all fully vaccinated staff and incarcerated persons until further notice. Testing will continue for all incarcerated persons and employees, regardless of vaccination status, who are identified as close contacts of active cases. Testing for the incarcerated will also continue as described in the current movement matrix, as part of the in person visiting program and prior to dental encounters at institutions that have active COVID cases.

Institution Testing Schedule:
Mon - Fac A, E1A/B
Tues - Fac B, E1C,E2A/B
Wed - Fac C, E1D,E3A/B
Thu - Fac D, E1E, E4A/B
Fri - Fac E1F, E5A/B

- **Patients housed in a unit with staff or patients who are positive for COVID are tested on day #5 and day #12 post exposure. The unit is CTQ – no movement in or out and solo programming within the unit. The unit is released when the unit's test result come back as normal or 14 days, whichever is greater. The patient remains in isolation for 14-21 days depending on symptoms and risk.**

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)

- **Testing strategy remains the same.**
  - **Patients housed in a unit with staff or patients who are positive for COVID are tested on day #5 and day #12 post exposure. The unit is CTQ – no movement in or out and solo programming within the unit. The unit is released when the unit's test result come back as normal or 14 days whichever is greater. The patient remains in isolation for 14-21 days depending on symptoms and risk.**
  - **Patients will be tested who return from the Hospital and ER settings, pre- and post-transfer patients, and any patients with new symptoms.**

c. Is the institution on track to meet testing requirements per the testing calendar / schedule? **Yes**

7. COVID Test Turnaround Time (Days) – Patients **M d** **R r**

CHCF	Statewide Average
3	**2**

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
2417	2052	54	4	1998	0.15%

9. Staff Testing Plan

a. Required frequency per protocol, **d** b. Upcoming testing activity

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

MEMORANDUM

Date: July 28, 2021

To: California Department of Corrections & Rehabilitation (CDCR) All Staff
California Correctional Health Care Services (CCHCS) All Staff

DocuSigned by:
Connie Gipson
60F75B6E86804F7...

From:

Connie Gipson

DocuSigned by:
Joseph Bick
347167202A8A404...

Director, Division of Adult Institutions CDCR

Joseph Bick, M.D.
Director, Health Care Services
CCHCS

Subject: EXTENSION OF ROUTINE SURVEILLANCE COVID TESTING EXEMPTION FOR THOSE EMPLOYEES AND PATIENTS WHO ARE FULLY VACCINATED

During May, June and July, CDCR and CCHCS exempted fully vaccinated staff and inmates from routine surveillance testing for COVID. This action was taken based upon the finding that fully vaccinated individuals appear to be less likely to transmit the virus to others. .

We continue to monitor the spread of newer more transmissible COVID variants, some of which have been shown to be more likely to lead to hospitalization and death. The Delta strain is now the most common variant among recently infected CDCR/CCHCS staff. This variant is much easier to transmit, and more likely to result in hospitalization. We encourage those of you who are not yet vaccinated to request one now so that you, your families, and all of those around you are protected going forward.

CDCR and CCHCS are at this time extending the hiatus from routine surveillance testing for all fully vaccinated staff and incarcerated persons **until further notice**. Testing will continue for all incarcerated persons and employees, regardless of vaccination status, who are identified as close contacts of active cases. Testing for the incarcerated will also continue as described in the current movement matrix, as part of the in person visiting program and prior to dental encounters at institutions that have active COVID cases. .

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

If you were vaccinated outside of CDCR, please refer to the May 19, 2021, memo titled, "*Submission of COVID-19 Vaccination Record*" for instructions on how to incorporate that information to your CDCR Employee Vaccination Record. The memo can be viewed here: http://lifeline/ExecutiveOperations/Communications/Documents/SubmissionCOVID- 19VacRecordCardMemo.pdf.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES P.O. Box 588500 Elk Grove,

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

10. COVID Test Turnaround Time – Staff

CHCF	24 hour turn around	SW Average	N/A	

11. Anticipated Movement

Any COVID19 positive patients will be moved to an AIIR or a COVID19 designated housing unit.

12. Movement Matrix Adherence - rd " r r r" d" r r" rr r d

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	18		0	13	13	0
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	209	98	89	98	119	18

Supplies and Equipment Plan - r d D D D d r r d d r r d d d r D r d D R r d r

13. COVID Test Kits M d r R r

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

SOPHIA: 631 **Quest PCR Test Kits: 7,100**	**N/A**	**SOPHIA: 562** **Quest PCR Test Kits: 7,200**

14. N95 Masks

Current Inventory	**BYD: 430,901** **MMM Plus: 112,550**
Who uses N95 masks and in which locations?	**CHCF is currently working on FIT testing all staff. Staff interacting with COVID19 positive patients are wearing N-95s or PAPRs. Staff not working in CTQ/quarantined units are to wear ear loop masks in all areas of the facility. Dental clinical staff providing treatment are wearing N-95 masks or PAPR's. Laboratory and Radiology staff as necessary. Effective 3/1/2021, surgical masks are to be worn at all times by all staff and patients while in the CHCF Dialysis facility. The previous mandate (memo dated 11/30/2020) to wear an N-95 mask while in the CHCF Dialysis facility will no longer be in effect.**

15. Resource Requests

At this time as CHCF has adequate supplies of PPE and SOPHIA testing kits.

16. PPE Inventory Report - r D R r r d r d R r
Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks	**899,150 boxes 50 per box**	**20,000 a week**		
Gloves	**51,571 boxes**	**6,000 a week**		
KN95 Masks	**204,480**	**Varies**		
N95 Masks	**BYD: 430,901** **MMM Plus: 112,550**	**500 a week**		
Eye Protection	**Face Shield: 91,748** **Safety Goggles: 25,000**	**500 a week**		
Gowns	**182,920**	**500 a week**		
Cloth Masks	**0**	**N/A**		
Other (e.g., wipes, hand sanitizer, PPE/Spill kits)	**PAPR sm: 235cs** **PAPR lg: 238cs** **Purple top wipes: 19,160cn**	**Spill Kits 12 a week**		

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

	Purell hand sanitizer: 29bt **O2 tanks full-207** **O2 tanks sm full-5** **Spill kits: 96**	**Purple tops 500 a week**		

Staffing Plan - D r d r r d r d d d r r rd r d r d r r r d

17. Nursing ***(Review Clinical Operations Reports through Regional or HQ Nursing leadership)***

https://cchcs.ca.gov/covid-19-interim-guidance/

18. Custody

https://cchcs.ca.gov/covid-19-interim-guidance/

19. Providers

https://cchcs.ca.gov/covid-19-interim-guidance/

20. Administrative / Other Staff

https://cchcs.ca.gov/covid-19-interim-guidance/

Other Operations/Stakeholders

21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
  - Feeding / showers / phones / canteen / programming / ventilation

In addition to our frequencies of service, in accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE also does 4 times a day disinfection cleaning, twice on 2nd watch and twice on 3rd watch for high touch points in dayrooms.

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

- **Physical Distancing – PRIDE maintains and respects 6ft social distancing while on grounds. In addition, our staff are required to wear disposable surgical masks.**
- **Disinfection Cleaning – PRIDE disinfects using an EPA-registered disinfectant.**
- **Environment Controls**
- **Feeding – PRIDE cleans the stainless-steel appliances and countertops inside the pantry of each housing unit we service and clean and disinfect the clean utility. PRIDE is not present or part of feeding distribution.**
- **Showers – PRIDE cleans the showers in each housing unit we service. In accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE clean and disinfects twice on 2nd watch and twice on 3rd watch. In addition, there are pump sprayers that have State issued chemical, Cell Block 64, available for in-between use disinfection.**
- **Phones – PRIDE cleans phones in each housing unit we service. In accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE clean and disinfects twice on 2nd watch and twice on 3rd watch.**
- **Canteen - PRIDE does not service in the Canteen. Need to follow up with AW Business Services for EVS cleaning schedule.**
- **Programming – PRIDE cleans and disinfects the program rooms inside housing units.**
- **Ventilation – PRIDE does not service ventilation systems. Per task sheets, vents are dusted weekly.**

The following are lists of buildings PRIDE provides the cleaning services:

Building A1 A2

Building B1 – B8

Building D1 – D7

FSS Areas: Dialysis, SEMS, Dental, Laboratory (Specimen Collection), Diagnostic Imaging & Procedure

COVID OUTBREAK MANAGEMENT for EVS Program

In addition to our frequencies of service outlined on our Daily Service Logs, in accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, Environmental Services also provides a 4 times a day disinfection cleaning of all high touch points in all of the areas EVS services.

Our current areas of service are:

- **Building C1-C6**
- **FSS: CD Program, PMU, Pharmacy, Bio Med, Staff Dining, AB Management, Group Activities, Religious, Visiting, Medical Records, Central Services, PMR, Education, and Library.**
- **E-Yard: Clinic, Mental Health Group, Mental Health Offices, Admin, and Chapel**
- **Admin: Business Services, Human Resources, Case Records, Front Entrance, IST, and Admin Visiting**

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

- **Physical Distancing- Environmental Services maintains and abides by the 6ft social distancing precaution while on grounds. In addition, our staff (EVS) are required to wear a disposable surgical mask and are provide two upon entry to the facility.**
- **Disinfection Cleaning- EVs uses Cell Block 64 (a state approved/CALPIA disinfectant) with a stronger, yet approved dilution for all disinfecting purposes. Patient rooms on Isolations/quarantine are serviced as scheduled on the daily log. EVS will continue our modified three day rotation cleaning of the Patient rooms, however, in all COVID positive units, we will add additional resources to increase our cleaning frequencies to everyday patient room cleaning to combat the buildup of the virus in the effected patient room disinfecting using Cell Block 64. Exam Rooms and all areas involving direct patient care are disinfected in accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTION which states EVS provides a 4 times a day disinfection cleaning of all high touch points in all of the areas EVS services.**
- **Environment controls- All buildings/units on CTQ have been provided additional custodial support to provide effective disinfection. In addition, additional cleaning supplies and supervisor checks have been initiated. All biohazard waste is immediately removed from the units and placed in the FSS Mutt bio hazard collecting area to control excessive overflow of hazardous waste in the units' soiled utility (due to the limited space).**
- **Feeding- EVS has continued cleaning all appliances and surface areas in the pantries inside of the units. In addition we also provide a daily cleaning/disinfecting of both the clean and soiled utility in each unit. EVS has no involvement with feeding distribution.**
- **Showers- for buildings on CTQ, EVS disinfects the showers in all housing units we service In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS. Showers are disinfected twice on 2nd watch and twice on third watch. In addition, there are pump sprayers that have state issued Cell Block 64, available for in-between use disinfection.**
- **Phones- EVS/medical staff disinfects the phones in between each use. In addition, In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, EVS disinfects the phones as a part of high touch 4 times per day (twice per shift).**
- **Programming- EVS disinfects all dayrooms, outside (yards), and communal patient areas In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, EVS disinfects all high touch points 4 times a day (twice on 2nd watch and twice on third).**
- **Ventilation- EVS dusts and disinfects the vents in the areas we service on a monthly basis in accordance with our master schedule. In addition, during any emergency cleans or terminals, the vents are serviced.**

Per Plant Ops: There are no changes needed for the institution ventilation. Our system is designed to provide 12 air changes per hour.

Mandatory proper mask wearing at all times by staff. Memos and training provided to all staff. Random audits conducted and identified as non-compliant staff will receive progressive discipline.

The COVID-19 test is mandatory for all susceptible staff. Susceptible staff are tested weekly unless the test result is positive or as of May 1, 2021, fully vaccinated staff will be exempt from testing until directed to resume. The institution conducts screening for all staff, vendors, contractor and visitors each time they enter the institution. The screening takes place at the entrance gate, while individuals are in their vehicles. The COVID19 entrance screening consists of the following two-step process: 1. Symptoms and Exposure Risk Screening and 2. Temperature measurement. Individuals who respond "no" to all screening

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

questions and have a temperature measured less than 100.4° shall be granted entry to the facility. All staff is provided two (2) procedure masks per shift at the Sally Port entrance.

22. Education/Communication Plan

- Residents and Staff
- Community and/or Public Health Outreach

Interim Guidance on Coronavirus (COVID-19) - All State Employees 3-12-2020 .docx

Employee Information

Patient Education: Posters, Nursing education during rounding, announcements over speaker system.
IPs have been educated by staff. There are several posters, handouts, signage that have been posted throughout their housing units, FSS areas, and Clinics.

23. Pre-Procedural COVID Testing for Dental Patients

- Effectiveness/challenges of program

Dental uses the BD Veritor POC test on each patient once they arrive in the clinic. This test is collected by the dentist and run by the dental assistants. It takes approximately 15 minutes to complete the test and get a result. Each test is logged in a log kept in the dental laboratory where the test is run. The dentist is responsible to enter the Test and the result into EHRS and noted on the dentists clinical note. If a positive test is found, the patient is immediately isolated and the patient's primary care provider and the infection control nurse is notified.

24. Other

- How are CPAP patients being managed?

Currently patients diagnosed with moderate or higher OSA are provided a CPAP which has two filters on the unit. CPAP patients are scheduled for urgent and emergent needs such are replacement of the hose, mask, filters, etc. Any patient testing positive will be transferred to an AIIR (Negative Pressure Room).

# of Patients with CPAP Equipment	275

25. Status on Pending Action Items from Previous Meetings

- CEO/Warden Comments

None at this time.

26. RHE/AD Comments

None at this time.

Additional Resources to Review

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/3/2021 12:06:06 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred*
- *Questions about this report? Contact QMStaff@CDCR.ca.gov*

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

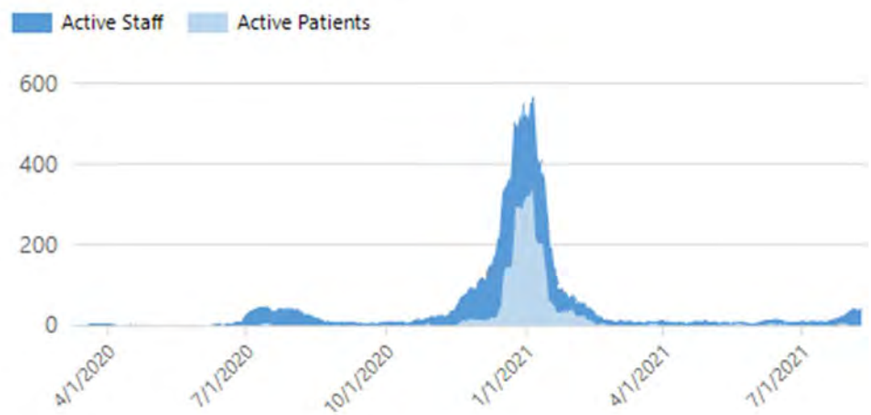
Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined

New COVID Cases in the last 14 days over time



New COVID Confirmed Active Cases over the past 14 days by Facility as of: 8/10/2021 3:12:52 PM

No Data Available

COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
38	38	0	0

Facility	CHCF-A	CHCF-B	CHCF-C	CHCF-D	CHCF-E	Offsite	Total
Confirmed Active	0	0	0	0	0	0	0
Isolation	0	2	4	0	0	0	6
Quarantine	33	265	106	155	19	1	579
Susceptible	230	438	554	391	806	0	2419

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing, cont.

2. Isolation and Quarantine Housing

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Isolation Housing

DATA PULLED @8/10/2021 3:11:34 PM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Are any patients refusing to move to designated ISO areas?	N/A	If so, where are they housed? (Location & # of patients)	N/A
How many new COVID positive cases since last report?	0	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

Quarantine Housing

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

DATA PULLED @8/10/2021 3:11:34 PM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients
Quarantine Description:	**CHCF Count** **1** Patients from outside institutions, Out-to-court, Out-to-medical, and county jail intakes will be isolated on droplet precautions for 14 days and COVID-19 quarantine surveillance will be conducted at least twice daily for 14 days. **502** Patients quarantined for either high risk exposure to Covid positive patients and or staff.

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
A1A	30	4	26	5 post transfers	N	Single Cell, Solid Door
A1B	30	10	20	2 post transfers 10 post Covid positive exposure-staff	N	Single Cell, Solid Door
A2A	39	1	38	1 pre transfer 1 post transfer	N	Single Cell, Solid Door
A2B	38	17	21	1 post transfer 17 post Covid positive exposure-staff	N	Single Cell, Solid Door
B1A	30	17	13	1 post transfer 17 post Covid positive exposure-staff	N	Single Cell, Solid Door

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

B1B	25	24	1	1 post transfer 24 post Covid positive exposure-staff	N	Single Cell, Solid Door
B2A	30	4	26	2 post transfers 4 post Covid positive exposure-staff	N	Single Cell, Solid Door
B2B	30	26	4	1 pre transfer 26 post Covid positive exposure-staff	N	Single Cell, Solid Door
B3A	30	29	1	3 post transfers 29 post Covid positive exposure-patient	N	Single Cell, Solid Door
B3B	30	28	2	4 post transfers 28 post Covid positive exposure-patient	N	Single Cell, Solid Door
B4A	30	17	13	3 post transfers 17 post Covid positive exposure-staff	N	Single Cell, Solid Door
B4B	30	13	17	3 post transfers 13 post Covid positive exposure-staff	N	Single Cell, Solid Door
B5A	30	30	0	3 post transfers 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
B5B	30	1	29	2 post transfers	N	Single Cell, Solid Door
B6A	30	0	30	1 post transfer	N	Single Cell, Solid Door
B6B	30	0	30	1 post transfer	N	Single Cell, Solid Door

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

B7A	30	28	2	3 post transfers 28 post Covid positive exposure-staff	N	Single Cell, Solid Door
B7B	30	29	1	1 post transfer 29 post Covid positive exposure-staff	N	Single Cell, Solid Door
B8A	30	30	0	2 post transfers	N	Single Cell, Solid Door
B8B	30	1	29	2 post transfers	N	Single Cell, Solid Door
C1A	50	2	48	2 post Covid positive exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C1B	50	2	48	1 pre transfer 1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C2A	48	0	48	2 post transfers	N	Single Cell, Solid Door
C2B	48	1	47	2 post transfers	N	Single Cell, Solid Door
C3A	48	2	46	1 pre transfer 4 post transfers	N	Single Cell, Solid Door
C3B	48	22	26	2 post transfers 22 post Covid positive exposure-patient	N	Single Cell, Solid Door
C4A	50	1	49	1 pre transfer 1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C4B	48	44	4	2 post transfers 44 post Covid positive exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C5A	50	46	4	1 post transfer 46 post Covid positive exposure-patient	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

C5B	50	2	48	2 post transfers	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C6A	50	1	49	1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C6B	50	3	47	4 post transfers	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
D1A	30	30	0	3 pre transfers 3 post transfers 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
D1B	30	1	29	3 post transfers	N	Single Cell, Solid Door
D2A	30	2	28	1 pre transfer 5 post transfers	N	Single Cell, Solid Door
D2B	30	2	28	2 post transfers	N	Single Cell, Solid Door
D3A	30	30	0	1 post transfer 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
D3B	30	29	1	1 post transfer 29 post Covid positive exposure-staff	N	Single Cell, Solid Door
D4A	30	26	4	4 post transfers 26 post Covid exposure-staff	N	Single Cell, Solid Door
D4B	30	2	28	2 post transfers	N	Single Cell, Solid Door
D5A	30	28	2	4 post transfers 28 post Covid positive exposure-patient and staff	N	Single Cell, Solid Door
D5B	30	3	27	3 post transfers	N	Single Cell, Solid Door
D6A	30	0	30	1 post transfer	N	Single Cell, Solid Door

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

D6B	30	2	28	1 post transfer	N	Single Cell, Solid Door
D7A	30		30	1 post transfer	N	Single Cell, Solid Door
D7B	30	0	30	1 post transfer	N	Single Cell, Solid Door
E1B-1	50	9	41	7 post transfers 9 post Covid positive exposure-patient	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1B-2	50	10	40	10 post transfers	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1D-1	42	0	42	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1D-2	50	0	50	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1E-1	50	0	50	1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1E-2	50	0	50	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E2A DORM	88	0	88	1 pre transfer 3 post transfers	Y	Covid positive patients located in a Covid designated pod, not behind a solid door.
E2B DORM	89	0	89	2 pre transfers 1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E3A DORM	88	0	88	1 pre transfer 1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E3B DORM	89	0	89	3 post transfers	Y	Covid positive patients located in a Covid designated pod, not behind a solid door.

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

E4A DORM	88	0	88	2 pre transfers 1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E5B DORM	89	0	89	1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.

Are any patients refusing to move to designated Quarantine areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new Quarantine cases since last report?	306	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

ADA Accommodations

Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	No	If so, where are they housed? (Location & # of patients)	N/A
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	N/A

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

930	279	556	187

3. Clinical Management of COVID Patients - d r d d r D M r R r d r d r

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	19	3

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0	N/A	19

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	6.10.2021 EMS COVID Hospitalization Press Release Good afternoon, Please see the attached press release regarding the latest San Joaquin County COVID-19 hospitalization data. **This will be the final COVID press release distributed on a daily basis.** Future press releases may be distributed as the need arises

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Testing and Movement Plan

5. Vaccination of Patients and Staff d r d d r r d r

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
3841	104	2331		2468	30	2128	316

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)

Per Memo dated July 28, 2021:

During May, June and July, CDCR and CCHCS exempted fully vaccinated staff and inmates from routine Surveillance testing for COVID. This action was taken based upon the finding that fully vaccinated individuals appear to be less likely to transmit the virus to others.

We continue to monitor the spread of newer more transmissible COVID variants, some of which have been shown to be more likely to lead to hospitalization and death. The Delta strain is now the most common variant among recently infected CDCR/CCHCS staff. This variant is much easier to transmit, and more likely to result in hospitalization. We encourage those of you who are not yet vaccinated to request one now so that you, your families, and all of those around you are protected going forward.

CDCR and CCHCS are at this time extending the hiatus from routine surveillance testing for all fully vaccinated staff and incarcerated persons until further notice. Testing will continue for all incarcerated persons and employees, regardless of vaccination status, who are identified as close contacts of active cases. Testing for the incarcerated will also continue as described in the current movement matrix, as part of the in person visiting program and prior to dental encounters at institutions that have active COVID cases.

Institution Testing Schedule:
Mon - Fac A, E1A/B
Tues - Fac B, E1C,E2A/B
Wed - Fac C, E1D,E3A/B
Thu - Fac D, E1E, E4A/B
Fri - Fac E1F, E5A/B

- **Patients housed in a unit with staff or patients who are positive for COVID are tested on day #5 and day #12 post exposure. The unit is CTQ – no movement in or out and solo programming within the unit. The unit is released when the unit's test result come back as normal or 14 days, whichever is greater. The patient remains in isolation for 14-21 days depending on symptoms and risk.**

b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)

- **Testing strategy remains the same.**
  - **Patients housed in a unit with staff or patients who are positive for COVID are tested on day #5 and day #12 post exposure. The unit is CTQ – no movement in or out and solo programming within the unit. The unit is released when the unit's test result come back as normal or 14 days whichever is greater. The patient remains in isolation for 14-21 days depending on symptoms and risk.**
  - **Patients will be tested who return from the Hospital and ER settings, pre- and post-transfer patients, and any patients with new symptoms.**

c. Is the institution on track to meet testing requirements per the testing calendar / schedule? **Yes**

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

7. COVID Test Turnaround Time (Days) – Patients **M d** **R r**

CHCF	Statewide Average
3	2

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
2419	2186	9	6	2177	0.04%

9. Staff Testing Plan

a. Required frequency per protocol, **d** b. Upcoming testing activity

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

MEMORANDUM

Date: August 5, 2021

To: All CHCF Staff

From:
Brittany Brizendine, PsyD, MBA, CCHP-MH
Chief Executive Officer (A)
California Health Care Facility
DocuSigned by: Brittany Brizendine

Robert Burton
Warden (A)
California Health Care Facility
DocuSigned by: Robert Burton

Subject: EFFECTIVE MONDAY 8/9/21 TWICE WEEKLY COVID19 TESTING IS REQUIRED

All CCHCS and CDCR employees that have been fully vaccinated are not presently required to report for COVID-19 testing until further notice per July 28, 2021 Memorandum authored by Directors Dr. Bick and Ms. Gibson.

Effective August 9, 2021 **all unvaccinated or partially (incompletely) vaccinated** staff are now **required** to test TWICE (2) WEEKLY for COVID-19 until further notice

For the purpose of tracking, a "week" is defined as Monday thru Friday and does not include holidays. Staff who fail to report for testing two (2) day's Monday thru Friday of the current week will have their name placed on the negative list and face progressive discipline. If a staff person has a medical condition or any other reason that precludes them from COVID-19 testing, they should contact the Return to Work Coordinator.

Mobile-Med Clinic testing is located in the Old Visiting Center Monday through Friday, from 0500-1700 hours.

The Delta variant has become the dominant variant in California and is significantly more transmissible leading to a significant rise in COVID-19 cases in the community and a sharp increase in hospitalizations. Proper wearing of masks and eye protection are more important than ever as the nose, eyes and mouth are portals of entry; as such appropriate PPE guidelines should be followed. All staff must continue to work together to fight the spread of COVID-19. Each of us plays a vital part in reducing the spread of this virus. Please continue to wash your hands, practice physical distancing, wear appropriate face coverings, use personal protective equipment as recommended, and get tested. We highly encourage all staff to get vaccinated as current data shows the Delta variant is well controlled by the Covid vaccines. People who are fully vaccinated are less likely to have hospitalizations and death.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
P.O. Box 32050
Stockton, CA 95213

DocuSign Envelope ID: BC902199-E855-4C50-AFD3-1B57DEAAC0F9

MEMORANDUM

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

10. COVID Test Turnaround Time – Staff

CHCF	24 hour turn around	SW Average	N/A	

11. Anticipated Movement

Any COVID19 positive patients will be moved to an AIIR or a COVID19 designated housing unit.

12. Movement Matrix Adherence - rd " r r r" d" r r" rr r d

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	20		0	16	16	0
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	196	101	101	101	131	23

Supplies and Equipment Plan - r d D D D d r r d d r r d d d r D r d D R r d r

13. COVID Test Kits M d r R r

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply
SOPHIA: 498 Quest PCR Test Kits: 7,600	N/A	SOPHIA: 448 Quest PCR Test Kits: 7,500

14. N95 Masks

Current Inventory	BYD: 427,761 MMM Plus: 112,550

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Who uses N95 masks and in which locations?	**CHCF is currently working on FIT testing all staff. Staff interacting with COVID19 positive patients are wearing N-95s or PAPRs. Staff not working in CTQ/quarantined units are to wear ear loop masks in all areas of the facility. Dental clinical staff providing treatment are wearing N-95 masks or PAPR's. Laboratory and Radiology staff as necessary. Effective 3/1/2021, surgical masks are to be worn at all times by all staff and patients while in the CHCF Dialysis facility. The previous mandate (memo dated 11/30/2020) to wear an N-95 mask while in the CHCF Dialysis facility will no longer be in effect.**

15. Resource Requests

At this time as CHCF has adequate supplies of PPE and SOPHIA testing kits.

16. PPE Inventory Report - r D R r r d r d R r
Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks	**872,350 boxes 50 per box**	**20,000 a week**		
Gloves	**51,591 boxes**	**6,000 a week**		
KN95 Masks	**204,480**	**Varies**		
N95 Masks	**BYD: 427,761** **MMM Plus: 112,550**	**500 a week**		
Eye Protection	**Face Shield: 90,516** **Safety Goggles: 25,000**	**500 a week**		
Gowns	**182,120**	**500 a week**		
Other (e.g., wipes, hand sanitizer, PPE/Spill kits)	**PAPR sm: 235cs** **PAPR lg: 238cs** **Purple top wipes: 19,160cn** **Purell hand sanitizer: 29bt** **O2 tanks full-207** **O2 tanks sm full-5** **Spill kits: 96**	**Spill Kits 12 a week** **Purple tops 500 a week**		

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Staffing Plan - D r d r r d r d d d r r rd r d r d r r r d

17. Nursing *(Review Clinical Operations Reports through Regional or HQ Nursing leadership)*

https://cchcs.ca.gov/covid-19-interim-guidance/

18. Custody

https://cchcs.ca.gov/covid-19-interim-guidance/

19. Providers

https://cchcs.ca.gov/covid-19-interim-guidance/

20. Administrative / Other Staff

https://cchcs.ca.gov/covid-19-interim-guidance/

Other Operations/Stakeholders

21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
  - Feeding / showers / phones / canteen / programming / ventilation

In addition to our frequencies of service, in accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE also does 4 times a day disinfection cleaning, twice on 2nd watch and twice on 3rd watch for high touch points in dayrooms.

- **Physical Distancing – PRIDE maintains and respects 6ft social distancing while on grounds. In addition, our staff are required to wear disposable surgical masks.**
- **Disinfection Cleaning – PRIDE disinfects using an EPA-registered disinfectant.**
- **Environment Controls**
- **Feeding – PRIDE cleans the stainless-steel appliances and countertops inside the pantry of each housing unit we service and clean and disinfect the clean utility. PRIDE is not present or part of feeding distribution.**

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

- **Showers – PRIDE cleans the showers in each housing unit we service. In accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE clean and disinfects twice on 2nd watch and twice on 3rd watch. In addition, there are pump sprayers that have State issued chemical, Cell Block 64, available for in-between use disinfection.**
- **Phones – PRIDE cleans phones in each housing unit we service. In accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE clean and disinfects twice on 2nd watch and twice on 3rd watch.**
- **Canteen - PRIDE does not service in the Canteen. Need to follow up with AW Business Services for EVS cleaning schedule.**
- **Programming – PRIDE cleans and disinfects the program rooms inside housing units.**
- **Ventilation – PRIDE does not service ventilation systems. Per task sheets, vents are dusted weekly.**

The following are lists of buildings PRIDE provides the cleaning services:

Building A1 A2

Building B1 – B8

Building D1 – D7

FSS Areas: Dialysis, SEMS, Dental, Laboratory (Specimen Collection), Diagnostic Imaging & Procedure

COVID OUTBREAK MANAGEMENT for EVS Program

In addition to our frequencies of service outlined on our Daily Service Logs, in accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, Environmental Services also provides a 4 times a day disinfection cleaning of all high touch points in all of the areas EVS services.

Our current areas of service are:

- **Building C1-C6**
- **FSS: CD Program, PMU, Pharmacy, Bio Med, Staff Dining, AB Management, Group Activities, Religious, Visiting, Medical Records, Central Services, PMR, Education, and Library.**
- **E-Yard: Clinic, Mental Health Group, Mental Health Offices, Admin, and Chapel**
- **Admin: Business Services, Human Resources, Case Records, Front Entrance, IST, and Admin Visiting**

- **Physical Distancing- Environmental Services maintains and abides by the 6ft social distancing precaution while on grounds. In addition, our staff (EVS) are required to wear a disposable surgical mask and are provide two upon entry to the facility.**
- **Disinfection Cleaning- EVs uses Cell Block 64 (a state approved/CALPIA disinfectant) with a stronger, yet approved dilution for all disinfecting purposes. Patient rooms on Isolations/quarantine are serviced as scheduled on the daily log. EVS will continue our modified three day rotation cleaning of the Patient rooms, however, in all COVID positive units, we will add additional resources to increase our cleaning frequencies to everyday patient room cleaning to combat the buildup of the virus in the effected patient room disinfecting using Cell Block 64. Exam Rooms and all areas involving direct patient care are disinfected in**

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTION which states EVS provides a 4 times a day disinfection cleaning of all high touch points in all of the areas EVS services.

- Environment controls- All buildings/units on CTQ have been provided additional custodial support to provide effective disinfection. In addition, additional cleaning supplies and supervisor checks have been initiated. All biohazard waste is immediately removed from the units and placed in the FSS Mutt bio hazard collecting area to control excessive overflow of hazardous waste in the units' soiled utility (due to the limited space).
- Feeding- EVS has continued cleaning all appliances and surface areas in the pantries inside of the units. In addition we also provide a daily cleaning/disinfecting of both the clean and soiled utility in each unit. EVS has no involvement with feeding distribution.
- Showers- for buildings on CTQ, EVS disinfects the showers in all housing units we service In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS. Showers are disinfected twice on 2nd watch and twice on third watch. In addition, there are pump sprayers that have state issued Cell Block 64, available for in-between use disinfection.
- Phones- EVS/medical staff disinfects the phones in between each use. In addition, In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, EVS disinfects the phones as a part of high touch 4 times per day (twice per shift).
- Programming- EVS disinfects all dayrooms, outside (yards), and communal patient areas In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, EVS disinfects all high touch points 4 times a day (twice on 2nd watch and twice on third).
- Ventilation- EVS dusts and disinfects the vents in the areas we service on a monthly basis in accordance with our master schedule. In addition, during any emergency cleans or terminals, the vents are serviced.

Per Plant Ops: There are no changes needed for the institution ventilation. Our system is designed to provide 12 air changes per hour.

Mandatory proper mask wearing at all times by staff. Memos and training provided to all staff. Random audits conducted and identified as non-compliant staff will receive progressive discipline. All staff is provided two (2) procedure masks per shift at the Sally Port entrance.

22. Education/Communication Plan

- Residents and Staff
- Community and/or Public Health Outreach

Interim Guidance on Coronavirus (COVID-19) - All State Employees 3-12-2020 .docx

Employee Information

Patient Education: Posters, Nursing education during rounding, announcements over speaker system.
IPs have been educated by staff. There are several posters, handouts, signage that have been posted throughout their housing units, FSS areas, and Clinics.

Date: 8/10/2021 3:12:52 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

23. Pre-Procedural COVID Testing for Dental Patients

- Effectiveness/challenges of program

Dental uses the BD Veritor POC test on each patient once they arrive in the clinic. This test is collected by the dentist and run by the dental assistants. It takes approximately 15 minutes to complete the test and get a result. Each test is logged in a log kept in the dental laboratory where the test is run. The dentist is responsible to enter the Test and the result into EHRS and noted on the dentists clinical note. If a positive test is found, the patient is immediately isolated and the patient's primary care provider and the infection control nurse is notified.

24. Other

- How are CPAP patients being managed? **Currently patients diagnosed with moderate or higher OSA are provided a CPAP which has two filters on the unit. CPAP patients are scheduled for urgent and emergent needs such are replacement of the hose, mask, filters, etc. Any patient testing positive will be transferred to an AIIR (Negative Pressure Room).**

# of Patients with CPAP Equipment	257

25. Status on Pending Action Items from Previous Meetings

- CEO/Warden Comments

None at this time.

26. RHE/AD Comments

None at this time.

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred*
- *Questions about this report? Contact QMStaff@CDCR.ca.gov*

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

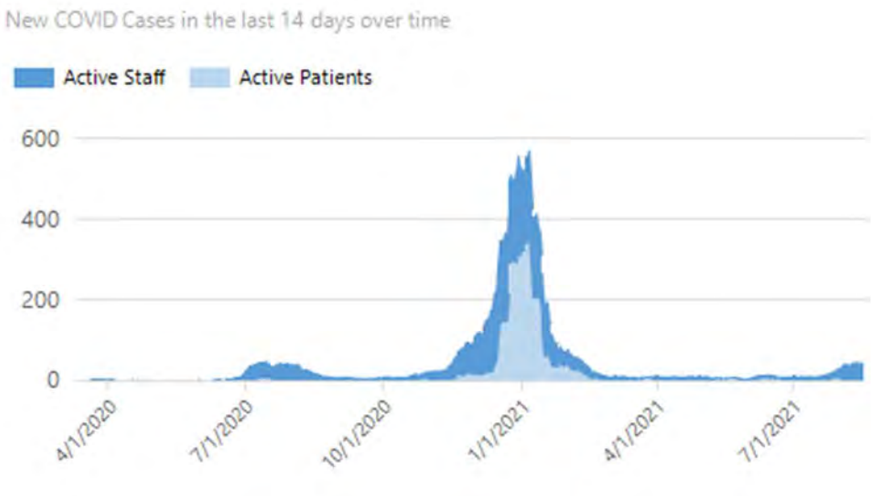
Recent Changes

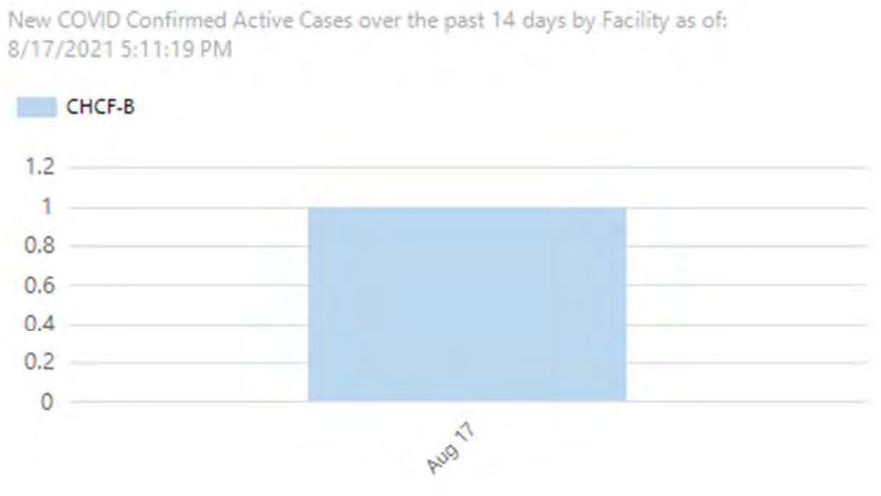
Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined





COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
36	36	1	1

Facility	CHCF-A	CHCF-B	CHCF-C	CHCF-D	CHCF-E	CHCF-S	Offsite	Total
Confirmed Active	0	1	0	0	0	0	0	1
Isolation	3	4	2	0	0	0	0	9
Quarantine	14	301	275	131	17	0	5	743
Susceptible	238	436	562	393	790	1	0	2420

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

COVID OUTBREAK MANAGEMENT REPORT

Date: 8/17/2021 5:11:19 PM	Institution: (CHCF)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing, cont.

2. Isolation and Quarantine Housing

r r r D M r R r d d r D r r r
r rd r d rd r R r r r r r r d d

Isolation Housing

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Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
B3A	2	1	2	0	N	Single Cell, Solid Door

Are any patients refusing to move to designated ISO areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new COVID positive cases since last report?	1	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Yes, all new positive cases have been moved to the appropriate housing units within the appropriate timeframe.

Quarantine Housing

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

DATA PULLED @8/17/2021 5:10:55 PM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients
Quarantine Description:	**CHCF Count** **1** Patients from outside institutions, Out-to-court, Out-to-medical, and county jail intakes will be isolated on droplet precautions for 14 days and COVID-19 quarantine surveillance will be conducted at least twice daily for 14 days. **709** Patients quarantined for either high risk exposure to Covid positive patients and or staff.

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
A1A	30	2	28	5 post transfers 2 post Covid positive exposure-staff	N	Single Cell, Solid Door
A1B	30	6	24	2 post transfers 6 post Covid positive exposure-staff	N	Single Cell, Solid Door
A2A	39	3	36	1 pre transfer 1 post transfer 3 post Covid positive exposure-staff	N	Single Cell, Solid Door
A2B	38	18	20	1 post transfer 18 post Covid positive exposure-staff	N	Single Cell, Solid Door

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

A4A	94	3	91	3 pre transfers 1 post transfer	N	Single Cell, Solid Door
A4B	102	4	98	4 post Covid positive exposure-staff	N	Single Cell, Solid Door
B1A	30	17	13	1 pre transfer 1 post transfer 17 post Covid positive exposure-staff	N	Single Cell, Solid Door
B1B	25	23	2	1 pre transfer 1 post transfer 23 post Covid positive exposure-staff	N	Single Cell, Solid Door
B2A	30	26	4	2 post transfers 26 post Covid positive exposure-staff	N	Single Cell, Solid Door
B2B	30	26	4	26 post Covid positive exposure-staff	N	Single Cell, Solid Door
B3A	30	29	1	2 post transfers 29 post Covid positive exposure-staff	N	Single Cell, Solid Door
B3B	30	27	3	1 post transfer 27 post Covid exposure-staff	N	Single Cell, Solid Door
B4A	30	28	2	2 post transfers 28 post Covid exposure-staff	N	Single Cell, Solid Door
B4B	30	3	27	2 post transfers 3 post Covid positive exposure-staff	N	Single Cell, Solid Door

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

B5A	30	30	0	2 post transfers 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
B5B	30	1	29	1 pre transfer 1 post transfer	N	Single Cell, Solid Door
B6A	30	1	29	1 post transfer	N	Single Cell, Solid Door
B7A	30	27	3	2 post transfers 27 post Covid exposure-staff	N	Single Cell, Solid Door
B7B	30	29	1	29 post Covid positive exposure-staff	N	Single Cell, Solid Door
B8A	30	30	0	2 post transfers 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
B8B	30	26	4	3 post transfers 26 post Covid positive exposure-staff	N	Single Cell, Solid Door
C1A	50	50	0	1 pre transfer 50 post Covid positive exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C1B	50	46	4	1 pre transfer 4 post transfers 46 post Covid positive exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C2A	48	1	47	2 post transfers	N	Single Cell, Solid Door
C2B	48	48	0	4 post transfers 48 post Covid positive exposure-staff	N	Single Cell, Solid Door

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

C3A	48	1	47	2 post transfers	N	Single Cell, Solid Door
C3B	48	4	44	2 pre transfers 3 post transfers	N	Single Cell, Solid Door
C4A	50	2	48	1 post transfer	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C4B	48	0	48	1 pre transfer 2 post transfers	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C5A	50	46	4	46 post Covid positive exposure-Patient	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C5B	50	48	2	4 post transfers 48 post Covid exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C6A	50	27	23	2 post transfers 27 post Covid positive exposure-staff	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
C6B	50	2	48	4 post transfers	N	Pre and Post transfer patients are placed in a single cell observation room, solid door.
D1A	30	30	0	3 pre transfers 6 post transfers 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
D1B	30	0	30	4 post transfers	N	Single Cell, Solid Door
D2A	30	3	27	1 pre transfer 4 post transfers	N	Single Cell, Solid Door
D2B	30	29	1	4 post transfers 29 post Covid positive exposure-staff	N	Single Cell, Solid Door
D3A	30	1	29	1 post transfer	N	Single Cell, Solid Door
D3B	30	29	1	1 post transfer 29 post Covid	N	Single Cell, Solid Door

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

				positive exposure-staff		
D4A	30	28	2	6 post transfers 28 post Covid positive exposure-staff	N	Single Cell, Solid Door
D4B	30	30	0	3 post transfers 30 post Covid positive exposure-staff	N	Single Cell, Solid Door
D5A	30	3	27	3 post transfers	N	Single Cell, Solid Door
D5B	30	3	27	2 post transfers	N	Single Cell, Solid Door
D6A	30	2	28	2 post transfers	N	Single Cell, Solid Door
D6B	30	0	30	1 post transfer	N	Single Cell, Solid Door
D7A	30	0	30	3 post transfers	N	Single Cell, Solid Door
D7B	30	2	28	2 post Covid positive exposure-staff	N	Single Cell, Solid Door
E1B-1	50	5	45	5 post transfers	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1B-2	50	10	40	11 post transfers	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1C-2	50	2	48	1 pre transfer 1 post transfer	Y	Precautionary post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1D-1	42	0	42	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E1D-2	50	0	50	1 pre transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

E1E-2	50	0	50	3 pre transfers 2 post transfers	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E2B DORM	89	0	89	2 pre transfers 1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E3A DORM	88	0	88	2 pre transfers 1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E4A DORM	88	0	88	1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E5A DORM	88	0	88	1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.
E5B DORM	89	0	89	1 post transfer	Y	Precautionary pre/post transfer quarantine segregated in a 2 man cell behind a solid door within a shared housing unit.

Are any patients refusing to move to designated Quarantine areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new Quarantine cases since last report?	309	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Yes, all new positive cases have been moved to the appropriate housing units within the appropriate timeframe.

ADA Accommodations

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	No	If so, where are they housed? (Location & # of patients)	N/A
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	N/A

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
926	273	557	183

3. Clinical Management of COVID Patients - d r d d r D M r R r d r d r

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	9	6

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0	N/A	19

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	6.10.2021 EMS COVID Hospitalization Press Release Good afternoon, Please see the attached press release regarding the latest San Joaquin County COVID-19 hospitalization data. **This will be the final COVID press release distributed on a daily basis.** Future press releases may be distributed as the need arises

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Testing and Movement Plan

5. Vaccination of Patients and Staff d r d d r r d r

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
3893	101	2361		2462	28	2127	313

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)

CDCR and CCHCS are at this time extending the hiatus from routine surveillance testing for all fully vaccinated staff and incarcerated persons until further notice. Testing will continue for all incarcerated persons and employees, regardless of vaccination status, who are identified as close contacts of active cases. Testing for the incarcerated will also continue as described in the current movement matrix, as part of the in person visiting program and prior to dental encounters at institutions that have active COVID cases.

b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)

Testing strategy remains the same.

Patients housed in a unit with staff or patients who are positive for COVID are tested on day #5 and day #12 post exposure. The unit is CTQ – no movement in or out and solo programming within the unit. The unit is released when the unit's test result come back as normal or 14 days whichever is greater. The patient remains in isolation for 14-21 days depending on symptoms and risk.
Patients will be tested who return from the Hospital and ER settings, pre- and post-transfer patients, and any patients with new symptoms.

c. Is the institution on track to meet testing requirements per the testing calendar / schedule? **Yes**

7. COVID Test Turnaround Time (Days) – Patients M d R r

CHCF	Statewide Average

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

3	2

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
2420	2267	24	13	2243	0.04%

9. Staff Testing Plan

a. Required frequency per protocol, **d** b. Upcoming testing activity

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

MEMORANDUM

Date: August 5, 2021

To: All CHCF Staff

From:
Brittany Brizendine, PsyD, MBA, CCHP-MH
Chief Executive Officer (A)
California Health Care Facility
DocuSigned by: Brittany Brizendine

Robert Burton
Warden (A)
California Health Care Facility
DocuSigned by: Robert Burton

Subject: EFFECTIVE MONDAY 8/9/21 TWICE WEEKLY COVID19 TESTING IS REQUIRED

All CCHCS and CDCR employees that have been fully vaccinated are not presently required to report for COVID-19 testing until further notice per July 28, 2021 Memorandum authored by Directors Dr. Bick and Ms. Gibson.

Effective August 9, 2021 **all unvaccinated or partially (incompletely) vaccinated** staff are now **required** to test TWICE (2) WEEKLY for COVID-19 until further notice

For the purpose of tracking, a "week" is defined as Monday thru Friday and does not include holidays. Staff who fail to report for testing two (2) day's Monday thru Friday of the current week will have their name placed on the negative list and face progressive discipline. If a staff person has a medical condition or any other reason that precludes them from COVID-19 testing, they should contact the Return to Work Coordinator.

Mobile-Med Clinic testing is located in the Old Visiting Center Monday through Friday, from 0500-1700 hours.

The Delta variant has become the dominant variant in California and is significantly more transmissible leading to a significant rise in COVID-19 cases in the community and a sharp increase in hospitalizations. Proper wearing of masks and eye protection are more important than ever as the nose, eyes and mouth are portals of entry; as such appropriate PPE guidelines should be followed. All staff must continue to work together to fight the spread of COVID-19. Each of us plays a vital part in reducing the spread of this virus. Please continue to wash your hands, practice physical distancing, wear appropriate face coverings, use personal protective equipment as recommended, and get tested. We highly encourage all staff to get vaccinated as current data shows the Delta variant is well controlled by the Covid vaccines. People who are fully vaccinated are less likely to have hospitalizations and death.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
P.O. Box 32050
Stockton, CA 95213

DocuSign Envelope ID: BC902199-E855-4C50-AFD3-1B57DEAAC0F9

MEMORANDUM

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

10. COVID Test Turnaround Time – Staff

CHCF	24 hour turn around	SW Average	N/A	

11. Anticipated Movement

Any COVID19 positive patients will be moved to an AIIR or a COVID19 designated housing unit.

12. Movement Matrix Adherence - rd " r r r" d" r r" rr r d

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	36		11	31	31	3
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	188	94	97	101	121	16

Supplies and Equipment Plan - r d D D d r r d d r r d d d r D r d D R r d r

13. COVID Test Kits M d r R r

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply
SOPHIA: 375 Quest PCR Test Kits: 7,100	N/A	SOPHIA: 318 Quest PCR Test Kits: 6,900

14. N95 Masks

Current Inventory	BYD: 427,761 MMM Plus: 112,550
Who uses N95 masks and in which locations?	CHCF is currently working on FIT testing all staff. Staff interacting with COVID19 positive patients are wearing N-95s or PAPRs. Staff not working in CTQ/quarantined units are to wear ear loop masks in all areas of the

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

facility. Dental clinical staff providing treatment are wearing N-95 masks or PAPR's. Laboratory and Radiology staff as necessary. Effective 3/1/2021, surgical masks are to be worn at all times by all staff and patients while in the CHCF Dialysis facility. The previous mandate (memo dated 11/30/2020) to wear an N-95 mask while in the CHCF Dialysis facility will no longer be in effect.

15. Resource Requests

At this time as CHCF has adequate supplies of PPE and SOPHIA testing kits.

16. PPE Inventory Report - r D R r r d r d R r
Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks	872,350 boxes 50 per box	20,000 a week		
Gloves	51,591 boxes	6,000 a week		
KN95 Masks	204,480	Varies		
N95 Masks	BYD: 427,761 MMM Plus: 112,550	500 a week		
Eye Protection	Face Shield: 90,516 Safety Goggles: 25,000	500 a week		
Gowns	182,120	500 a week		
Cloth Masks	PAPR sm: 235cs PAPR lg: 238cs Purple top wipes: 19,160cn Purell hand sanitizer: 29bt O2 tanks full-207 O2 tanks sm full-5 Spill kits: 96	Spill Kits 12 a week Purple tops 500 a week		
Other (e.g., wipes, hand sanitizer, PPE/Spill kits)				

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

Staffing Plan - D r d r r d r d d d r r rd r d r d r r r d

17. Nursing *(Review Clinical Operations Reports through Regional or HQ Nursing leadership)*

https://cchcs.ca.gov/covid-19-interim-guidance/

18. Custody

https://cchcs.ca.gov/covid-19-interim-guidance/

19. Providers

https://cchcs.ca.gov/covid-19-interim-guidance/

20. Administrative / Other Staff

https://cchcs.ca.gov/covid-19-interim-guidance/

Other Operations/Stakeholders

21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
  - Feeding / showers / phones / canteen / programming / ventilation

In addition to our frequencies of service, in accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE also does 4 times a day disinfection cleaning, twice on 2nd watch and twice on 3rd watch for high touch points in dayrooms.

- **Physical Distancing – PRIDE maintains and respects 6ft social distancing while on grounds. In addition, our staff are required to wear disposable surgical masks.**
- **Disinfection Cleaning – PRIDE disinfects using an EPA-registered disinfectant.**
- **Environment Controls**
- **Feeding – PRIDE cleans the stainless-steel appliances and countertops inside the pantry of each housing unit we service and clean and disinfect the clean utility. PRIDE is not present or part of feeding distribution.**

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

- **Showers – PRIDE cleans the showers in each housing unit we service. In accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE clean and disinfects twice on 2nd watch and twice on 3rd watch. In addition, there are pump sprayers that have State issued chemical, Cell Block 64, available for in-between use disinfection.**
- **Phones – PRIDE cleans phones in each housing unit we service. In accordance with Memorandum Dated April 8, 2020, Subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUITONS, PRIDE clean and disinfects twice on 2nd watch and twice on 3rd watch.**
- **Canteen - PRIDE does not service in the Canteen. Need to follow up with AW Business Services for EVS cleaning schedule.**
- **Programming – PRIDE cleans and disinfects the program rooms inside housing units.**
- **Ventilation – PRIDE does not service ventilation systems. Per task sheets, vents are dusted weekly.**

The following are lists of buildings PRIDE provides the cleaning services:

Building A1 A2

Building B1 – B8

Building D1 – D7

FSS Areas: Dialysis, SEMS, Dental, Laboratory (Specimen Collection), Diagnostic Imaging & Procedure

COVID OUTBREAK MANAGEMENT for EVS Program

In addition to our frequencies of service outlined on our Daily Service Logs, in accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, Environmental Services also provides a 4 times a day disinfection cleaning of all high touch points in all of the areas EVS services.

Our current areas of service are:

- **Building C1-C6**
- **FSS: CD Program, PMU, Pharmacy, Bio Med, Staff Dining, AB Management, Group Activities, Religious, Visiting, Medical Records, Central Services, PMR, Education, and Library.**
- **E-Yard: Clinic, Mental Health Group, Mental Health Offices, Admin, and Chapel**
- **Admin: Business Services, Human Resources, Case Records, Front Entrance, IST, and Admin Visiting**

- **Physical Distancing- Environmental Services maintains and abides by the 6ft social distancing precaution while on grounds. In addition, our staff (EVS) are required to wear a disposable surgical mask and are provide two upon entry to the facility.**
- **Disinfection Cleaning- EVs uses Cell Block 64 (a state approved/CALPIA disinfectant) with a stronger, yet approved dilution for all disinfecting purposes. Patient rooms on Isolations/quarantine are serviced as scheduled on the daily log. EVS will continue our modified three day rotation cleaning of the Patient rooms, however, in all COVID positive units, we will add additional resources to increase our cleaning frequencies to everyday patient room cleaning to combat the buildup of the virus in the effected patient room disinfecting using Cell Block 64. Exam Rooms and all areas involving direct patient care are disinfected in**

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTION which states EVS provides a 4 times a day disinfection cleaning of all high touch points in all of the areas EVS services.

- Environment controls- All buildings/units on CTQ have been provided additional custodial support to provide effective disinfection. In addition, additional cleaning supplies and supervisor checks have been initiated. All biohazard waste is immediately removed from the units and placed in the FSS Mutt bio hazard collecting area to control excessive overflow of hazardous waste in the units' soiled utility (due to the limited space).
- Feeding- EVS has continued cleaning all appliances and surface areas in the pantries inside of the units. In addition we also provide a daily cleaning/disinfecting of both the clean and soiled utility in each unit. EVS has no involvement with feeding distribution.
- Showers- for buildings on CTQ, EVS disinfects the showers in all housing units we service In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS. Showers are disinfected twice on 2nd watch and twice on third watch. In addition, there are pump sprayers that have state issued Cell Block 64, available for in-between use disinfection.
- Phones- EVS/medical staff disinfects the phones in between each use. In addition, In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, EVS disinfects the phones as a part of high touch 4 times per day (twice per shift).
- Programming- EVS disinfects all dayrooms, outside (yards), and communal patient areas In accordance with the Memorandum issued throughout the institution dated: April 8th, 2020, subject: COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS, EVS disinfects all high touch points 4 times a day (twice on 2nd watch and twice on third).
- Ventilation- EVS dusts and disinfects the vents in the areas we service on a monthly basis in accordance with our master schedule. In addition, during any emergency cleans or terminals, the vents are serviced.

Per Plant Ops: There are no changes needed for the institution ventilation. Our system is designed to provide 12 air changes per hour.

Mandatory proper mask wearing at all times by staff. Memos and training provided to all staff. Random audits conducted and identified as non-compliant staff will receive progressive discipline. All staff is provided two (2) procedure masks per shift at the Sally Port entrance.

22. Education/Communication Plan

- Residents and Staff
- Community and/or Public Health Outreach

Interim Guidance on Coronavirus (COVID-19) - All State Employees 3-12-2020 .docx

Employee Information

Patient Education: Posters, Nursing education during rounding, announcements over speaker system.
IPs have been educated by staff. There are several posters, handouts, signage that have been posted throughout their housing units, FSS areas, and Clinics.

Date: 8/17/2021 5:11:19 PM **Institution:** (CHCF)

TOPICS FOR DISCUSSION

23. Pre-Procedural COVID Testing for Dental Patients

- Effectiveness/challenges of program

Dental uses the BD Veritor POC test on each patient once they arrive in the clinic. This test is collected by the dentist and run by the dental assistants. It takes approximately 15 minutes to complete the test and get a result. Each test is logged in a log kept in the dental laboratory where the test is run. The dentist is responsible to enter the Test and the result into EHRS and noted on the dentists clinical note. If a positive test is found, the patient is immediately isolated and the patient's primary care provider and the infection control nurse is notified.

24. Other

- How are CPAP patients being managed?

Currently patients diagnosed with moderate or higher OSA are provided a CPAP which has two filters on the unit. CPAP patients are scheduled for urgent and emergent needs such are replacement of the hose, mask, filters, etc. Any patient testing positive will be transferred to an AIIR (Negative Pressure Room).

# of Patients with CPAP Equipment	272

25. Status on Pending Action Items from Previous Meetings

- CEO/Warden Comments

None at this time.

26. RHE/AD Comments

None at this time.

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred*
- *Questions about this report? Contact QMStaff@CDCR.ca.gov*

EXHIBIT 10

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

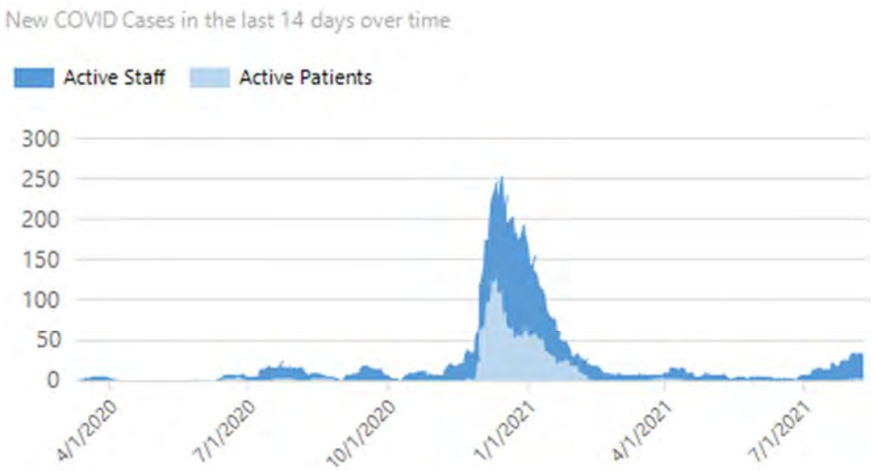
Recent Changes

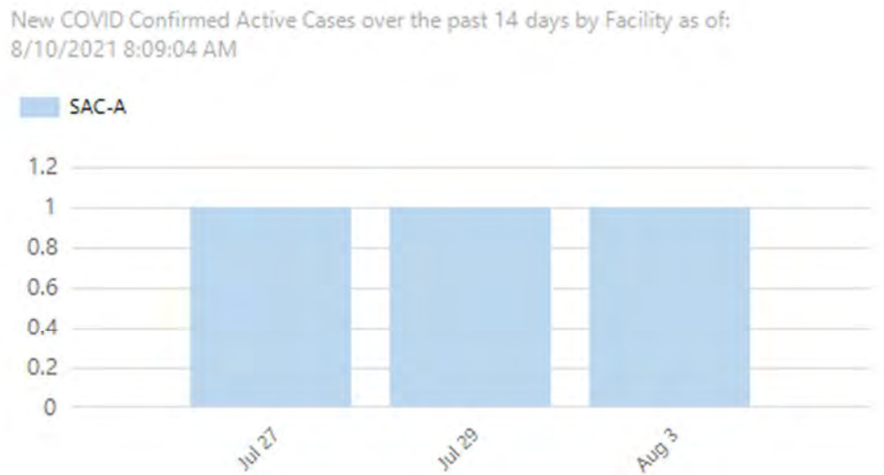
Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined





COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
25	25	3	3

Facility	Offsite	SAC-A	SAC-B	SAC-C	SAC-M	SAC-S	SAC-	Total
Confirmed Active	0	2	0	1	0	0	0	3
Isolation	0	2	0	1	0	0	0	3
Quarantine	1	116	9	7	0	7	4	144
Susceptible	0	608	568	713	65	19	92	2065

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Status of COVID Patients and Isolation/Quarantine Housing, cont.

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

2. Isolation and Quarantine Housing

r r DM r R r d dr D r r r rdr d
rd r R r r r r r r d d

Isolation Housing

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Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
Isolation: C8 B Section	40	0	40	0	N	180 Solid
Isolation: C8 C Section	48	1	47	0	N	180 Solid

Are any patients refusing to move to designated ISO areas?	Y	If so, where are they housed? (Location & # of patients)	A3
How many new COVID positive cases since last report?	None	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	No, 2 patients are refusing to move and currently reside in A3. Attempts will continue to be made.

Quarantine Housing

DATA PULLED @8/10/2021 8:08:54 AM

Field Name	Definition

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
Quarantine: A2 B Section	20	11	9	11	N	180 Solid; All post transfer
Quarantine: A8 B Section	40	14	26	14	N	180 Solid; All post transfer
Quarantine: C7 B Section	40	4	36	4	N	180 Solid; All post transfer
Quarantine: C8 A Section	40	2	38	2	N	180 Solid; All post transfer
Quarantine: STRHU	24	1	22	1	N	180 Solid; For pre transfer

Are any patients refusing to move to designated Quarantine areas?	N	If so, where are they housed? (Location & # of patients)	N/A
How many new Quarantine cases since last report?	None	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

ADA Accommodations

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	N	If so, where are they housed? (Location & # of patients)	N/A
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	None

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
281	4	40	1

3. Clinical Management of COVID Patients - d r d d r D M r R r d r d r

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	8	1

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0		1

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	Report link no longer appears to work. Multiple attempts to access in the past few weeks and states that report may have been deleted. IT request submitted. Emailed Dr. Song as well.

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

Testing and Movement Plan

5. Vaccination of Patients and Staff

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
1922	37	920		2094	71	1387	644

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)
b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)
c. Is the institution on track to meet testing requirements per the testing calendar / schedule?

Once weekly testing of units placed in quarantine and of inmate critical workers. Testing of unvaccinated inmates pending visits. Surveillance testing of other units determined weekly by Nursing/Medical.
If an inmate is on quarantine (individual or unit), they shall have a negative PCR test within 72 hours prior to release. If they refused 72 hour test, they shall remain on quarantine for seven more days.

If an inmate is scheduled to transfer, they shall complete a negative PCR test within five days of transfer and also complete a negative POC test no more than 24 hours prior to transfer. If they accept/ refuse the five day PCR and/or refuse the 24 hour POC, they shall be quarantine for a total of 21 days.

If inmate is scheduled for contact visit, POC testing is required 48-72 hours before visit for unvaccinated patient inmates (PI s) only. PCR testing is to be completed for all visiting PI s (vaccinated and unvaccinated) 3 - 4 days after the contact visit. If PI s refuse POC, they will not be allowed to visit. If PI s refuse PCR, they will be placed on 21 day quarantine.

7. COVID Test Turnaround Time (Days) – Patients

SAC	Statewide Average
2 - 5 days	Unknown

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
2065	1151	52	14	1099	0.63%

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

9. Staff Testing Plan

a. Required frequency per protocol, **d** b. Upcoming testing activity

Due to a recent increase in positive staff cases, unvaccinated staff will be testing twice per week from 7/19 8/16. Staff are expected to space out the tests to the best of their ability. Testing is now offered 7 days a week.
Staff testing for week of 8/1/21 8/7/21 721 (43) tested out of approximately 1675 staff.

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

10. COVID Test Turnaround Time – Staff

SAC	Approximately 1-2 days	SW Average	Approximately 3 days	

11. Anticipated Movement

19 Pre-Transfers

12. Movement Matrix Adherence - rd " r r r" d" r r" rr r d

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	19		0	17	17	0
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	128	81	66	44	88	2

Supplies and Equipment Plan - r d D D D d r r d d r r d d d r D r d D R r d r

13. COVID Test Kits M d r R r

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply
1210 PCR tests 400 POC tests	None	Full inventory available, as needed

14. N95 Masks

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

Current Inventory	188,956
Who uses N95 masks and in which locations?	Institution is utilizing N95 masks for quarantine/isolation and transportation as required.

15. Resource Requests

None

16. PPE Inventory Report - r D R r r d r d R r

Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks	1,524,813	-1,610	947	3/13/2024
Gloves	759,265	-5,708	133	12/20/2021
KN95 Masks	39,575	-23	1,724	4/29/2026
N95 Masks	188,956	-603	313	6/18/2022
Eye Protection	237,042	-90	2,641	11/1/2028
Gowns	85,958	-105	816	11/3/2023
Cloth Masks	3,400	N/A	N/A	N/A
Other (e.g., wipes, hand sanitizer, PPE/Spill kits)	No shortages			

Staffing Plan - D r d r r d r d d d r r rd r d r d r r r d r

17. Nursing *(Review Clinical Operations Reports through Regional or HQ Nursing leadership)*

Nursing staffing remains at Phase 3 shortage.

18. Custody

High custody vacancy rates continue. Starting 05/24/21, the institution is now under PSR SAC-CUS-21-005 until further notice. To address the staffing shortage, 25 Officers from FOL started on 06/28/2021 and 25 Officers from MCSP started on 08/02/2021.

19. Providers

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

SAC MH is currently operating under a non-COVID-19 linked staffing shortage with 2 mental health staff on long term leave and approximately 9 vacant mental health positions. Continued staffing shortage for medical providers. A new provider position is no longer active- CEO/CME trying to get it reactivated due to the ongoing need.

20. Administrative / Other Staff

No COVID-19 Outbreak related staffing challenges at this time.

Other Operations/Stakeholders

21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
- Feeding / showers / phones / canteen / programming / ventilation

The institution is utilizing surgical masks for all staff and N95 masks/PPE as required for quarantine/isolation housing and transportation.

Phase Report:
A Yard: Phase 3
B Yard: Phase 3
C Yard: Phase 3
STRH: Phase 3
MSF: Phase 3

All yards with exception of quarantined units programming with ISUDT and education. Mental Health is seeing 1:1s in treatment centers and providing six hours of group per week in EOP and 10 hours of group per week in ASU and PSU for non-quarantined units. Medical is seeing routine appointments as scheduled.

Dental is providing services detailed in the Memo Update 6 which include, periodontal and prosthodontic care, dental hygiene series, and Urgent/Emergent services. Yard, day room, and canteen in cohorts for non-quarantined units. The Inmate Visiting Program will continue to expand incrementally through Phases 2 and 3 as cycles of testing and vaccination data indicated we can move forward safely.

22. Education/Communication Plan

- Residents and Staff
- Community and/or Public Health Outreach

Continuous communication via email/posters/meetings of an upcoming changes and new guidelines.

Weekly Infection Control and COVID related conference calls with HQ CDC, CDPH and DOC webinars and website f/u on any updates and evidence-based practice procedures related to COVID and Infection Control/Prevention.

Date: 8/10/2021 8:09:04 AM **Institution:** (SAC)

TOPICS FOR DISCUSSION

Regular communication being maintained with County Public Health regarding positive cases.

23. Pre-Procedural COVID Testing for Dental Patients

- Effectiveness/challenges of program

No current challenges identified.

Dental is providing services detailed in the Memo Update 6 which include, periodontal and prosthodontic care, dental hygiene series, and Urgent/Emergent services.

24. Other

- How are CPAP patients being managed?

# of Patients with CPAP Equipment	46	CPAP patients (all moderate to severe obstructive sleep Apnea patients) are provided their CPAP machines and moved to single cell status to prevent unnecessary exposures.

25. Status on Pending Action Items from Previous Meetings

- CEO/Warden Comments

None

26. RHE/AD Comments

None

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred*
- *Questions about this report? Contact QMStaff@CDCR.ca.gov*

EXHIBIT 11

Quarantine Update, Week of 8-19-2021

Institution	Current Quarantine Total	Pre - Transfer Quarantine	Post Transfer Qurantine	Exposure Quarantine	County to RC
ASP	54		149	15	
CAC	55		106	1	
CAL	28	1	67		
CCC	190	7	12	186	
CCI	144	3	47	88	
CCWF	244	9	28	242	87
CEN	50	2	154	1	
CHCF	743	5	117	811	
CIM	59	2	175	10	
CIW	51	4	29	43	
CMC	54		139		
CMF	25	1	83	2	
COR	132	5	149	104	
CRC	33		251	35	
CTF	20		51	20	

CVSP	26	2	84	36	
DVI					
FSP	56		151		
HDSP	309	7	88	270	
ISP	17	1	57		
KVSP	59	6	124		
LAC	47	2	107	7	
MCSP	42	7	63		
NKSP	753	21	60	11	601
PBSP	727	42	39	41	
PVSP	47		132	42	
RJD	24	1	133	4	
SAC	169	11	82	41	
SATF	39	1	112	22	
SCC	319	13	12	263	
SOL	52	1	84	52	
SQ	13	2	115	13	
SVSP	61	4	140		
VSP	1		100	41	
WSP	8	20	53	11	566
Total	4651	180	3293	2412	1254

** Highlighted only for CCWF/NKSP/WSP

* CVSP OMT Current Quarantine Total and Patient Confirmed, Active updated August 19, 2021 from QM; Expo

Patient Confirmed, Active

Institution	Confirmed
ASP	
CAC	
CAL	
CCC	1
CCI	
CCWF	3
CEN	
CHCF	1
CIM	
CIW	1
CMC	1
CMF	
COR	5
CRC	
CTF	
CVSP	
DVI	
FSP	
HDSP	10
ISP	
KVSP	
LAC	
MCSP	
NKSP	4
PBSP	44
PVSP	
RJD	
SAC	2
SATF	1
SCC	41
SOL	16
SQ	1
SVSP	
VSP	
WSP	
Total	**131**

sure Quarantine Data updated August 10, 2021 from CVSP OMT submission

EXHIBIT 12

Sophie Hart <sophieh@prisonlaw.com>

COVID Data Summary for 08-27-21 (External Stakeholders)

2 messages

Fri, Aug 27, 2021 at 12:46 PM

[redacted]

NOTABLE INFORMATION:

#7 Active Staff cases chart has been replaced

New chart -Data reflecting **3rd vaccination dose** information for the patient population

1. POPULATION VACCINATION EFFORTS:

98,573 patients (98.8%) have been offered at least one dose of vaccine; acceptance rate is 78% among those offered.

77,091/98,573 (78% of those offered, 77% of total CDCR population) accepted at least one dose of vaccine.

Percent of COVID-naïve patients vaccinated: 73% (27% of COVID-naïve patients are unvaccinated)

Percent of COVID-resolved patients vaccinated: 83%

49,833 have had a COVID diagnosis.

2. STATEWIDE POPULATION VACCINE DATA:

Updated:	8/6/2021	8/13/2021	8/20/2021	8/27/2021

Patients 65+, Covid Naïve	n=2,553	n= 2,559	n=2,563	n= 2,570
Offered:	2,540 (99.5%)	2,547 (99.5%)	2,555 (99.6%)	2,557 (99.4%)
Accepted (at least 1 dose):	2,350	2,359	2,366	2,368
Declined:	190	188	189	202
Acceptance Rate:	93%	93%	93%	93%
Patients Covid Score ≥6, Covid Naïve	n=2,783	n= 2,813	n=2,834	n=2843
Offered:	2,771 (99.5%)	2802 (99.6%)	2,827 (99.7%)	2,831 (99.5%)
Accepted (at least 1 dose):	2,594	2,625	2,648	2,651
Declined:	177	177	179	180
Acceptance Rate:	94%	94%	94%	94%
Patients Covid Score ≥3, Covid Naïve	n=8,882	n=8,938	n=8,979	n=9001
Offered:	8,842 (99.5%)	8,899 (99.5%)	8,946 (99.6%)	8902 (98.9%)
Accepted (at least 1 dose):	7,826	7,889	7,941	7,978
Declined:	1,016	1,010	1,005	986
Acceptance Rate:	89%	89%	89%	89%
All Patients	n=99,358	n= 99,472	n= 99,548	n=99,672
Offered:	97,990 (98.6%)	98,141 (98.6%)	98,345 (98.7%)	98,573 (98.8%)
Accepted (at least 1 dose):	75,520	76,081	76,660	77,091
Declined:	22,470	22,060	21,685	21,482
Acceptance Rate:	77%	77%	78%	78%

929 561 579 431

431+ pts

than 08/20/21

3. VACCINE ACCEPTANCE RATE BY MH LOC AND CLARK/ARMSTRONG STATUS

Statewide	PIP	MHCB	EOP	MHSDS Overall	DDP	DPP
Acceptance %	**75%**	**77%**	**81%**	**80%**	**88%**	**90%**

Updated 08/27/21

4. PATIENTS NOT OFFERED VACCINE (by Institution):

	# Pts Not Offered Vaccine And Currently in Institution As of 08/27/21			
Inst	COVID Risk Score ≥6	COVID Risk Score 3-5	COVID Risk Score <3	Total Pts
ASP			3	3
CAC				0
CAL				0
CCC				0
CCI				0
CCWF*	1	2	22	25
CEN			1	1
CHCF	1	1		2
CIM			2	2
CIW				0
CMC			1	1
CMF			2	2

COR				0	
CRC			1	1	
CTF				0	
CVSP				0	
DVI				0	
FSP			2	2	
HDSP			8	8	
ISP	1		2	3	**
KVSP				0	
LAC				0	
MCSP				0	
NKSP*	2	5	100	107	
PBSP				0	
PVSP				0	
RJD				0	
SAC				0	**
SATF				0	
SCC			6	6	
SOL			2	2	
SQ			1	1	
SVSP			3	3	
VSP				0	
WSP*	1	9	337	347	

* Reception centers	**516**

**Two patients allergic to vaccine. (ISP & SAC)

Total	- Allergy	- RCs	=
516	2	459	55

5. INSTITUTIONAL EMPLOYEE VACCINATION EFFORTS:

29,942 institutional staff have been vaccinated with at least one dose of vaccine

29,942 / 55,584 = 54% of institutional staff have been administered at least one dose of vaccine

A total of 17,830 institutional staff have had a COVID diagnosis

6. STATEWIDE STAFF VACCINE DATA:

Updated:	8/6/2021	8/13/2021	8/20/2021	8/27/2021
Staff Vaccine Data:	n=65,754	n= 65,764	n=65,810	n= 65,921
Total Staff Received 1st Dose:	36,059 (55%)	36,236 (55%)	36,451 (56%)	37,069 (56%)
Institutional Staff Data:	n=55,462	n= 55,473	n=55,513	n=55,584
Inst Staff Received 1st Dose:	29,225 (53%)	29,369 (53%)	29,549 (54%)	29,942 (54%)

7. PATIENT 3RD DOSE NEEDED AND ADMINISTERED BY INSTITUTION

Inst	Dose 3 Needed	Dose 3 Administered
ASP	8	7
CAC	9	4
CAL	12	0
CCC	1	0
CCI	14	0

CCWF*	75	5
CEN	17	4
CHCF	312	0
CIM	314	101
CIW	66	44
CMC	92	13
CMF	238	6
COR	38	0
CRC	17	22
CTF	92	80
CVSP	37	22
FSP	66	17
HDSP	23	11
ISP	19	12
KVSP	29	7
LAC	165	1
MCSP	491	0
NKSP*	17	5
PBSP	19	4
PVSP	1	1
RJD	319	84
SAC	82	62
SATF	51	39
SCC	14	12

SOL	198	0
SQ	249	14
SVSP	76	55
VSP	90	79
WSP*	19	7
Totals:	**3,270**	**718**

* RCs

Updated
08/27/21

[redacted]

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

2 attachments

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES **image003.jpg**
4K

Copy of COVID Vaccine Refusal Rate by Mental Health Level of Care Armstrong and Clark 20210827.xlsx
15K

[redacted]

EXHIBIT 13

Plata | Plaintiffs' Urgent Concerns Regarding Current COVID-19 Outbreaks
December 30, 2020

Avenal State Prison (ASP)

As we raised previously, the 12/29 OMT continues to report patients are on quarantine in dorms, despite available beds in A 140 (the celled set-aside). Specifically, the OMT reports 97 beds are available in A 140, and that 140 patients are quarantined in C 310, and 192 are quarantined in F 350. We believe ASP should move as many patients on quarantine as possible to A 140 for safer housing, including particularly COVID-naïve patients and high risk patients. The 12/28 OMT reported that ASP had "[p]erformed extensive review of quarantine patients identifying 48 patients to relocate to HU 140" and that ASP would "relocate patients in cohorts." However, from reviewing the 12/29 OMT, it does not appear these patients were relocated to A 140.

Answered previously by CCHCS in an email dated 1/8/2021, in response to questions raised 12/16/2020 and Region 3 raised 1/5/2021.

Please note additional response below by ASP:

As of 1/6/2021, the celled set-aside space was fully occupied.

The 12/29 OMT reports a patient, whose COVID status is unknown, refused to relocate to A 140 (celled housing) from F 350 (a dorm). The OMT reports that "[c]onsequently, all patients in HU placed on quarantine." The OMT does not say what has been done to incentivize this patient to move to A 140, or whether he has given any reason for his refusal to move. We believe ASP must make every effort to encourage this patient to move, and if unsuccessful, must offer others at risk of exposure in F 350 (and particularly those who are high risk) the option to move to safer housing.

Answered previously by CCHCS in an email dated 1/8/2021, in response to questions raised 12/16/2020 and Region 3 raised 1/5/2021.

California City Correctional Facility (CAC)

According to the 12/29 OMT, in A1-B, there are six patients on precautionary isolation who are co-located. There are no notes regarding a plan to move these patients, nor is there an indication that patients are refusing to move. There appear to be beds available in other isolation housing units.

On 12/29/20 CAC had 6 inmates that were co-located with inmates on quarantined housing.

CAC has 3 separate terms for COVID patient housing. CAC medically tracks and reports using these terms to Region 3 medical.

- **Isolation- any inmate who has tested positive for COVID. Inmates that are COVID positive do not house in the same pod as non-positive inmates.**

- **Precautionary Isolation- any inmate who tests negative for COVID, but displays symptoms. These inmates are normally housed in a separate pod, but when space is unavailable, they are single-celled in a pod with other inmates on quarantine.**

- **Quarantine- an inmate who comes back from court, medical, or cellmate of a positive inmate who tests negative and does not have symptoms. They are cohort or single celled.**

On 12/29/20, the 6 "precautionary isolation" inmates were appropriately housed with other quarantined inmates.

Calipatria State Prison (CAL)

According to the 12/30 OMT, in D4, there are patients in isolation who are co-located with those not known to be positive. There are no notes regarding a plan to fix this, nor is there an indication that patients are refusing to move. There appear to be beds available in other isolation housing units.

Approximately 62 D4 Housing Unit patients at Calipatria State Prison (CAL) initially received positive COVID-19 test results. Accordingly, movement to other housing was offered to those with negative or pending results but was refused by all patients. Two CAL Captains came in after hours to educate those who refused to move to alternate housing. A subsequent communication with CAL's Chief Nurse Executive resulted in CAL adopting a process wherein both custody leadership and nursing leadership engage in collaborative interventions in an effort to educate the population on strategies related to reducing/mitigating the spread of COVID-19. Additionally, this item will be discussed as part of CAL's Incident Command Post, which meets daily and has both custody and Health Care leadership representation.

Centinela State Prison (CEN)

According to the 12/29 OMT, there are 40 patients in isolation who are co-located with those not known to be positive in D3. There are no notes regarding a plan to fix this, nor is there an indication that patients are refusing to move. There appear to be beds available in other isolation housing units.

Facility D Building 3 is identified as an Isolation unit for SNY. All inmate-patients identified as having tested positive for COVID are rehoused into the Isolation unit and remain there for the duration of their 14-day observation period. At the conclusion of their 14th day, Healthcare Services conducts a final evaluation and, if cleared, those patients are released from the Isolation unit. Facility D Gym was activated to accommodate patients being released from Isolation. As of December 31, 2020, there were 39 confirmed COVID positive patients housed in Facility D Building 3. On December 29, 2020, Medical released four (4) of the 47 patients who were housed in D3 on isolation status at that time. All 4 inmates were re-housed into non-isolation buildings on December 30, 2020. Custody received the discharge chronos at 5:57 pm on the 29th. Facility D is limited on bed space due to having a designated Isolation Building and a designated Quarantine Building, staff made the needed consolidation bed moves before CEN was able to rehouse the previously positive patients who were removed from Isolation status.

All pre-transfer out inmates are CTQ in place (current assigned cell) for 14 days prior to transfer. All new arrivals are housed in CEN's designated quarantine buildings (B4/D5) for 14 days and cleared by medical prior to being housed in general population.

Central California Women's Facility (CCWF)

The 12/29 OMT shows a total of 217 active cases while the Tracker show 326. If there are 326 patients, it's not clear where all are housed. The concern is if there are current active patients are in dorms, or otherwise co-located with those not known to be positive.

As of January 5, 2021, Central California Women's Facility (CCWF) had a total population of 1,999 inmates. CCWF had 447 active COVID-19 cases and 1,345 inmates on quarantine. Of the 447 active cases, 224 were housed in CCWF's primary isolation Building 502; 211 were housed in Building 501; and 62 were housed in Building 509, which were converted into overflow isolation units due to the recent surge of active cases. Additionally, 1 of the active cases is housed in Building 504 due to the patients being max custody, 7 are out to medical, and 1 is housed in the Skilled Nursing Facility (SNF).

Of the 1,345 inmates quarantined, 108 are housed in CCWF's primary quarantine Building 503. The other patients are housed in Housing units based on being placed on Quarantine status from a positive inmate case(s) or positive staff cases with exposure. There are 82 patients housed in Building 504, 52 patients housed in Building 505, 131 patients housed in Building 506, 115 patients housed in Building 507, 5 patients housed in Building 508, 125 patients housed in Building 510, 65 patients housed in Building 511, 159 patients housed in Building 512, 139 patients housed in Building 513, 104 patients housed in Building 514, 153 patients housed in Building 515, 86 patients housed in Building 516, and 21 patients housed in the SNF.

It should be noted that Building 501, 502 and house Active Isolated patients only. Inmates housed in 504 are placed in cells away from other cells with a buffer cell on either side of the isolated patients. Additionally, 59 patients had their isolation orders discontinued and are pending movement to non-isolation housing.

CCWF is working to move quarantine inmates into appropriate cell quarantine space.

California Health Care Facility, Stockton (CHCF)

The recent OMTs, including for 12/28, repeatedly state that active positive patients are not co-located with those not known to be positive. However, the data provided showing the number of people in each housing unit on isolation (due to active COVID status) and on quarantine seem to clearly show that there are co-located patients in essentially all housing units, including in some Facility C buildings with dorm housing and Facility E dorms 3A, 4A, and 4B.

As of January 7th, CHCF did not have any COVID positive patients cohabitating with COVID naïve inmates.

On Facilities A (Crisis Bed), B (PIP), C (OHU), and D (CTC), CHCF has single-celled housing that, in some cases, house both COVID positive and COVID naïve patients within the same housing unit. In these circumstances, the inmates are housed in single cells (based on facility design) and are behind solid cell doors. There are no circumstances of cohabitation between COVID positive and COVID naïve inmates in a celled living environment.

Facilities C (OHU) and E (Level II NDPF) consist of dorm-style housing.

1. **On Facility C, several units are designed with dorm-style housing (4-person dorms) that are all adjoined to a common dayroom behind a solid cell door. In these buildings, there are separate dorms occupied by COVID positive patients and COVID naïve patients; however, there are no circumstances of cohabitation between COVID positive and COVID naïve patients within the same dorm. Additionally, this population (OHU) has been deemed unsuitable for tent living based on their medical needs as supported by their OHU level of care.**

2. **On Facility E, the dorm-style housing consists of common area living space with approximately 88 beds split into three separate pods. The pods are divided by perforated expanded metal and do not provide the level of separation that is provided by solid cell doors relative to cross contamination. In these dorms, there are no circumstances of cohabitation between COVID positive and COVID naïve patients. COVID positive and COVID naïve patients are separated by the A and B sides of the housing unit. Please note the A and B sides are separated by solid doors which operate as sallyports and have their own shower and toilet facilities. CHCF has been able to work closely with its CCHCS partners to house COVID positive patients in identified dorms and COVID naïve patients in entirely different dorms.**

It is noteworthy that CHCF's tents were deemed suitable for occupancy on Monday, January 4, 2021, and prior to that date, there were circumstances that justified the activation of the tents in place on Facility E; however, the tents were uninhabitable and the institution worked collaboratively with its CCHCS partners to house patients in a manner that minimized the risk of exposure to COVID naïve inmates.

Since Monday, January 4, 2021, (the date the tents were deemed habitable) CHCF has not cohabitated COVID positive patients with COVID naïve inmates, except in circumstances described above where these populations are separated from one another by solid cell doors at a minimum.

California Institution for Men (CIM)

Per the 12/29 OMT, it appears that nearly 90 people in Facility A and nearly 100 people in Facility D, are quarantined not in single or double cells, but common air space open dorms.

CIM is moving forward with filling B1 (Cypress Hall), its designated quarantine unit. CIM is working closely with Healthcare Access to identify patients from the buildings identified as quarantine. CIM is focusing on high risk medical as priority for placement.

Patients are being educated by Healthcare and encouraged to move. Those refusing to move will be documented in CERNER and referred to custody. Custody Supervisors will begin the interactive process to get the patients to move, documenting all refusals on 128s and progressing in the inmate disciplinary process.

California Medical Facility (CMF)

According to the 12/30 OMT, the designated quarantine space is identified as W1, W3, H1 and H2, all of which combined have over 100 vacant beds. On the other hand, there are over 400 patients on quarantine status in A-facility, which consists of various housing units, some of which are large dorms. It is not apparent from the OMT whether the quarantined-in-place units are dorms. If so, we ask that you consider moving high risk medical patients from those congregate living spaces into celled housing in the designated quarantine spaces.

CMF is currently using H-1, H-2, W-1, and W-3 as designated quarantine space. There will be some vacancies in H-1 and H-2 as those housing units have small dormitories (8-10 person). H-1 has a capacity of 57, however, 36 of the beds are in dorms. H-2 has a capacity of 92, however, 50 of the beds are in dorms. The housing in W-3 is all cell-based, however, it is located on the third floor of W-Wing that does not have elevator access. Many patients with high COVID risk scores will not be able to climb three flights of stairs. In collaboration with the Chief Medical Executive, high risk medical patients from congregate living spaces will be moved to celled housing as it becomes available. All housing decisions are made with input from both medical/clinical and custody staff.

California Men's Colony (CMC)

We continue to have the same concerns as those raised in previous weeks Patients are quarantined on F and G yards in dorms while there appears to remain vacant cells available to quarantine behind solid doors. It is unclear why those patients housed in dorms have not been all moved into celled housing for the remainder of their quarantine period, or if – at minimum- the dorm patients on quarantine who are medically high risk have been offered cell moves.

It appears that in that last week, CMC-West has activated three new dorm isolation units, in Dorms 1, 17 and 25. According to the 12/17/20 Bed Audit, these dorms were all occupied then, at 130% capacity or more. We are concerned about whether/ how quarantine was conducted for the occupants of those dorms who were apparently relocated, and whether people from different dorms were cohoused for quarantine.

CMC is taking immediate steps to exhaust all the designated quarantine cells in Building 6 low side (150 cells) to house inmates at a higher risk for COVID, and from dorms to decrease cohorts within the dorms. This process will be ongoing and CMC will continue to fill the vacancies in Building 6 low side as inmates are removed from quarantine status. This process will ensure CMC is fully utilizing the designated quarantine cells.

CMC proactively reviews the West Facility inmate population to identify those inmates at higher risk for COVID or other medical complications for placement into cells on the East Facility. The inmates have meaningful discussions with professional health care providers to ensure they understand the possible risks to their health if they remain housed in congregate living areas. These inmates are allowed to move to non-quarantine cells within the East Facility.

When Dorms 1 and 17 became isolation dorms due to the increase in COVID positives in the dorm, CMC quarantined the remaining non-COVID inmates in celled housing in building 6 low side. Dorm 25 is a quarantine dorm and does not house inmates from other dorms. CMC does not allow inmates from separate quarantine dorms to cohabitate together; inmates will either quarantine in place within their own dorm or will be relocated to individual quarantine cells in Building 6. As of January 6th, all quarantine beds were filled. As patients move to isolation, the newly vacant quarantine beds will be filled.

Correctional Training Facility (CTF)

Per the 12/29 OMT, patients on isolation are co-located with those not known to be COVID positive in X-wing (1 patient), North Lassen B (2 patients), North Rainier A (6 patients), North Rainier B (11 patients), North Shasta A (5 patients), North Shasta B (2 patients), and North Whitney A (10 patients). There appear to be hundreds of available beds in isolation housing units that these patients could be moved to (including 160 in G wing, 200 in Y wing, 54 in Facility D Gym, and 177 in South Dorm 2).

Despite the apparent available beds, there is no plan noted in the OMT to move these patients and there is no indication that any of these patients are refusing to move. We believe they should be moved to isolation housing immediately.

CTF is consistently moving patients in and out of quarantine and isolation areas based on current test results and clinical recommendations. On December 29, 2020, CTF received mass test results with many positives requiring a great deal of movement. The data relayed during the OMT call was a point in time when the movement had been initiated but not completed. A review of data from the date in question reveals that many of the test results were received during first watch hours (2200-0600). In these instances, the men were moved on second watch when staffing numbers allowed for safe movement. CTF ICP staff (custody and medical) meet every morning at 0900 to confirm test results and housing, the expectation being that all patients are moved quickly, and that was accomplished here.

The 12/29 OMT reports significant custody shortages are impacting access to care. Specifically, the OMT says that "custody has implemented rolling blackouts, meaning they are in 1 Watch staffing with no movement. This is impacting access to care in the areas that are blacked-out which is Facility A, B, C. The location on blackout changes daily starting with Facility A on one day, then B the next, then C." The OMT also reports that CCHCS/CDCR is "looking into custody staffing resources from other institutions" and "looking into having counselors do officer overtime as counselors may be more available." However, the OMT reports these blackouts began on 12/16, and CTF's OMTs since 12/21 have stated that the institution is "looking into custody staffing resources from other institutions," but the problem apparently persists. Staff should be redirected and approved for overtime as necessary immediately to address this shortage.

On December 29, 2020, CTF's staff vacancy rate was twenty eight (28) percent. CTF had been using its staff contingency plan as of that date and continues to do so. CTF had also instituted a rolling blackout to try and cover a temporary spike in vacant posts. This temporary spike is a result of twenty-one (21) patients being sent to hospitals in the area, requiring 126 posts, twenty-nine (29) of CTF's own staff being quarantined/ isolated (Monterey County has been very high rate of infection, 25 percent infection rate being reported) and the numerous alternate housing areas requiring housing staff and fire watch. CTF is also using sergeants and lieutenants to cover officer posts, however, the high volume of vacancies within those ranks meant there were no volunteers. CCIs are now being offered the overtime to cover offices posts and that is helping but during the time period being discussed, that had not been authorized and was pending. All means to fully staff the prison were used and continue to be used.

Ironwood State Prison (ISP)

The 12/29 OMT reports that ISP converted A1, C2, C5, and D3 into isolation buildings after many tested positive in those buildings, and that patients who tested negative were moved into other housing units and quarantined "as necessary." The OMT does not say where those who tested negative were moved, or whether they were kept separate from others when moved. We are concerned about the possibility that these moves could spread the virus, if these patients were then housed with those who were not previously exposed (or had a different exposure). We believe anyone who tested negative in A1, C2, C5, and D3 should be housed separately (i.e., should not share a cell with) those from other housing units, and should also be kept separate from others for purposes of dayroom, pill line, etc.

A thorough inquiry was been conducted for the purpose of this response. Patients who tested negative in Housing Units Al and C5 were housed separated from the four other housing units and kept separate from others. Housing Units C2 and D3 were already identified as isolation units and only housed patients who had tested positive for COVID-19.

For clarification purposes, mass inmate COVID-19 testing completed during the last 2 weeks of December 2020 revealed a large number of COVID-19 positive patients on Facilities A (Level III SNY) and C (Level III GP). The number of patients requiring isolation exceeded ISP's original identified capacity in Housing Unit C2. As a result, ISP utilized Housing Units A1, C5 and D3 as isolation units, in addition to ISP's previously-identified isolation unit (C2).

Housing Unit A1

Due to a large number of patients testing positive in Housing Unit Al, it was determined that the best course of action was to utilize the housing unit as an isolation unit and move the patients who had not tested positive into quarantined housing. Housing Unit A2 was utilized for quarantine of these patients. Housing Unit A2 houses only quarantined patients.

- **A2 only houses patients on quarantine.**
- **Housing is in cells with solid doors.**
- **Cellmates from A1 who both tested negative remained cellmates in the quarantined housing units.**
- **Patients who tested negative for COVID-19, but whose cellmates tested positive were given a Sofia test. If they still tested negative, they were single-celled in the quarantine unit. Quarantined patients from Al were not housed with those who were not previously exposed (or had a different exposure).**
- **Patients in quarantine do not go to yard/dayroom until after the 14-day quarantine expires.**
- **Health Care conducts medication line at cell front.**

Housing Unit C2

- **Housing Unit C2 was already identified as ISP's Isolation unit.**
- **No patients were moved out of Housing Unit C2 to facilitate use as an isolation unit.**

Housing Unit C5

Due to a large number of patients testing positive in Housing Unit C5, it was determined that the best course of action was to utilize the housing unit as an isolation unit and move the patients who had not tested positive into quarantined housing. Housing Unit Cl was utilized for quarantine of these patients. Housing Unit Cl was already identified as ISP's quarantine unit and only houses quarantined inmates.

- **Cl only houses patients on quarantine.**
- **Housing is in cells with solid doors.**
- **Cellmates from C5 who both tested negative remained cellmates in the quarantine Housing Unit Cl.**
- **Patients who tested negative for COVID-19, but whose cellmates tested positive were given a Sofia test. If they still tested negative they were single-celled in the quarantine unit. Quarantined patients from C5 were not housed with those who were not previously exposed (or had a different exposure).**
- **Patients in quarantine do not go to yard/dayroom until after the 14-day quarantine expires.**
- **Health Care conducts medication line at cell front.**

Housing Unit D3

- **Housing Unit D3 was activated as an isolation unit on December 18, 2020. Prior to this, D3 was vacant due to construction.**
- **No patients were moved out of Housing Unit D3 to facilitate use as an isolation unit.**

To summarize, in order to utilize Housing Units Al and C5 as isolation units, ISP moved patients from Housing Units Al and C5, who tested negative, to quarantine Housing Units A2 and C2. ISP followed quarantine guidelines and did not house these patients with other inmates who were not exposed or had different exposure dates. Housing Units C2 and D3 were already isolation units, therefore no patients needed to be moved from these two units to facilitate use as an isolation unit.

ISP follows specific criteria for placement in order to mitigate the spread of the COVID-19 virus, as it does for all quarantine buildings:

- **Quarantined patients are housed in quarantine units (can be housed with their cell mate only if they had the same exposure).**
- **If exposure was different, quarantined patients are single-celled in the quarantine unit.**
- **Quarantined patients are kept separate from all other inmates.**

CSP-Los Angeles County (LAC)

Per the 12/30 OMT, positive patients on isolation or those on precautionary isolation are co-located with those not known to be positive in approximately 20 different housing units, with only a relatively small portion of those so housed for isolation said to be in there units because of a refusal to move. This has not changed over the last few weeks.

Answered previously by CCHCS in an email dated 1/8/2021, in response to questions raised 12/16/2020 and Region 3 raised 1/5/2021.

Please note additional response below by LAC:

COVID positive, Isolation/Precautionary and Quarantined patients were housed throughout LAC due to the extremely high number of refusals when ordered to rehouse. Patients who are were willing to move are rehoused as soon as possible to designated housing. LAC has five different missions where inmates cannot be moved from one Facility to another, creating further challenges with respect to inmate movement.

On December 31, 2020, Facility C had a total of 122 COVID positive patients housed on the Facility, of which 61 were housed appropriately in housing unit C-5. The remaining 61 inmates were housed in C-1 thru C-4, all of whom refused to be rehoused in LACs designated isolation unit C-5. In addition, the cellmates of those patients also refused to be moved to another cell where they would not be housed with a COVID-positive inmate.

Daily multi-disciplinary check-ins are occurring with these patients to encourage them to move to the designated building.

Richard J. Donovan Correctional Facility (RJD)

Per the 12/29 OMT, approximately three weeks after the current outbreak began, positive patients continue to be housed in several units with those not known to be infected.

Patients continue to refuse to move to isolation. Medical staff provide patient education and refusals are documented.

As reported last week, during a 12/22/20 Armstrong call with RJD custody and medical executives, it appeared that efforts to keep positive patients and others from mixing in these buildings was a challenge, with efforts in this regard seemingly not well-organized.

Health care provides housing unit staff a list of all positive patients within the housing unit. Isolation patients in these units are kept separate from other inmates when it is necessary to exit their cell.

Wasco State Prison (WSP)

According to the 12/29 OMT, there are 62 people in dorms on C Yard and 140 on H yard who are currently on quarantine status. There also appear to be well over 650 empty beds in cells on A, B and D yards. We understand that, because Wasco is currently experiencing a surge with over 350 cases, the Matrix's requirement for quarantining in a cell are suspended. Nevertheless, we are concerned about what appears to be a large number of empty cell beds, when 200 people are currently quarantined in dorms, and ask that you consider moving high risk medical patients into celled housing.

On January 5, 2021, WSP currently had 204 inmates on quarantine in dorm housing, 56 of which were due to come off quarantine that same day as soon as their final test results were received, which would leave 148 who need celled quarantine housing.

WSP's health care leadership has advised to house patients together in quarantine that were exposed in the same building, and have the same quarantine date, and housing assignments are being made accordingly.

None of the patients recently housed in dorms were designated as high risk, as those who have a COVID risk score of 3 or above are immediately moved to celled housing once designated.

As of January 8th, there are no quarantine patients in dorms. All are in cells.

EXHIBIT 14

Prison Law Office

Prison-specific COVID-19 questions for week of July 12, 2021

Questions regarding:

CRC

RJD

SATF

CRC

Per the most recent OMT, a number of individuals are scheduled to arrive at CRC this week
7/12: 1 from FSP *Vaccinated*
7/13: 5 from NKSP *All vaccinated*
7/13: 5 from WSP *All vaccinated*
7/15: 6 from WSP *None vaccinated (Dorm 104)*
7/15: 3 from NKSP *2 vaccinated/1 unvaccinated (Dorm 102)*
7/15: 1 from SATF *Vaccinated*
7/15: 1 from DVI *Vaccinated*

It is noted that two dorms are ready and available to house unvaccinated patients for precautionary quarantine. Of those who need to be quarantined, are patients from different buses mixed together in a single dorm?
No.

Please explain.
CRC has identified Dorms 204/302 as precautionary quarantine space to accommodate intake for unvaccinated patients. CRC continues to perform compactions to create additional precautionary quarantine space as needed. CRC only houses patents together received on the same day, from the same location, on the same bus.

RJD

People in the RJD Facility C EOP report greatly limited programming over the last approximately two weeks, and what they believe are abnormally high in-cell temperatures, with reports that the ventilation system is blowing warm air into the cells.

Has there been limited program in that EOP in the days since July 1, and if so is it COVID related, including due to quarantine, staff absences due to active cases or quarantine?

In regards to limited programming, the Richard J. Donovan Correctional Facility (RJDCF) has experienced abnormally high staff vacancies in the prior two weeks. These vacancies have resulted in extreme program closures throughout the Institution, affecting all areas to include but not limited to, the Enhanced Out Patient programming areas. These closures were necessary to operate the institution safely for staff and inmates alike. RJDCF continues to monitor the situation and is making every effort to afford maximum programming opportunities to the population.

Does RJD Facility C EOP housing units' ventilation system include air conditioning?

No. The air-conditioning units have been procured and are on grounds. The replacement ducting needs to be sent out for bid and purchased. Plant Operations plans to install the new units in mid to late September 2021.

If not, how does the cooling function work?

Currently, there are three (3) air handler units on Housing Units 14 and 15 each, one for each section A, B and C. The units supply a mixture of outside air and recirculated air during the colder months of the year. During the warmer months the units supply 100% outside air. These air handler units are operating as designed per Design Criteria.

From July 1 until now, have those housing unit ventilation systems operated on 100% outside air, or a mix of outside and recirculated air (and if so, what percentages)?

As of mid-April 2021, these units have been operating on 100% outside air with Minimum Efficiency Reporting Value (MERV) 13 filters installed, as per requested by Facilities Asset Management Branch.

SATF

Two patients who recently transferred to SATF have tested positive. [redacted] and [redacted] both transferred from Solano to SATF on 6/30, and both tested positive for COVID-19 on their first post-transfer tests (collected 7/5). Both appear to have been tested multiple times at Solano pre-transfer, and repeatedly tested negative.

Were [redacted] and [redacted] transported on the same bus? *Yes*

Were any other patients on that bus? *Yes*

If so, how many, and have any of those patients tested positive?

4 inmates were on the bus. ([redacted])
2 of the 4 inmates tested positive. ([redacted])
[redacted] *have had at least two negative PCR tests. (day 5 and day 12 post transfer)*

EXHIBIT 15

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date : July 23, 2021

To : Steven Fama, Prison Law Office

Subject : **PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO OUTPATIENT HOUSING UNIT BED AVAILABILITY**

California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (CDCR) are providing the italicized information below in response to your e-mail inquiry dated July 8, 2021.

> Was and is there more generally an unavailability of OHU beds such that residents who need such beds who are housed in prisons' general populations must wait weeks for such a bed to become available? We would appreciate it if you could please let us know, including any underlying reasons and the number, for men and women, respectively, of OHU beds, the number vacant (again, and the number of general population patients waiting for transfer to such a bed).
>
> *Please refer to Attachment A, which indicates there is availability of Outpatient Housing Unit (OHU) beds in numerous institutions. Note, the waitlist is point in time data and does not include information that relates to specific vacant beds on the same day. In general, specific case factors exclude patients from going to certain institutions. OHU cases are reviewed by Utilization Management and endorsed; the acceptance and dialogue between the sending and receiving institution usually occurs within 24 to 48 hours, including transport. More complex cases may require longer dialogue, review, and/or clarification between the institutions, which may include but is not limited to specialty clearances, overrides, Regional Deputy Medical Executive intervention, and special transportation.*

Thank you.

cc: Clark Kelso, Receiver
Directors, CCHCS
CCHCS Office of Legal Affairs
Office of Legal Affairs, CDCR
Office of the Attorney General
Hanson Bridgett, LLP
Jackie Clark, Deputy Director (A), Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Joseph Williams, Deputy Director, Corrections Services, CCHCS
Erin Hoppin, Associate Director, Risk Management Branch, CCHCS

ATTACHMENT A

ATTACHMENT A

MANAGEMENT INFORMATION SUMMARY OF HEALTH CARE POPULATION BY INSTITUTION AND SPECIALIZED MEDICAL BED HOUSING

Data Refreshed: 7/6/21 7:00 PM

Specialized Medical Beds (SMB) Population Summary

Institution	Hospice				Correctional Treament Center (CTC)				Outpatient Housing Unit (OHU)				Total Medical Patients in SMBs
	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP									28	13	46 %	15	**13**
CAL									18	18	100 %	0	**18**
CCC									19	6	32 %	13	**6**
CCI									16	5	31 %	11	**5**
CEN					13	11	85 %	2					**11**
CHCF					360	348	97 %	12	652	589	90 %	63	**937**
CIM									44	43	98 %	1	**43**
CMC					37	24	65 %	13					**24**
CMF	17	13	76 %	4	55	53	96 %	2	47	45	96 %	2	**111**
COR					50	44	88 %	6	18	18	100 %	0	**62**
CRC									10	8	80 %	2	**8**
CTF									17	14	82 %	3	**14**
CVSP													
DVI									24	14	58 %	10	**14**
FOL													
HDSP					20	14	70 %	6					**14**
ISP									14	4	29 %	10	**4**
KVSP					10	10	100 %	0					**10**
LAC					4	4	100 %	0					**4**
MCSP					2	1	50 %	1					**1**
NKSP					6	6	100 %	0					**6**
PBSP					9			9					
PVSP					9			9					
RJD					14	13	93 %	1					**13**
SAC					2	1	50 %	1					**1**
SATF					18	18	100 %	0					**18**
SCC									10			10	
SOL					6	6	100 %	0	0			0	**6**
SQ					10	8	80 %	2					**8**
SVSP					12	10	83 %	2					**10**
VSP									20	20	100 %	0	**20**
WSP					10	9	90 %	1					**9**
Male Subtotals	**17**	**13**	**76%**	**4**	**647**	**580**	**90%**	**67**	**937**	**797**	**85%**	**140**	**1,390**
CCWF					26	18	69 %	8					**18**
CIW					8			8	16	10	63 %	6	**10**
FWF													
Female Subtotals	**0**	**0**		**0**	**34**	**18**	**53%**	**16**	**16**	**10**	**63%**	**6**	**28**
Grand Total	**17**	**13**	**76%**	**4**	**681**	**598**	**88%**	**83**	**953**	**807**	**85%**	**146**	**1,418**

WAITLIST SUMMARY	
Hospice	0
OHU	40
CTC	0
TOTAL	**40**

Footnote: CCWF Correctional Treatment Center capacity is designated as Skilled Nursing Facility.

ATTACHMENT A

MANAGEMENT INFORMATION SUMMARY OF HEALTH CARE POPULATION BY INSTITUTION AND SPECIALIZED MEDICAL BED HOUSING

Data Refreshed: 7/12/21 7:01 PM

Specialized Medical Beds (SMB) Population Summary

Institution	Hospice				Correctional Treament Center (CTC)				Outpatient Housing Unit (OHU)				Total Medical Patients in SMBs
	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP									28	12	43 %	16	**12**
CAL									18	17	94 %	1	**17**
CCC									19	6	32 %	13	**6**
CCI									16	5	31 %	11	**5**
CEN					13	8	62 %	5					**8**
CHCF					360	354	98 %	6	652	598	92 %	54	**952**
CIM									44	43	98 %	1	**43**
CMC					37	28	76 %	9					**28**
CMF	17	11	65 %	6	55	55	100 %	0	47	47	100 %	0	**113**
COR					50	45	90 %	5	18	18	100 %	0	**63**
CRC									10	9	90 %	1	**9**
CTF									17	12	71 %	5	**12**
CVSP									14	2	14 %	12	**2**
DVI									24	12	50 %	12	**12**
FOL													
HDSP					20	16	80 %	4					**16**
ISP									14	1	7 %	13	**1**
KVSP					10	10	100 %	0					**10**
LAC					4	2	50 %	2					**2**
MCSP					2	2	100 %	0					**2**
NKSP					6	6	100 %	0					**6**
PBSP					9	1	11 %	8					**1**
PVSP					9			9					
RJD					14	14	100 %	0					**14**
SAC					2	1	50 %	1					**1**
SATF					18	18	100 %	0					**18**
SCC									10			10	
SOL					6	6	100 %	0	0			0	**6**
SQ					10	9	90 %	1					**9**
SVSP					12	10	83 %	2					**10**
VSP									20	20	100 %	0	**20**
WSP					10	9	90 %	1					**9**
Male Subtotals	**17**	**11**	**65%**	**6**	**647**	**594**	**92%**	**53**	**951**	**802**	**84%**	**149**	**1,407**
CCWF					26	19	73 %	7					**19**
CIW					8	3	38 %	5	16	10	63 %	6	**13**
FWF													
Female Subtotals	**0**	**0**		**0**	**34**	**22**	**65%**	**12**	**16**	**10**	**63%**	**6**	**32**
Grand Total	**17**	**11**	**65%**	**6**	**681**	**616**	**90%**	**65**	**967**	**812**	**84%**	**155**	**1,439**

WAITLIST SUMMARY	
Hospice	0
OHU	40
CTC	0
TOTAL	**40**

Footnote: CCWF Correctional Treatment Center capacity is designated as Skilled Nursing Facility.

EXHIBIT 16

Are any of these "breakthrough" cases patients who have already had COVID and, if so, is there any indication whether these are true positives?

- *33 fully vaccinated patients have had a positive PCR test 14 or more days after their final covid vaccine dose and first tested positive more than 90 days before that breakthrough test date (i.e., breakthrough was a re-positive); 3 of these occurred in the last 14 days. Whether these cases represent "true positives" is currently under investigation through an examination of relevant laboratory and clinical data.*

How many "re-positive" cases have there been, how many are there currently, and how many such patients have been, and currently are, hospitalized for COVID-related reasons?

- *There have been 368 positive PCR tests at least 90 days after the first positive 3 of these were in the last 14 days*
- *3 current patients have been hospitalized for Covid-related reasons after a positive test 90 days after their first positive test. None of these occurred in the last 14 days*

COVID Vaccination – Residents

What are the vaccination percentages for residents by racial/ethnic characteristics?

Vaccination					
Category	Total number of Residents	Completely Vaccinated		Vaccinated with at Least 1 Dose	
		#	%	#	%
Asian	1387	1021	74%	1041	75%
Black	28436	17482	61%	18103	64%
Latino	44185	33358	75%	34128	77%
White	19638	15243	78%	15565	79%
Other	5177	3961	77%	4044	78%

What are the vaccination percentages for the following age groups: 18 through 29, 30 through 39, 40 through 49, 50 through 59, and 60 through 64 (you have provided the data for age 65 and older)?

Vaccination					
Category	Total number of Residents	Completely Vaccinated		Vaccinated with at Least 1 Dose	
		#	%	#	%
Age 18-29	19516	11094	57%	11534	59%
Age 30-39	29722	19638	66%	20226	68%
Age 40-49	22301	16988	76%	17417	78%
Age 50-59	16211	13505	83%	13744	85%
Age 60-64	5498	4788	87%	4855	88%
Age 65+	5575	5052	91%	5105	92%

EXHIBIT 17

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date	:	May 10, 2021
To	:	CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION - ALL STAFF CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES - ALL STAFF DIVISION OF JUVENILE JUSTICE - ALL STAFF
From	:	DocuSigned by: Connie Gipson 60F75B6E86804F7... CONNIE GIPSON, Director Division of Adult Institutions California Department of Corrections and Rehabilitation
		DocuSigned by: Joseph Bick 347167202A8A404... JOSEPH BICK, M.D., Director Health Care Services California Correctional Health Care Services and California Department of Corrections and Rehabilitation
		DocuSigned by: Heather Bowlds 4637DDEB2DC34ED... HEATHER BOWLDS, Psy.D, Director Division of Juvenile Justice California Department of Corrections and Rehabilitation
		DocuSigned by: 81BB38397B8F4F4... GUILLERMO VIERA ROSA, Director Division of Adult Parole Operations California Department of Corrections and Rehabilitation
Subject	:	**RECOMMENDED COVID-19 PERSONAL PROTECTIVE EQUIPMENT AND PHYSICAL DISTANCING REQUIREMENTS FOR STAFF AND INMATE-PATIENTS UPDATE (5.7.21)**

This memorandum provides updated guidance on the Novel Coronavirus Disease 2019 (COVID-19) types of Personal Protective Equipment (PPE) and physical distancing requirements at California Department of Corrections and Rehabilitation (CDCR), California Correctional Health Care Services (CCHCS), and Division of Juvenile Justice (DJJ) institutions, headquarters, regional and field offices, fire camps, and youth facilities.

This memorandum supersedes expectations and guidance provided in previous memoranda including:

- "Staff Wearing Facial Coverings and Physical Distancing Requirements in Institutions and Facilities," dated October 27, 2020.
- "Authorized Facial Coverings for All Employees, Contractors, and Visitors Entering CDCR Institutions and DJJ Youth Facilities – Procedure Mask Distribution and Use," dated November 19, 2020,
- "Staff Wearing Facial Coverings and Physical Distancing Requirements at Headquarters, Regional, and Field Office Locations," dated December 4, 2020.
- "Clarification for Offenders Wearing Face Covering," dated December 11, 2020.
- "Recommended Covid-19 Personal Protective Equipment for Staff and Inmate-Patients Update," dated March 18, 2021.

To protect all staff and inmate-patients from transmission of the COVID-19 pathogen, staff and all inmate-patients shall adhere to required proper infection control practices, including frequent hand hygiene, six-foot physical distancing, and adherence to the universal use of face masks.

The PPE recommended for staff and inmate-patient varies to include, but not limited to, masks, gloves, face shields, eye protection, and gowns. The type of PPE that is required also varies depending on location and circumstances to include, but not limited to whether six-foot physical distancing is feasible, the level of contact they have with symptomatic inmate-patients, COVID-19 cases, contaminated/aerosolized material and/or whether activities are indoors or outdoors. This guidance may include PPE recommendations and requirements exceeding Center for Disease Control and Prevention and California Department of Public Health guidelines. Properly worn face coverings shall cover the nose, mouth, and chin. This should be in concert with the practice of maintaining at least six feet of physical distance from others at all times.

STAFF AND VISITORS

All employees, contractors, and visitors working, visiting, or performing duties at CDCR institutions or DJJ facilities must wear either a polypropylene procedure mask (also referred to as a surgical mask), N95, or KN95 mask at all times while, except while:

1) Eating or drinking, if a minimum of six feet of physical distance is maintained from all others.
2) Alone in an office with the door closed.
3) Alone in a tower or enclosed control booth with no others present.
4) Outdoors, if a minimum of six feet of physical distance is maintained from all others. An appropriate mask must be kept on person at all times and must be worn if within six feet of others.

Under no circumstances shall a procedure or KN95 mask be worn as a substitute for an N95 respirator, which is required in specific areas of institutions and facilities.

HEADQUARTERS, REGIONAL, AND FIELD OFFICE STAFF

All staff working or performing duties at any CDCR, CCHCS, or DJJ headquarters, regional, and field office location shall practice physical distancing and properly wear facial coverings at all times, except as noted above. Staff may wear a cloth mask, N95, KN95 or polypropylene procedure mask (also referred to as a surgical mask) at these locations. Sleeve-style facial coverings (gaiter masks), bandanas, and facial coverings with exhalation valves or vents shall not be worn. These staff shall adhere to institutional face covering mandates when visiting any of the CDCR institutions or DJJ facilities.

INMATE-PATIENTS

Inmate-patients shall continue to use approved facial coverings made according to California Prison Industry Authority standards. Additionally, they may be provided procedure or KN95 masks. All inmate-patients on institutional grounds shall wear the approved facial coverings at all times, except while:

1) In assigned cell or in their immediate assigned bunk area.
2) Eating or drinking, if a minimum of six feet of physical distance is maintained from all others.
3) Showering, bathing, shaving, or performing oral hygiene in common areas, if a minimum of six feet of physical distance is maintained from all others.
4) Outdoors, if a minimum of six feet of physical distance is maintained from all others. An appropriate facial covering must be kept on person at all times and must be worn if within six feet of others.
5) Participating in outdoor firefighter training, such as the Forestry Training Program.

When staff observe inmate-patients failing to adhere to facial covering or physical distancing directives, the inmate-patient will be directed to return to their assigned housing. Further violations will result in corrective action and progressive discipline, including the following:

- Verbal Counseling
- Counseling Only Rules Violation Report
- Rules Violation Report

REASONABLE ACCOMMODATIONS AND RELIGIOUS ACCOMMODATIONS

Staff unable to wear an approved face covering due to a medical, mental health, or developmental disability shall notify their supervisor and Return-to-Work Coordinator to engage in the interactive process. Staff requesting a religious accommodation shall contact their local Equal Employment Opportunity Coordinator. Staff who have submitted a request for reasonable or religious accommodation due to the inability to comply with CDCR/CCHCS face covering or Personal Protective Equipment guidelines may request permission to remain off work using leave credits or an unpaid leave of absence pending a determination on their request. The Department shall engage in the interactive process with staff to ensure that a timely reasonable or religious accommodation determination is made.

REQUIREMENTS FOR NON-COMPLIANCE

All departmental supervisors and managers are responsible for ensuring subordinate staff consistently wear approved facial coverings correctly and practice physical distancing. When managers or supervisors observe a subordinate employee failing to adhere to facial covering or physical distancing directives, corrective action shall be taken in accordance with Department Operations Manual, Article 22, Employee Discipline, section 33030.8, Causes for Corrective Action. Progressive discipline includes the following:

- Verbal Counseling
- Employee Counseling Record (CDC Form 1123)
- Letter of Instruction
- Adverse Action or Rejection During Probation, dependent on the employee's tenure.

Additionally, supervisors and managers shall document each instance of non-compliance with any directives contained within this memorandum on facial coverings and physical distancing to track repeat offenses and take corrective and adverse actions, as appropriate.

For each instance of staff non-compliance, supervisors and managers shall immediately notify the respective Employee Discipline Unit, Employee Advocacy and Prosecution Team, Office of Legal Affairs, CDCR, or Performance Management Unit (PMU), CCHCS. The Non-Compliance Tracking Log shall be completed with information provided by each supervisor or manager and maintained by the respective Employee Discipline Unit, Employee Advocacy and Prosecution Team, Office of Legal Affairs, CDCR, or PMU, CCHCS. The Non-Compliance Tracking Log shall be retained until further notice and will be requested for, unannounced as well as regularly scheduled, audits or reviews.

Supervisors and managers who fail to enforce these directives shall also be subject to progressive discipline.

As a reminder, the Employee Discipline Unit or your area's assigned Health Care Employee Relations Officer in PMU are available to provide assistance throughout the progressive discipline process.

DISTRIBUTION AND STORAGE

Each institution and youth facility shall maintain an inventory of no less than two days' supply at each entrance gate at all times. Additional distribution locations throughout the institution or facility where staff may obtain extra masks throughout their shift or when working a double shift shall be established by the institution's Warden and Chief Executive Officer (CEO) or Superintendent for DJJ facilities.

Each institution's Chief Support Executive and Associate Warden, Business Services, or Chief Financial Officer for DJJ, shall develop a local operational procedure to ensure a ready supply of procedure masks are available and replenished at entry points and the additional distribution locations throughout the day.

Institutions and DJJ facilities shall ensure warehouse staff accept all procedure mask inventory delivered to their location and identify local processes for managing and anticipating needed inventory for staff. Institutions that exceed typical storage capacity may need to consider non-typical storage locations (e.g., gymnasiums, vocational education areas) for procedure masks, while adhering to standard storage requirements.

DISPOSAL OF PROCEDURE MASKS

Procedure masks are not intended to be used for more than one shift. Additionally, if an employee's mask is damaged or soiled, or if breathing through the mask becomes difficult, the employee shall remove the mask, discard it safely, and replace it with a new one. To safely discard a mask, the employee shall take the elastic from around the ears, avoid touching the front of the mask, as it may be contaminated, and place the mask in a non-bio hazard waste bin. The employee shall then wash their hands with soap and water or use hand sanitizer as soon as possible.

SUPPLY AND SUSTAINABILITY

PPE shall be ordered using established processes by submitting either a Purchase Requisition for CCHCS or Resource Request Message (ICS 213 RR) for CDCR. All transactions shall be recorded in Systems, Applications and Products (SAP) in a timely manner.

PPE USE IN SPECIFIC LOCATIONS

Please be aware that eye protective face shields do not constitute a facial covering. Eye protection, gowns, surgical masks, and N95 respirators should be worn within the attached appendix, "PPE Utilization Guidance in Specific Locations." Gowns can be assessed for their requirement, based on part with the activities listed above and the guidance below.

Staff, inmate-workers, or volunteers should wear the recommended PPE for that assignment, in addition to the minimum required facial covering (N95 respirator, surgical mask, cloth mask). N95 respirator and eye protection (goggles, safety glasses that cover the entire eye and sides of the face or face shields with side coverage) are indicated when engaged in activities with a high-risk area of transmission or high likelihood of infection (e.g. Health Facility Maintenance Worker).

N95 RESPIRATOR LENGTH OF TIME FOR USE

The length of time an individual could safely wear the N95 respirator may be different from person to person. The N95 respirator should only be worn for a **maximum of eight hours**. Should an employee work in excess of eight hours, a new N95 should be donned. However, if at anytime the respirator becomes damp/wet, visually dirty, or if an individual has difficulty breathing through the respirator after a short time (e.g. half an hour), he/she should remove and discard the respirator.

ATTACHMENTS:

Appendix 1: PPE Utilization Guidance in Specific Locations

The following guide refers to the staff, inmate workers, and residents in and around these locations. The PPE recommendations do NOT apply to the inmate/patients who are the population in question.

Population in the location	Staff, Residents, and Inmate work protection needed from the populations in the locations				
	N95 Respirator	Surgical or Procedure Mask	Eye Protection	Gloves[2]	Gowns [2,4]
The Receiving and Release Processing (RRP) Areas and/or Reception Centers (RC)					
Symptomatic or asymptomatic Inmate/Patient (I/P) or confirmed/suspected COVID-19 I/P or in quarantine (Always wear an N95 in RRP and RC areas)	√	N/A	√	√	√
Areas where I/Ps are incoming from institutions/jail[3]	√	N/A	√	√	√
Custody Escort					
Escorting symptomatic or asymptomatic confirmed/suspected COVID-19 I/P or quarantined I/P	√	N/A	√	√	√
Escorting asymptomatic I/P[3] who is not quarantined or a suspect or confirmed case	N/A	√	√[2]	√	N/A
Transportation Vehicle					
All persons involved in vehicular transfers	√	N/A	√	√	N/A
All Those Working in the Correctional Treatment Center (CTC)					
If the CTC houses patients who have either influenza-like illness or suspected/confirmed COVID	√	N/A	√*	√*	√*
If the CTC has NO patients who have either influenza-like illness or suspected/confirmed COVID	N/A	√	√*	√*	√*
**If involved in close contact with patient*					
Outpatient Housing Unit (OHU)					
Symptomatic or asymptomatic confirmed/suspected COVID-19 I/P or quarantined I/Ps	√	NA	√	√	√
Asymptomatic I/P[3] who is not quarantined or a suspect or confirmed case and who is not sharing OHU airspace/ventilation with symptomatic, quarantined, or confirmed/suspected I/Ps	NA	√	√[2]	√	√
Quarantine/Precautionary Quarantine/Isolated Areas					
Symptomatic or asymptomatic I/P, symptomatic or asymptomatic confirmed/suspected COVID-19 I/P or quarantined I/P (Always wear an N95 in Quarantine and Isolation areas)	√	N/A	√	√	√
Pre/Post transfer Quarantine (no known exposure)	√	N/A	√	√	N/A
Control Booth					
Symptomatic or asymptomatic confirmed/suspected COVID-19 I/P or quarantined patient	√	N/A	√	√[2]	√[2]
Asymptomatic I/P[3] who is not in quarantine or a suspect or confirmed case	N/A	√	√[2]	√	N/A
Anyone Present During					
Procedure on a confirmed/suspected COVID-19 case that may generate respiratory aerosols	√	N/A	√	√	√
Collection of diagnostic respiratory specimens	√	N/A	√	√	√

Population in the location	Staff, Residents, and Inmate work protection needed from the populations in the locations				
	N95 Respirator	Surgical or Procedure Mask	Eye Protection	Gloves[2]	Gowns [2,4]
Field Staff (e.g., DAPO)[1] or Inmate Workers					
During face-to-face interview: Symptomatic I/P, quarantined or confirmed/suspected COVID-19 I/P	√	N/A	√	√	√
During face-to-face interview: Asymptomatic I/P[3] who is not in quarantine	N/A	√	√[2]	√	N/A

[1] *A cloth mask is not PPE. A face mask includes surgical mask, procedure mask, medical mask, KN95 respirators, etc.*

[2] *Field staff should identify the risk levels and adhere to standard precautions and determine the level of transmission-based precautions.*

[3] *PPE user should determine the reliability of the "Asymptomatic patient status" when the patient claims he/she has no symptoms.*

[4] *Gowns can be assessed for their requirement. Activities involving aerosol-generating procedures, the possibility of splashes and sprays, close contact activities, such as close bedside care and bathing, or direct handling of infectious waste require gowns.*

[5] *Field staff should identify the exposure risk levels and consider the outbreak and employee and resident case rate of the institution or housing unit.*

EXHIBIT 18

CDCR PATIENTS: CONFIRMED COVID-19 AND OUTCOMES

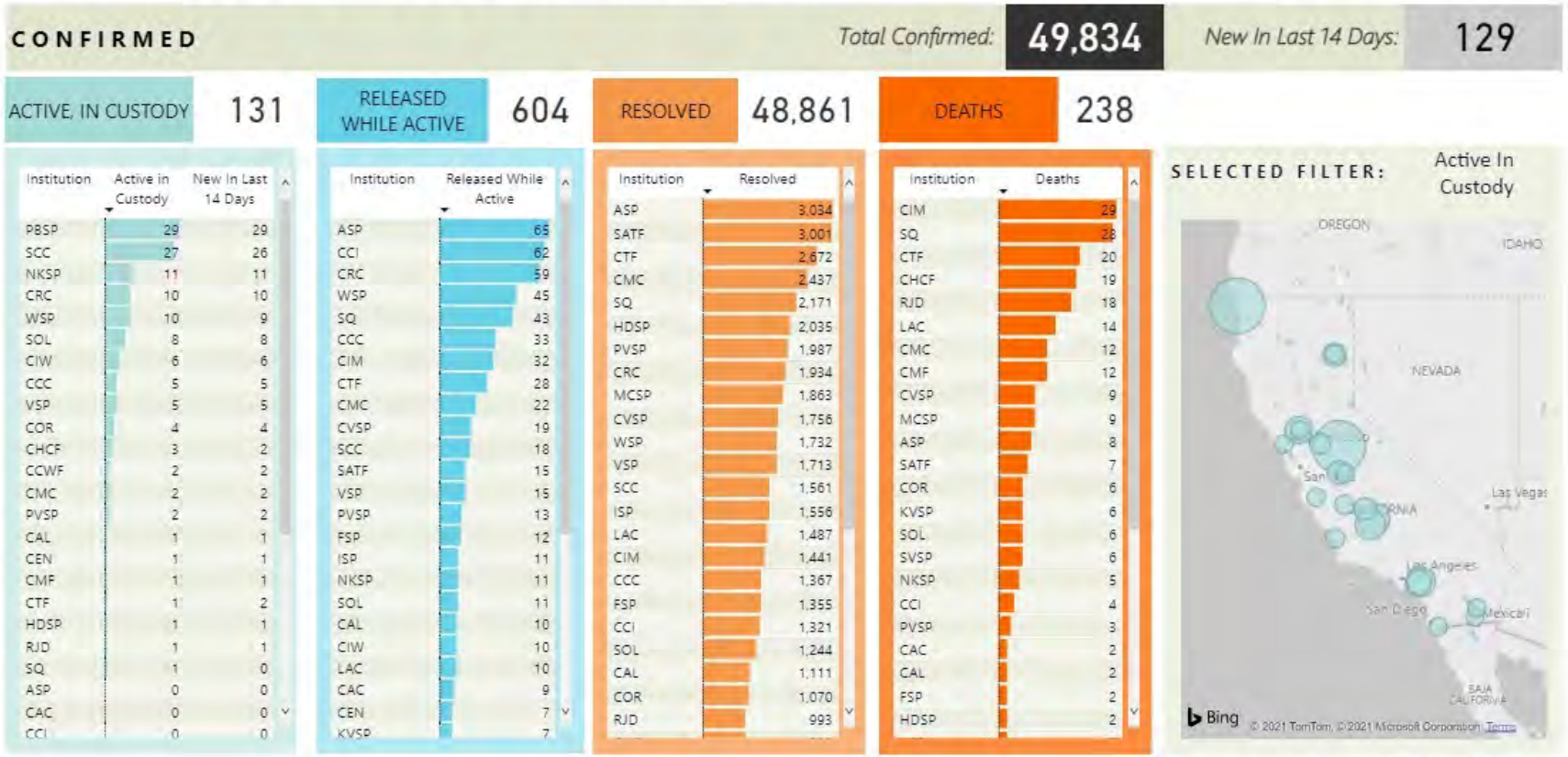

EXHIBIT 19

CDCR/CCHCS COVID-19 Employee Status

Current number of active staff cases: 642

Updated as of Aug. 27, 2021 (next update scheduled for Sept. 3)

Locations	Cumulative Confirmed	Staff Returned to Work	Active Cases	New Cases in Last 14 Days
Avenal State Prison (ASP)	**596**	**581**	**15**	**15**
California City Correctional Facility (CAC)	315	310	5	6
Calipatria State Prison (CAL)	408	399	9	10
California Correctional Center (CCC)	368	352	16	18
California Correctional Institution (CCI)	766	749	17	21
Central California Women's Facility (CCWF)	352	338	14	16
California State Prison, Centinela (CEN)	471	468	3	3
California Health Care Facility (CHCF), Stockton	808	784	24	25
California Institution for Men (CIM)	649	640	9	9
California Institution for Women (CIW)	420	408	12	13
California Men's Colony (CMC)	635	603	32	35
California Medical Facility (CMF)	415	408	7	7
California State Prison, Corcoran (COR)	862	826	36	36
California Rehabilitation Center (CRC)	544	534	10	10
Correctional Training Facility (CTF)	398	390	8	9
Chuckawalla Valley State Prison (CVSP)	316	313	3	5
Deuel Vocational Institution (DVI)	285	283	2	2
Folsom State Prison (FSP)	292	276	16	16
High Desert State Prison (HDSP)	686	650	36	36
Ironwood State Prison (ISP)	445	429	16	16
Kern Valley State Prison (KVSP)	658	633	25	25
California State Prison, Los Angeles County (LAC)	690	681	9	9
Mule Creek State Prison (MCSP)	536	522	14	15
North Kern State Prison (NKSP)	685	667	18	18
Pelican Bay State Prison (PBSP)	437	389	48	49
Pleasant Valley State Prison (PVSP)	491	481	10	10
Richard J. Donovan Correctional Facility (RJD)	602	592	10	10

Locations	Cumulative Confirmed	Staff Returned to Work	Active Cases	New Cases in Last 14 Days
California State Prison, Sacramento (SAC)	481	460	21	22
California Substance Abuse Treatment Facility and State Prison, Corcoran (SATF-CSP, Corcoran)	762	736	26	26
Sierra Conservation Center (SCC)	346	315	31	36
California State Prison, Solano (SOL)	369	352	17	17
San Quentin State Prison (SQ)	495	485	10	11
Salinas Valley State Prison (SVSP)	662	647	15	15
Valley State Prison (VSP)	345	326	19	21
Wasco State Prison (WSP)	615	601	14	14
Northern California Youth Correctional Center (NCYCC)	45	43	2	2
NA Chaderjian Youth Correctional Facility (NAC)	61	58	3	3
OH Close Youth Correctional Facility (OH Close)	38	35	3	3
Pine Grove	12	12	0	0
Ventura	83	81	2	2
Richard A. McGee Correctional Training Center, Galt	139	126	13	15
Alameda County	2	2	0	0
Fresno County	21	21	0	0
Humboldt County	1	1	0	0
Imperial County	9	9	0	0
Kern County	24	24	0	0
Los Angeles County	90	90	0	0
Mendocino County	2	2	0	0
Merced County	2	2	0	0
Monterey County	3	3	0	0
Orange County	14	14	0	0
Riverside County	20	20	0	0
Sacramento County	475	433	42	45
San Bernardino County	69	69	0	0
San Diego County	5	5	0	0
San Francisco County	3	3	0	0
San Joaquin County	14	14	0	0
San Luis Obispo County	0	0	0	0
San Mateo County	1	1	0	0
Santa Barbara County	2	2	0	0
Santa Clara County	5	5	0	0

Locations	Cumulative Confirmed	Staff Returned to Work	Active Cases	New Cases in Last 14 Days
Solano County	3	3	0	0
Stanislaus County	1	1	0	0
Tulare County	2	2	0	0
Ventura County	6	6	0	0
Yolo County	2	2	0	0
STATEWIDE TOTAL	**19359**	**18717**	**642**	**676**

Current number of COVID-19 related staff deaths: 29

1. May 30, 2020—Staff member from California Rehabilitation Center
2. July 11, 2020—Staff member from North Kern State Prison
3. July 21, 2020—Staff member from California Correctional Institution
4. July 24, 2020—Staff member from Centinela State Prison
5. July 26, 2020—Staff member from Central California Women's Facility
6. July 27, 2020—Staff member from Ironwood State Prison
7. Aug. 2, 2020—Staff member from Valley State Prison
8. Aug. 9, 2020—Staff member from San Quentin State Prison
9. Oct. 4, 2020—Staff member from Wasco State Prison
10. Dec. 14, 2020—Staff member from Mule Creek State Prison
11. Dec. 25, 2020—Staff member from California State Prison, Los Angeles County
12. Jan. 3, 2021—Staff member from Valley State Prison
13. Jan. 7, 2021—Staff member from Centinela State Prison
14. Jan. 9, 2021—Staff member from California Health Care Facility
15. Jan. 11, 2021—Staff member from Richard J. Donovan Correctional Facility
16. Jan. 11, 2021—Staff member from Valley State Prison
17. Jan. 15, 2021—Staff member from Salinas Valley State Prison
18. Jan. 15, 2021—Staff member from Correctional Training Facility
19. Jan. 17, 2021—Staff member from California Institution for Men
20. Jan. 17, 2021—Staff member from California Institution for Men
21. Jan. 20, 2021—Staff member from Deuel Vocational Institution
22. Jan. 20, 2021—Staff member from Chuckawalla Valley State Prison
23. Jan. 21, 2021—Staff member from Correctional Training Facility
24. Jan. 26, 2021—Staff member from California Institution for Women
25. Feb. 1, 2021—Staff member from Calipatria State Prison
26. Feb. 20, 2021—Staff member from California Institution for Women
27. March 7, 2021—Staff member from Sacramento County
28. May 3, 2021— Staff member from California Institution for Women
29. July 27, 2021— Staff member from California City Correctional Facility
30. Aug. 4, 2021– Staff member from Substance Abuse Treatment Facility and State Prison, Corcoran

EXHIBIT 20

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
State Public Health Officer & Director

State of California—Health and Human Services Agency
California Department of Public Health

GAVIN NEWSOM
Governor

August 5, 2021

TO: All Californians

SUBJECT: Health Care Worker Vaccine Requirement

Related Materials: Health Care Worker Vaccine Requirement Q&A

State Public Health Officer Order of August 5, 2021

The COVID-19 pandemic remains a significant challenge in California. COVID-19 vaccines are effective in reducing infection and serious disease. At present, 63% of Californians 12 years of age and older are fully vaccinated with an additional 10% partially vaccinated. California is currently experiencing the fastest increase in COVID-19 cases during the entire pandemic with 18.3 new cases per 100,000 people per day, with case rates increasing ninefold within two months. The Delta variant is highly transmissible and may cause more severe illness. In fact, recent data suggests that viral load is roughly 1,000 times higher in people infected with the Delta variant than those infected with the original coronavirus strain, according to a recent study. The Delta variant is currently the most common variant causing new infections in California.

Unvaccinated persons are more likely to get infected and spread the virus, which is transmitted through the air. Most current hospitalizations and deaths are among unvaccinated persons. Thanks to vaccinations and to measures taken since March 2020, California's health care system is currently able to address the increase in cases and hospitalizations. However, additional statewide facility-directed measures are necessary to protect particularly vulnerable populations, and ensure a sufficient, consistent supply of workers in high-risk health care settings.

Hospitals, skilled nursing facilities (SNFs), and the other health care facility types identified in this order are particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations including hospitalization, severe illness, and death. Further, the settings in this order share several features. There is frequent exposure to staff and highly vulnerable patients, including elderly, chronically ill, critically ill, medically fragile, and disabled patients. In many of these settings, the patients are at high risk of severe COVID-19 disease due to underlying health conditions, advanced age, or both.

Vaccinations have been available in California from December 2020 to the present, and from January 1, 2021, to July 12, 2021, a total of 9,371 confirmed COVID-19 outbreaks and 113,196 outbreak-related cases were reported to CDPH. Increasing numbers of health care workers are among the new positive cases, despite vaccinations being

prioritized for this group when vaccines initially became available. Recent outbreaks in health care settings have frequently been traced to unvaccinated staff members.

Vaccination against COVID-19 is the most effective means of preventing infection with the COVID-19 virus, and subsequent transmission and outbreaks. As we respond to the dramatic increase in cases, all health care workers must be vaccinated to reduce the chance of transmission to vulnerable populations.

For these reasons, COVID-19 remains a concern to public health and, in order to prevent its further spread in hospitals, SNFs, and other health care settings, new public health requirements are necessary at this time.

NOW, THEREFORE, I, as State Public Health Officer of the State of California, order:

1. All workers who provide services or work in facilities described in subdivision (a) have their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30, 2021:

a. Health Care Facilities:

i. General Acute Care Hospitals
ii. Skilled Nursing Facilities (including Subacute Facilities)
iii. Intermediate Care Facilities
iv. Acute Psychiatric Hospitals
v. Adult Day Health Care Centers
vi. Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
vii. Ambulatory Surgery Centers
viii. Chemical Dependency Recovery Hospitals
ix. Clinics & Doctor Offices (including behavioral health, surgical)
x. Congregate Living Health Facilities
xi. Dialysis Centers
xii. Hospice Facilities
xiii. Pediatric Day Health and Respite Care Facilities
xiv. Residential Substance Use Treatment and Mental Health Treatment Facilities

b. Two-dose vaccines include: Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization. The one-dose vaccine is: Johnson and Johnson [J&J]/Janssen. All COVID-19 vaccines that are currently authorized for emergency use can be found at the following links:

i. By the US Food and Drug Administration (FDA), are listed at the FDA COVID-19 Vaccines webpage.
ii. By the World Health Organization (WHO), are listed at the WHO COVID-19 Vaccines webpage.

c. "Worker" refers to all paid and unpaid individuals who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose. This includes workers serving in health care or other health care settings who have the potential for direct or indirect exposure to patients or SARS-CoV-2 airborne aerosols. Workers include, but are not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

2. Workers may be exempt from the vaccination requirements under section (1) only upon providing the operator of the facility a declination form, signed by the individual stating either of the following: (1) the worker is declining vaccination based on Religious Beliefs, or (2) the worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.

a. To be eligible for a Qualified Medical Reasons exemption the worker must also provide to their employer a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and indicating the probable duration of the worker's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).

3. If an operator of a facility listed above under section (1) deems a worker to have met the requirements of an exemption pursuant to section (2), the unvaccinated exempt worker must meet the following requirements when entering or working in such facility:

a. Test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services. Testing must occur twice weekly for unvaccinated exempt workers in acute health care and long-term care settings, and once weekly for such workers in other health care settings.

b. Wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering facepiece respirator, at all times while in the facility.

4. Consistent with applicable privacy laws and regulations, the operator of the facility must maintain records of workers' vaccination or exemption status. If the worker is exempt pursuant to section (2), the operator of the facility then also must maintain records of the workers' testing results pursuant to section (3).

a. The facility must provide such records to the local or state Public Health Officer or their designee promptly upon request, and in any event no later than the next business day after receiving the request.

b. Operators of the facilities subject to the requirement under section (1) must maintain records pursuant to the CDPH Guidance for Vaccine Records Guidelines & Standards with the following information: (1) full name and date of birth; (2) vaccine manufacturer; and (3) date of vaccine administration (for first dose and, if applicable, second dose).

c. For unvaccinated workers: signed declination forms with written health care provider's statement where applicable, as described in section (2) above. Testing records pursuant to section (3) must be maintained.

5. Nothing in this Order limits otherwise applicable requirements related to Personal Protective Equipment, personnel training, and infection control policies and practices.

6. Facilities covered by this Order are encouraged to provide onsite vaccinations, easy access to nearby vaccinations, and education and outreach on vaccinations, including:

a. access to epidemiologists, physicians, and other counselors who can answer questions or concerns related to vaccinations and provide culturally sensitive advice; and

b. access to online resources providing up to date information on COVID-19 science and research.

7. The July 26 Public Health Order will continue to apply.

8. This Order shall take effect on August 5, 2021, and facilities must be in full compliance with the Order by September 30, 2021.

9. This Order is issued pursuant to Health and Safety Code sections 120125, 120140, 120175,120195 and 131080 and other applicable law.

Tomás J. Aragón, MD, DrPH

Director and State Public Health Officer

California Department of Public Health

EXHIBIT 21

Public Health Order Questions & Answers: Health Care Worker Vaccine Requirement

8/20/2021

Related Materials: Health Care Worker Vaccine Requirement State Public Health Officer Order

Updates as of August 20, 2021:

- Added questions and answers for health care worker vaccine requirement

Are there any exemptions to the vaccination mandate?

The Order allows for two exemptions: (1) the worker is declining vaccination based on Religious Beliefs or (2) the worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.

What are Qualifying Medical Reasons?

To determine qualifying medical reasons, the physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician should refer to Interim Clinical Considerations for Use of COVID-19 Vaccines from the CDC, specifically, clinical considerations, as well as contraindications and precautions. The identified contraindications include:

- Documented history of severe allergic reaction to one or more components of all the COVID-19 vaccines available in the U.S.
- Documented history of severe or immediate-type hypersensitivity allergic reaction to a COVID-19 vaccine, along with a reason why you cannot be vaccinated with one of the other available formulations.

Additionally, the Interim Clinical Considerations for Use of COVID-19 Vaccines provides information on what are neither contraindications nor precautions to COVID-19 vaccination, which includes:

- Allergic reactions (including severe allergic reactions) not related to vaccines (COVID-19 or other vaccines) or injectable therapies, such as allergic reactions related to food, pet, venom, or environmental allergies, or allergies to oral medications.

Will the State be providing a template declination / exemption form for use?

No, the State will not be providing a template declination/exemption form for use. Facilities may use any existing form or process previously used for other mandated vaccines. If an entity does not have a previously used form, they should ensure that the requirements as stated in the Order are met, including written health care provider's statement where applicable, and testing records pursuant to section (3) of the Order.

Does a worker have to provide proof for a religious exemption?

The Public Health Order requires only that workers provide the operator of the facility a declination form, signed by the worker, stating that the worker is declining vaccination based on Religious Beliefs.

Do people exempt from vaccination need to be tested if they have had COVID in the last 90 days?

Workers meeting qualified exemptions from the vaccination requirement, who have recovered from a diagnosis of COVID-19 in the last 90 days, and remained asymptomatic, do not need to submit to testing until after 90 days has expired but must self-monitor for symptoms and continue to follow all other infection control requirements, including masking, as stated in the July 26 Order. Workers must provide documentation of previous diagnosis from a healthcare provider or confirmed laboratory results to refrain from testing. Workers must immediately follow self-isolation guidelines and resume testing if new COVID-19 symptoms occur during the 90 days post-infection.

Does this Order cover those who are not directly employed by the facility, but may be providing services or care in the facility? Is there a minimum frequency of time spent within a facility that falls under this Order that would make this Order apply to those who are not technically employed by the facility but provide service within the facility?

The Order applies to any individual who works in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose. This includes workers serving in health care or other health care settings who have the potential for direct or indirect exposure to patients or SARS-CoV-2 airborne aerosols. This would include workers, who may not be directly employed by the facility, but who are providing care on site at one of the covered facilities, as well as persons not directly involved in delivering health care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

What should a facility do if they suspect a fraudulent vaccine card is being presented as proof?

Facilities should work with their counsel and may report suspected cases of healthcare fraud to the U.S. Health and Human Services through their tip line at 1-800-HHS-TIPS or by using other ways to contact the hotline.

Which tests qualify for workers who have a valid exemption? (e.g., point of care tests, rapid tests, community testing sites and do tests need to be approved by the FDA?)

Antigen, PCR, or any Nucleic acid amplification (NAAT) test would qualify and must either have Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.

When does the Order take effect?

The Order will go into effect August 5, 2021.

Does a worker need to be fully vaccinated by September 30, 2021?

No. They must have either their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30, 2021.

Will the July 26 Public Health Order continue to apply?

Yes.

What facilities are impacted by the order?

The following health care facilities will be impacted by the Order:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities
- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

How will you verify workers are vaccinated or tested?

Each facility will be required to verify and keep record of vaccination status or test results. Pursuant the CDPH Guidance for Vaccine Records Guidelines & Standards, facilities have multiple options to verify vaccine status.

Will this take staff away from already busy hospitals?

Keeping both workers and patients safe is our top priority and the purpose of this Order. We do not believe it will take staff away from already busy hospitals.

Can a worker opt to regularly test instead of getting vaccinated?

No. Testing will be an alternate means for satisfying this Order only for those who are granted an exemption pursuant to the Order.

Is California the first to do this?

We are not aware of another state with such comprehensive requirements.

Is it everyone in these settings or just workers who interact with patients?

It applies to all individuals who are either paid or unpaid and are in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose.

Who will be responsible for enforcement of the requirements under this Order?

Each covered facility will be required to enforce the vaccine mandate and testing requirements of their respective staff (including any staff that may come from a contracted staffing agency).

To the extent that the covered facilities are subject to state regulation, the state's regulating entities will ensure each facility is meeting the requirements for vaccine verification/exemptions. For example, the California Department of Public Health will enforce this requirement at hospitals, skilled nursing facilities, intermediate care facilities, and the other health care facilities it licenses; and the Department of Health Care Services will enforce this requirement at residential substance use treatment and mental health treatment facilities. Local health jurisdictions may also enforce the orders.

Are High Risk Congregate Settings covered under this Order?

No. Those settings—Adult and Senior Care Facilities, Homeless Shelters, and State and Local Correctional Facilities — remain covered by the July 26 Order. Additionally, State and Local Correctional Facilities with integrated health care settings are subject to the State Public Health Officer’s August 19 Order.

Are dental offices included in this Order?

No. Dental offices are not included in this Order.

EXHIBIT 22

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
State Public Health Officer & Director

State of California—Health and Human Services Agency
California Department of Public Health

GAVIN NEWSOM
Governor

August 19, 2021

TO: All Californians

SUBJECT: State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement

State Public Health Officer Order of August 19, 2021

I, as State Public Health Officer of the State of California, order:

1. All individuals in section (2) below must have their first dose of a one-dose regimen or their second dose of a two-dose regimen by October 14, 2021:

    a. Two-dose vaccines include: Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization. The one-dose vaccine is: Johnson and Johnson [J&J]/Janssen. All COVID-19 vaccines that are currently authorized for emergency use can be found at the following links:

        i. By the US Food and Drug Administration (FDA), are listed at the FDA COVID-19 Vaccines webpage.

        ii. By the World Health Organization (WHO), are listed at the WHO COVID-19 Vaccines webpage.

2. The following workers are subject to the requirements of this Order:

a. All paid and unpaid individuals who are regularly assigned to provide health care or health care services to inmates, prisoners, or detainees. This may include nurses, nursing assistants, nurse practitioners, physicians, physician assistants, technicians, therapists, phlebotomists, pharmacists, mental health providers, students and trainees, dietary, and contractual staff not employed by the correctional facility or detention center.

b. All paid and unpaid individuals who are regularly assigned to work within hospitals, skilled nursing facilities, intermediate care facilities, or the equivalent that are integrated into the correctional facility or detention center in areas where health care is provided. This includes workers providing health care to inmates, prisoners, and detainees, as well as persons not directly involved in delivering health care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, janitorial services, laundry, correctional officers, facilities maintenance staff, administrative, inmate workers, and volunteer personnel).

3. Workers in section (2) may be exempt from the vaccination requirements under section (1) only upon providing the operator of the correctional facility or detention center a declination form, signed by the individual stating either of the following: (1) the worker is declining vaccination based on religious beliefs, or (2) the worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.

a. To be eligible for a Qualified Medical Reasons exemption the worker must also provide to their employer a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and indicating the probable duration of the worker's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).

4. If an operator of a correctional facility or detention center deems a worker to have met the requirements of an exemption pursuant to section (3), the unvaccinated exempt worker must meet the following requirements when entering or working in such facility:

a. Test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services. Testing must occur twice weekly for unvaccinated exempt workers in acute health care and long-term care settings, and once weekly for such workers in other health care settings.

b. Wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering facepiece respirator, at all times while in the facility.

5. Consistent with applicable privacy laws and regulations, the operator of the correctional facility or detention center must maintain records of workers' vaccination or exemption status. If the worker is exempt pursuant to section (3), the operator of the correctional facility or detention center then also must maintain records of the workers' testing results pursuant to section (4).

a. The correctional facility or detention center must provide such records to the local or state Public Health Officer or their designee promptly upon request, and in any event no later than the next business day after receiving the request.

b. Operators of correctional facility or detention center facilities subject to this Order must maintain records pursuant to the CDPH Guidance for Vaccine Records Guidelines & Standards with the following information: (1) full name and date of birth; (2) vaccine manufacturer; and (3) date of vaccine administration (for first dose and, if applicable, second dose).

c. For unvaccinated workers: signed declination forms with written health care provider's statement where applicable, as described in section (3) above. Testing records pursuant to section (3) must be maintained.

6. Nothing in this Order limits otherwise applicable requirements related to Personal Protective Equipment, personnel training, and infection control policies and practices.

7. Facilities covered by this Order are encouraged to provide onsite vaccinations, easy access to nearby vaccinations, and education and outreach on vaccinations, including:

a. access to epidemiologists, physicians, and other counselors who can answer questions or concerns related to vaccinations and provide culturally sensitive advice; and

b. access to online resources providing up to date information on COVID-19 science and research.

8. The July 26 Public Health Order will continue to apply.

9. This Order shall take effect on August 19, 2021, and facilities must be in full compliance with the Order by October 14, 2021.

10. This Order is issued pursuant to Health and Safety Code sections 120125, 120140, 120175,120195 and 131080 and other applicable law.

Tomás J. Aragón, MD, DrPH

Director and State Public Health Officer

California Department of Public Health
PO Box, 997377, MS 0500, Sacramento, CA 95899-7377
Department Website (cdph.ca.gov)

EXHIBIT 23

AMEND
CHANGING CORRECTIONAL CULTURE

Berkeley Public Health

Urgent Memo

COVID-19 Outbreak: San Quentin Prison

June 15, 2020

San Quentin California State Prison is experiencing a rapidly evolving COVID-19 (SARS-CoV-2) outbreak with profoundly inadequate resources to keep it from developing into a full-blown local epidemic and health care crisis in the prison and surrounding communities. The urgent resources San Quentin requires range from human capital to environmental risk reduction and rapid testing. Failure to meet these urgent needs will have dire implications for the health of people incarcerated at San Quentin, custody, staff, and the healthcare capacity of Bay Area hospitals. This document provides suggested guidance on immediate actions needed to address the outbreak with emphasis on both the short- and longer-term health of people currently incarcerated at San Quentin.

Background

San Quentin arrives at this tenuous moment with several significant assets including a strong Chief Medical Executive (Dr. Alison Pachynski) and a Chief Physician and Surgeon (Dr. Shanon Garrigan) who have spent the past 3.5 months doing everything in their power to prepare for an unavoidable COVID-19 outbreak. However, these two physicians, even with the enormous assistance they have received from many other healthcare staff, including a strong public health nurse, and a notably excellent partnership with custody leadership (Acting Warden Ronald Broomfield and the recently arrived Health Care Chief Executive Clarence Cryer), is simply not enough to meet the needs at San Quentin. As a result, there are multiple vulnerabilities that we witnessed at San Quentin during our visit on June 13, 2020 which must be urgently addressed to protect the health and safety of the thousands of people incarcerated there as well as staff and surrounding community members.

Although this memo outlines the urgent needs of San Quentin Prison, it is our belief that most – if not all – of these recommendations are important for all California Prisons that are certain to experience an outbreak if they have not already.

Urgent needs and immediate actions required:

1. **Develop a COVID-19 Outbreak Emergency Response Team:** At present, the over-reliance on existing local medical and custody staff to develop an outbreak response plan means that they are tasked with making multiple acute decisions on a daily basis without adequate resources, options, or support to operationalize a centralized plan or long term strategy. This responsibility – overwhelming on its own – is then magnified with the additional necessity of providing

implementation oversight of the ad-hoc outbreak plan. Instead, local leadership should have a team of staff who can implement and recommend adjustments to the overarching central COVID-19 control strategy as needed on the local level. There simply do not appear to be sufficient on-the-ground staff who are not working from home. This daily management of the acute phase of the outbreak has the secondary effect of making the lead physicians less available to coordinate the care and treatment of patients incarcerated at San Quentin who become acutely ill in the facility and also increases the vulnerability of San Quentin to errors with potentially dire consequences. Minimum positions required for such a team are included below. Dr. Pachynski and Dr. Garrigan appear to be personally responsible for all of the tasks described below with insufficient tools to support their success. While there may be some central guidance and support offered, additional human capital is urgently needed to achieve the CCHCS's pandemic response goals.

Minimum Recommended Leadership Team Positions:

- **Environment of Care Leader.** This position would be responsible for evaluating and addressing immediate needs regarding the physical plant of the prison for ventilation, sanitation, path of patient flow (e.g., developing policies and procedures for how people incarcerated at San Quentin who become infected are transferred through and out of the institution for care) and planning for how to reconfigure and reimagine needed space for quarantine, general population, or medical isolation units depending on how the number of affected people increases or decreases over time. This position would also work with plant operations to ensure that all air vents are cleaned and well functioning and would organize the creation of (a) field hospital(s) or quarantine tents as needed.

- **Healthcare – Custody Coordination Leader.** This position would focus on coordinating with Custody (and working closely with the Staff Healthcare Liaison Leader, described below) to review current placement on a daily basis, and to determine the appropriate way to cohort people currently incarcerated at San Quentin, staff, and custody including developing quarantine areas (in partnership with the Environment of Care Leader) to minimize risk of infection. This position would also be responsible for ensuring that all transfers *into* San Quentin are halted and that appropriate and timely testing is done to facilitate transfer out of Medical Isolation and Quarantine within the facility, to the community, and – in certain circumstances - to other facilities if medically necessary.

- **COVID-19 Testing Leader.** This position would be responsible for coordinating with the testing center (at this moment, QUEST Diagnostics) including reaching out through public and private sources and coordinating with the state and local departments of public health to improve testing turnaround time, running the list with medical staff (and the Epidemiologist, described below) on a daily basis to determine who has – and who needs – testing, and coordinating contact tracing in response to testing results and reporting of symptoms throughout the facility.

- **Staff Healthcare Liaison Leader.** This position would work with custody leadership (and Union representatives, as appropriate) to cohort staff/custody, develop plans that eradicate staff/custody working within more than one unit in rapid succession, train and enforce PPE rules, support contact tracing and administrative leave needs among exposed and infected staff/custody, and investigate alternatives to potential staff/custody transmission opportunities such as shared vanpools. This position would also track daily staff movements in order to assist with contact tracing when needed.

- **Epidemiologist Analyst Leader.** This position would be responsible for maintenance of a line listing of all active and resolved cases (people incarcerated at San Quentin and staff) and for all data analysis and reporting. This position would also be responsible for a "patient tracking process" of the facility including daily review of the COVID-19 Monitoring Registry to provide close scrutiny of who has tested positive or is in quarantine – where they are currently located (and were recently located), and the same for those who have tested negative. In addition, this position would assist the Environment of Care leader and the Healthcare – Custody Coordination Leader to manage patient movement to quickly clear people when they have tested negative and return them to the General Population and/or to the community. This position would also manage testing data (e.g., in the Reception Area, some have been tested 3-4 times and test results are coming in at different times).

2. **Address Unsafe Overcrowding.** There are currently 3547 people in total incarcerated at San Quentin, approximately ~1400 of whom have at least one COVID-19 risk factor (as do many, unknown, staff members). This means these individuals are at heightened risk of requiring ICU treatment and/or mortality if infected. We detail the units of most immediate concern below. Given the unique architecture and age of San Quentin (built in the mid 1800s and early 1900s), there is exceedingly poor ventilation, extraordinarily close living quarters, and inadequate sanitation. **We therefore recommend that the prison population at San Quentin be reduced to 50% of current capacity (even further reduction would be more beneficial) via decarceration**; this will allow every cell in North and West blocks to be single-room occupancy and would allow leadership at San Quentin to prioritize which units to depopulate further including the high-risk reception center and gymnasium environments. It is important to note that we spoke to a number of incarcerated people who were over the age of 60 and had a matter of weeks left on their sentences. It is inconceivable that they are still in this dangerous environment.

Housing units of most concern at San Quentin at present time:

- **North Block and West Block** have cells with open-grills, and are each 5-tier buildings with a capacity of 800 persons. Ventilation is poor – windows have been welded shut and the fan system does not appear to have been turned on for years; heat on the far side of the building can be stifling. Over 50% of those incarcerated in these units have at least 1 COVID-19 risk factor, and an alarming ~300 have 4 or more COVID-19 risk factors. An outbreak in North and West blocks could easily flood – and overwhelm – San Quentin as well as Bay

Area hospitals. (For example, see San Francisco hospital capacity: https://data.sfgov.org/stories/s/Hospital-Capacity/qtdt-yqr2/)

- **Reception center** currently has ~500 persons. In the reception Center's "Badger Unit" where people from CIM were transferred, the fear and outrage among the people incarcerated are palpable – people are yelling throughout the housing unit due to discontent about the COVID-19 situation including intake of transfers from CIM and loss of privileges/disruption to daily routine (thereby increasing the risk of COVID-19 spread throughout the tiers via respiratory droplets). It is hard to imagine that as a result of these conditions, that violent incidents will not occur—further threatening the safety and health of the people incarcerated in these units and staff alike.

- **The Gymnasium**, which has been converted to a dorm. There is little to no ventilation in this unit creating high-risk for a catastrophic super spreader event.[1] At a minimum, the gymnasium beds should be spread out more to ensure additional distance between beds, and the second set of doors in the gymnasium dorm must be opened to ensure air turnover. **This unit should be prioritized for closure as a dorm, once sufficient population reduction has been achieved through release.**

- **HVAC – in all units above and in other areas,** there is an immediate need to clean and turn on all fan and HVAC systems immediately (e.g., North Block, Gymnasium, Dorms) in order to maximize air exchange and ventilation as soon as possible. Of note, the exhaust pumps and filters appear dirty on visual inspection, and require clearing and cleaning. Since maximizing air exchange through better ventilation decreases COVID-19 transmission, doors and windows should be opened as much as possible (some have been welded shut and must be remediated). Note that the important aspect is *air exchange*, not the movement of air within the room. Fans that blow air around may help cool people, but they don't decrease rebreathing aerosols unless they filter the air or increase air exchange (diluting the aerosol).

3. **Immediately Improve Testing.** It is inconceivable that in the Bay Area the medical leadership at San Quentin is having to manage an outbreak in their massive antediluvian facilities with PCR tests on a 5-6 day turn-around time. We would argue that there is no higher testing priority for around 100 miles and resources need to be shifted immediately to respond or there will be a massive, uncontrollable outbreak (if it is not too late already). In addition (and this certainly goes without saying), **transfers into San Quentin must be halted immediately**. **Further, priority must be placed on reducing the prison population at San Quentin via decarceration as it will be extremely difficult to ensure the health and safety of all people in this extraordinarily old and**

[1] It is important to recognize that all of our recommendations regarding ventilation in different housing units at San Quentin were based on the observations of a team of public health professionals accompanying San Quentin medical staff. Although incarcerated persons and custody staff shared their understanding of the ventilation systems in the units and their operability, we neither had the opportunity to speak with any of the facilities staff nor were any members of our team experts in HVAC. We would strongly recommend seeking the advice of such experts and monitoring CO2 levels in different parts of the prison as one easy measure of the extent of rebreathing in a housing unit.

complex facility. The following recommendations both support these imperatives and, in some cases, are dependent on their implementation:

- **Liaise with testing laboratory to streamline testing,** including exploring observed self-collection of samples and alternate anatomic sites of testing (e.g. saliva, nares swabs).

- **Improve testing turnaround time at QUEST or go through other laboratories that will be able to improve turnaround time (5-6 days or more is completely unacceptable).** As an example, CMC was able to rapidly respond to their outbreak with a turnaround testing time of 24 hours at some points in the outbreak. Large-scale testing with rapid receipt of results is essential to allow the medical team to minimize community spread. If tests are sent to laboratories other than QUEST, support must be provided to San Quentin to add these results to the EMR as the current process of scanning and manual entry is overly laborious and resulting delays may lead to medical decisions based on outdated data.

- **The California Department of Public Health** should be compelled to prioritize specimens from San Quentin given the potential for super-spreading in that environment.

- **Testing of symptomatic patients must be done with individual testing. Testing of asymptomatic patients to identify people who are shedding virus can be done with pools of samples. Without additional information, pools of 10 should be used.** This approach can be used for frequent retesting of people at especially high risk of spreading the virus (staff/custody and people incarcerated in larger units — i.e. almost all of San Quentin).

- **San Quentin requires on-site testing –** including cartridges and well-trained staff to conduct these (currently they have inadequate staffing to conduct mass swabbing). Sample transport just adds time. San Quentin will need high volume testing for many months, perhaps years. They should have testing capacity on-site and available round-the-clock.

- **Of note, because testing time is so slow, little to no contact tracing can happen. Furthermore, people incarcerated at San Quentin cannot be appropriately transferred within the prison based on test results if results are returned 6 days later and new exposure may have occurred in the interim.** As a result, *entire units are put on lockdown status for the span of a quarantine*. This is not a viable solution. In the long term, as this pandemic will last at least another year and likely longer, this will have profound physical and mental health consequences for the incarcerated population and staff alike.

4. **Develop Additional Medical Isolation and Quarantine Housing.**

Background: It is our understanding that on May 30, transfers from CIM arrived at San Quentin on five buses. Several among those who were transported on Bus 5 tested positive at arrival. While all transfers on Bus 1 and 3 initially tested negative, several later developed COVID-19 symptoms. At the time of our visit, there were no reports of symptoms or positive tests among those who traveled on Buses 2 and 4. At the advice of the local health

department, all individuals from the five CIM buses who tested positive or reported symptoms were placed in the Adjustment Center. Those who either tested negative or did not report symptoms were placed individually and in every other cell on the Reception Area's Badger and Donner Units 4th and 5th tiers (among people who were incarcerated at San Quentin prior to the transfer).

June 13 Visit: As of our visit, those requiring *Quarantine* (i.e., people with a credible exposure to COVID-19 who are asymptomatic) are in the Reception Area's Carson Unit. Those requiring *Medical Isolation* (who have tested positive for COVID-19 **or** who have symptoms suggestive of COVID-19 and are still awaiting testing) are in the Adjustment Center as this is the only unit at San Quentin that has single cells with solid doors. Per our notes, there are ~106 cells in the Adjustment Center, with ~80 occupied at the time of our visit.

Urgent Concerns:

1. A massive outbreak at San Quentin will significantly and quickly overwhelm the availability of these 106 Adjustment Center cells, and there will quickly be nowhere for infectious cases to be moved. Further, we cannot emphasize enough the incredible fear that residents we spoke with expressed about being moved to cells typically used for administrative segregation/punishment or "death row" – potentially resulting in short- and long-term mental health consequences. Especially given that early identification of suspected COVID-19 cases depends on reporting of symptoms, **quarantine strategies relying on the Adjustment Center or cells usually used for punishment may thwart efforts for outbreak containment as people may be reluctant to report their symptoms**. In addition, people with COVID-19 are known to experience rapid physical decompensation; it may therefore be particularly detrimental for a patient with COVID-19 to be behind a solid door in the most secure areas of the prison out of the sight of medical or nursing staff in the case of an emergency. This may be particularly risky if there are structural barriers to communicating distress to staff (e.g., if accomodations are not readily accessible for people with disabilities or who speak other languages, and/or there are multiple security stages to pass through).

Given San Quentin's antiquated facilities, poor ventilation, and overcrowding, **it is hard to identify any options at San Quentin where it is advisable to house high-risk people with multiple COVID-19 risk factors for serious morbidity or mortality**. Again, for these reasons it will be exceedingly hard for medical staff to keep people safe from contracting COVID-19 at San Quentin and, once infected, it will be very hard to ensure that they do not pass the infection on to others with high health risks or experience rapid health declines themselves. **San Quentin is an extremely dangerous place for an outbreak, everything should be done to decrease the number of people exposed to this environment as quickly as possible.**

Our recommendations for Quarantine and Medical Isolation are as follows:

- Immediately create a field hospital by **converting nearby chapels (there are 3) or even the chow hall.** This field hospital can be designated for all people with confirmed COVID-19 ("Medical Isolation Unit") as there are not substantial risks to isolating infected patients together and these patients would then have access to supervising nurses who could regularly check their respiratory status and comfort levels. Such a unit could have different tiers of medical supervision as some people in medical isolation will be asymptomatic and will not require as close medical supervision. The chapels are large rooms with road access for ambulances and other transport. We recognize the plans for assigning units will become increasingly complex as people of multiple security levels require Quarantine or Medial Isolation. **This again reinforces the need for release** and a dedicated team leader (the **Healthcare – Custody Coordination Leader)** who oversees the work of partnering with custody to identify medically appropriate cohorting solutions.

- **For those currently in the Adjustment Center:** As individuals test negative (via recovery or because they never developed infection) they ideally should be moved out of the Adjustment Center as quickly as possible. However, with evidence of community spread at San Quentin, extreme caution must be exercised when moving persons out of the Adjustment Center who test negative for COVID-19 and who are at high risk for poor health outcomes if infected. For these individuals, we strongly recommend that central administration work with medical leaders at San Quentin to identify options for safer placement of individuals leaving the Adjustment Center (perhaps in temporary tents) or in other CDCR facilities (transfers would have to happen with exceptional caution given prior failure with transport including 2 weeks of quarantine on either side of transfer coupled with testing at the outset and end of 14-day quarantine in each site). Alternative housing options outside of San Quentin should also be explored, including nearby hotels or school dorms that can be converted in an effort to save lives. People at the Adjustment Center who test positive should be immediately moved to the new Medical Isolation Unit (e.g., in the converted chapels).

- **Physical and mental health during quarantine and medical isolation must be prioritized with adequate consideration for how need may vary across people incarcerated at San Quentin.** While awaiting testing results, people should receive resources to support their well-being as much as possible during isolation/14-day quarantine period (quarantine should not exceed 14 days after a single exposure). Such resources, at a minimum, should include free access to personal tablets with movies, increased access to free canteen items, personal effects and free phone calls, perhaps on state-owned cell phones, and daily opportunities for yard time. While some of these comforts may seem beyond the normal routine of prisons in California, they are simple, low-cost measures that are essential if there is any hope of minimizing the risk of adverse short- and long-term physical and mental health outcomes of isolation among those who are currently in the Adjustment Center for

quarantine or isolation. Alternatives for isolation or quarantine that do not involve the Adjustment Center must be immediately sought (e.g., quarantine tents or other areas of the prison where significant depopulation can allow for fewer occupied cells). **Ultimately, there are simply too few options for safe quarantine at San Quentin without prioritizing population reduction through release.**

5. **Improve General Prevention efforts throughout the facility.** In particular, we witnessed alarmingly suboptimal mask use by staff, and three "medical pass nurses" sitting in a work room without masks. Moreover, custody work stations are not set up to physically distance, no additional workstations appear to have been built yet. As a result, even with the best of efforts, officers wind up clustered near each other around a central podium. An infection control nurse and environmental assessment would go a long way towards identifying opportunities to partially alleviate these problems.

6. **Staff Cohorting is a necessity.** At present work shift plans are inadequate from a public health perspective. For example, we learned about staff who were working in the Medical Isolation Unit (Adjustment Center) during the shift and were scheduled to work the next shift in the dorms. This is an enormous risk for the spread of COVID-19 between units.

7. **Convene COVID-19 Inmates Council.** To ensure urgent health messaging is comprehensively communicated through trusted paths, we recommend that a COVID-19 Inmates Council be established (if one does not yet exist) in collaboration with any existing leadership groups/councils among people incarcerated at San Quentin. This council should be asked to provide critical feedback regarding all the above recommendations, how they may best be implemented and messaged to the population, and if there are considerations that have not been addressed that will maximize the urgent and long term health needs associated with this outbreak.

8. **Convene COVID-19 Inmate Family Council.** To ensure urgent health messaging is communicated to the families of people incarcerated at San Quentin, we recommend that a COVID-19 Inmate Family Council be established. This council may also provide critical feedback regarding all the above recommendations, how they may best be implemented, and if there are considerations that have not been addressed that will maximize the urgent and long term health needs associated with this outbreak.

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Amend at UCSF is a health-focused correctional culture change program led by experts in medicine, infectious diseases, public health, and correctional health and policy that is providing correctional leaders, policymakers, and advocates the evidence-based tools they need to protect the health and dignity of those who live and work in jails and prisons during the COVID-19 pandemic.

The University of California, Berkeley School of Public Health is working on the leading edge of research, educating the public, and mobilizing to serve California's most vulnerable populations during the COVID-19 pandemic.

For more information:

https://amend.us/covid

EXHIBIT 24

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2018 REVISION

Division of Correctional Health Care Services

Department of Corrections & Rehabilitation

TABLE OF CONTENTS

CHAPTER 5
Mental Health Crisis Bed

A. INTRODUCTION

The goal of the Mental Health Crisis Bed (MHCB) program is to provide services for conditions which require an inpatient setting to ameliorate mental health symptoms in the least restrictive environment. MHCB programs are located in California Department of Corrections and Rehabilitation (CDCR) institutions with facilities licensed as a Correctional Treatment Center (CTC) [California Code of Regulations (CCR), Title XXII, Division 5, Chapter 12, Article 4, Section 79739, Mental Health Treatment Program], General Acute Care Hospital (GACH), or Skilled Nursing Facility (SNF). The MHCB program operates 24 hours a day, 7 days a week. An inmate-patient admitted to the MHCB for mental health treatment may have acute symptoms of a serious mental disorder or may be suffering from a significant or life threatening disability. Refer also to the Correctional Treatment Center Policy and Procedure Manual, Volume VIII, Mental Health, for more detailed procedures.

Many conditions may precipitate a mental health crisis during institution confinement. At reception, the loss of the existing support system the individual had on the outside and/or the stress of initial imprisonment may lead to suicidal behavior, self-harm, or other symptoms. In mainline settings within institutions, stress factors unique to imprisonment may cause a pronounced degree of emotional strain and/or physical and interactive tension, and often compound existing stress factors inherent in everyday life. Such factors as the restrictions of confinement, pressures to conform to the prison lifestyle, and fear of more predatory inmates may disrupt an inmate's coping abilities. An inmate with no known mental health history may suffer acute symptoms, while another with mental illness in remission may have recurring symptoms. Prior to release, fears of delayed release or inability to cope with the outside world or loss of the institution support system of food, shelter, clothing, and structure of time may lead to crisis reactions.

The MHCB has a length of stay of up to ten days. The Chief Psychiatrist or designee, must approve exceptions to the length of stay. Not all crises require admission to the MHCB. Crisis episodes for some inmate-patients may be handled on an outpatient basis. Other inmate-patients, even if stabilized on medications, may require placement in a structured therapeutic environment for ongoing treatment and monitoring. This may necessitate a referral to an Enhanced Outpatient Program (EOP), or if longer-term intensive care is needed, to an inpatient facility operated by the Department of Mental Health (DMH).

Presenting problems may require continuous observation or monitoring before an inmate-patient's treatment needs can be fully assessed or the crisis brought under control. Where 24-

hour care is needed, an inmate-patient shall be placed in a MHCB for continuous nursing care.

B. PROGRAM OBJECTIVES

The primary objective of the MHCB is to evaluate the symptoms associated with the crisis and provide initial stabilization and recommendations for follow-up care, post discharge. More specific objectives include:

1. To observe, monitor, and provide continuous nursing assistance to inmate-patients whose condition requires 24 hours or more to achieve stabilization.

2. To assess the inmate-patient's symptoms, formulate a provisional or differential diagnosis, and develop an initial treatment plan. This may include a medical/neurological evaluation or an initiation of referral for such.

3. To control symptoms of serious mental illness, using emergency medication when necessary.

4. To alleviate psychiatric distress with appropriate therapy or counseling.

5. To refer the inmate-patient for placement in an appropriate level of care.

6. To provide an alternative to hospitalization for inmate-patients whose condition allows placement within ten calendar days to a less intensive level of care.

C. POPULATION SERVED

Overall Treatment Criteria

Overall treatment criteria have been developed for the Mental Health Services Delivery System (MHSDS). An inmate must meet the criteria in either 1 or 2 below in order to receive MHSDS treatment at any level of care:

1. Treatment and monitoring are provided to any inmate who has ***current*** symptoms and/or requires treatment for the current Diagnostic and Statistical Manual (DSM) diagnosed (may be provisional) Axis I serious mental disorders listed below:

   Schizophrenia (all subtypes)
   Delusional Disorder
   Schizophreniform Disorder
   Schizoaffective Disorder

Brief Psychotic Disorder
Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
Psychotic Disorder Due To A General Medical Condition
Psychotic Disorder Not Otherwise Specified
Major Depressive Disorders
Bipolar Disorders I and II

2. Medical Necessity: Mental health treatment shall be provided as needed. Treatment is continued as needed, after review by the Interdisciplinary Treatment Team (IDTT), for all cases in which:

Mental health intervention is necessary to protect life and/or treat significant disability/dysfunction in an individual diagnosed with, or suspected of having, a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT that the significant or life threatening disability/dysfunction continues or regularly recurs.

Specific Treatment Criteria for MHCB

In addition to the overall treatment criteria above, an inmate must meet the following specific criteria to receive treatment at the MHCB level of care:

- Marked impairment and dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour nursing care; and/or
- Dangerousness to Others as a consequence of a serious mental disorder/Dangerousness to Self.
- These conditions usually result in a Global Assessment of Functioning (GAF) score of less than 30.

D. REFERRAL AND TRANSFER

Referrals

An inmate-patient suffering from an acute, serious mental disorder resulting in serious functional disabilities, or who is dangerous to self or others, shall be referred to a MHCB.

MHCB Transfer

If the institution does not have a MHCB or there are no MHCB beds available in the institution where the inmate-patient is currently housed, the inmate-patient shall be

transferred to a designated MHCB institution. The inmate-patient shall be transferred within 24 hours of referral.

(See Inmate Medical Services Policies and Procedures, *Volume 4, Chapter 3, Health Care Transfer Process* and *Volume 6, Chapter 18, Transfer of Patient Health Records Within CDCR; Institution to Institution*, for specific requirements concerning transfers and Unit Health Records)

If the MHCB beds are not available at the designated hub institution, the inmate-patient shall be taken to an available MHCB bed that is able to provide MHCB care while simultaneously providing the commensurate level of custody and security. In most cases, movement from an institution to a MHCB bed shall be completed by institutional transportation staff via special transport within 24 hours. On weekends and after normal business hours, the mental health clinician on call or the physician on call at the referring institution shall contact the mental health clinician on call or the physician on call at other institutions to locate a vacant MHCB bed. **The Health Care Placement Oversight Program (HCPOP) may be contacted seven days a week to assist in locating a vacant MHCB bed.**

MHCB transfers shall be done under authority as "Emergency Medical Transfers" (Department Operations Manual [DOM] 62080.17). Since MHCB transfers are typically viewed as emergency moves, they do not require classification committee action or Classification Staff Representative (CSR) endorsement. MHCB transfers shall be done on a "Psychiatric and Return" basis.

Generally, the transfer process shall be initiated by the inmate-patient's psychiatrist, psychologist, or the Chief of Mental Health.

The transferring psychiatrist, psychologist, or Chief of Mental Health shall determine whether the inmate-patient is "medically cleared" to transfer. State law provides that, before a patient may be transferred to a health facility, the patient must be sufficiently stabilized to be safely transported. The transferring physician is responsible for determining whether the inmate-patient's condition will allow transfer. The CCR provides, in part, that a transfer or discharge may not be carried out if, in the opinion of the inmate-patient's physician, such transfer or discharge would create a medical hazard. The transferring physician must initially evaluate the relative benefits and risks associated with transporting the inmate- patient. The determination of whether the transfer creates an unacceptable risk or a "medical hazard" will depend upon the inmate-patient's condition, the expected benefits to the inmate- patient if he or she is transferred, and whether the risks to the inmate-patient's health are outweighed by the benefits.

The receiving facility must consent to the transfer. CCR, Title XXII, licensing standards provide that a patient shall not be transferred unless and until the receiving facility has

consented to accept the patient. Specifically, the CCR provides, in part, that no patient shall be transferred, or discharged for purposes of transferring, unless arrangements have been made in advance for admission to a health facility. Therefore, the transferring clinician must secure the receiving health facility's approval in advance for the inmate-patient's admission. The transferring clinician shall document in the inmate-patient's Unit Health Record (UHR) that approval was obtained and from whom.

Appropriate housing of inmate-patients pending MHCB transfer shall be determined by the sending institution and in the following order of preferred locations:

1. Inpatient beds

2. Outpatient Housing Unit

3. Outpatient Housing Unit overflow cells

4. Large holding cells with water/toilets including, but not limited to, "ZZ cells," "wet cells," and/or "clinic cells." Many CTC buildings have holding cells located outside of the entrance to the licensed bed area. These are typically located in the Specialty Care Clinic area. These cells are permissible for temporary housing pending transfer without violating licensing restrictions of the licensed bed area of the CTC building.

5. Large holding cells without water/toilets such as "Contraband Cells" (not in a CTC licensed area)

6. Triage and Treatment Area or other clinic physical examining room

7. Other unit-housing where complete and constant visibility can be maintained

8. When none of the above are available, small holding cells (not in a CTC licensed bed area) that are designed for the inmate-patient to sit or stand may be used for up to four hours by which time consideration of a rotation to one of the above listed options shall have been considered and the outcome of such consideration documented. Inmate- patients shall be retained in sit/stand cells only with approval of the watch commander and notification of on-call clinical staff.

9. Holding cells within the licensed bed area of the CTC building (notification to Department of Health Services of an unusual occurrence is required)

All inmates-patients housed in one of the above sites while pending transfer to a MHCB shall be provided, at minimum, with a safety (no-tear) mattress, safety (no-tear) blanket, and safety (no-tear) smock. If the inmate-patient subsequently attempts to use any or all of these items

to harm him or herself, a clinician may then order that one or more of these items be removed. Inmate-patients who are subsequently returned to their housing units shall receive appropriate clinical follow-up, which may include five-day custody and clinical wellness checks.

When an inmate-patient, identified as requiring MHCB care, is housed in an Outpatient Housing Unit, Administrative Segregation Unit, or any of the above sites, the HCPOP shall be notified of the need for MHCB placement.

Procedure

The Chief of Mental Health or designee at the sending institution shall contact the MHCB Clinical Director or designee at the receiving institution to obtain approval for the transfer.

In cases where the Clinical Director or designee at the receiving institution does not agree to the transfer, and the Chief of Mental Health at the sending institution believes the clinical need for transfer remains, the case shall be referred to the HCPOP and/or Mental Health Services at headquarters central office for assistance. If an agreement cannot be reached, the inmate shall be admitted and evaluated.

Upon receipt of approval to transfer, from the MHCB Clinical Director or designee at the receiving institution, the Chief of Mental Health or designee at the sending institution shall complete a CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, indicating acceptance. Copies of the completed CDCR 128-C, *Chrono – Medical/Psychiatric/Dental,* shall be forwarded to the MHCB Clinical Director or designee at the receiving institution and the Classification & Parole Representative (C&PR) at the sending institution.

The C&PR at the sending institution shall forward a copy of the completed CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, to the C&PR at the receiving institution.

The Chief of Mental Health or designee, MHCB Clinical Director or designee, and the C&PRs at both the sending and receiving institutions shall communicate to ensure all health care/classification/transportation aspects are addressed. The escort needs for each transport are different given the variation of custody and health care concerns that may arise. At times, the transportation may be accomplished with just custody staff. However, occasions do arise when a combination of custody and clinical staff are needed to accompany an escort. This may occur when the inmate-patient has highly sensitive and varying medication needs or when the presence of a clinical staff member may substantially reduce decompensating or disruptive inmate-patient behavior during transportation.

The C&PR at the receiving institution shall contact the Classification Services Unit (CSU) for teletype transfer approval. The transfer approval shall be obtained from a CSR if available on site.

Documentation and classification of inmate-patients accepted for transfer to another institution shall be consistent with procedures outlined in the DOM. The sending institution shall clearly indicate on CDCR 135, *Inmate Transfer Record*, that the purpose of the transfer is for psychiatric treatment.
The inmate-patient shall be informed of the reasons for and destination of the transfer.

The Receiving and Release sergeant at the receiving institution shall notify the MHCB when the inmate-patient arrives. An inmate-patient who arrives by special transport because of urgent acuity shall be screened by a physician. If immediate admission is not possible, an inmate-patient shall be housed in an appropriate medical setting until a bed is available (CCR, Title XXII, Section 79789).

E. ADMISSION

Pre-admission Screening

All inmate-patients referred to the MHCB shall receive a pre-admission screening for the purpose of determining the appropriateness of the admission to the MHCB program. During regular working hours, the screening shall be performed by a psychiatrist or a licensed psychologist privileged to practice in the MHCB, and documented in the Progress Notes. During weekends, holidays, and after normal business hours, the screening shall be performed by an on-site physician on duty or any other licensed health care staff. The pre- admission screening may be performed via telephone prior to transfer when the inmate- patient is at an institution without an available MHCB. An inmate-patient in crisis may be screened where the crisis occurs (such as in the cell), or in the emergency service area of the CTC/GACH/SNF, prior to admission to the MHCB.

All inmates attempting suicide and those having suicidal ideation or showing signs and symptoms of suicide potential will be evaluated by a mental health clinician (psychiatrist, psychologist, or Clinical Social Worker) on an emergency basis. Inmates referred to health care by custody because of suicide concerns, shall be immediately evaluated for suicide risk by a mental health clinician, which shall include a Suicide Risk Assessment Checklist (SRAC). On weekends, evenings, and holidays, the SRAC shall be performed by the Physician on Call (POC), Medical Officer of the Day (MOD), or Registered Nurse (RN) trained to administer the SRAC if mental health clinicians are not available. It is the responsibility of the Health Care Manager to establish procedures for suicide risk assessment by clinical staff outside of normal work hours. All SRACs shall be filed in the inmate- patient's UHR whether or not the inmate-patient is admitted to the MHCB. An inmate

showing suicidal potential cannot be refused admission until there is a face-to-face evaluation and SRAC completed by a clinician trained to conduct suicide risk assessments.

All inmates who are screened positive for possible admission to the MHCB on a weekend, holiday, or after normal business hours shall be referred to a MHCB psychiatrist or psychologist with admitting privileges (On Call or On Duty) for admission. The clinician facilitates the admission based on the admission criteria indicated in Section C above. The actual admission may be done by the MOD or POC in consultation with the psychiatrist or psychologist (On Call or On Duty). For all inmates not admitted, the psychiatrist or psychologist (On Call or On Duty) shall prepare a detailed Progress Note explaining the reason for the decision. A log shall be kept by the referring institution, and shall include the following information for all inmates referred to the MHCB and evaluated but not admitted:

- Date of referral
- Inmate-patient identification
- Reason for referral
- Reason for not being admitted
- Referring clinician

Admission/Transfer Log

Each mental health program with a MHCB unit shall develop and maintain a log of all MHCB admissions/transfers. This log shall include at least the following information:

- Date of referral
- Inmate identification
- Reason for referral to MHCB
- Current level of care
- Date of Admission to MHCB
- Whether a suicide risk assessment (including a SRAC) was performed upon admission (for suicidal inmates)
- Discharge diagnosis

- Whether a suicide risk assessment (including a SRAC) was performed upon discharge (for suicidal inmates)
- Date of clinical discharge from the MHCB
- Date of physical discharge from the MHCB
- Date of referral to new location/program
- Date of transfer to new location/program
- Location/program to which the inmate-patient has been transferred

All inmate-patients who receive a pre-admission evaluation for suicide potential, but who are not admitted, will be tracked in a separate log. The log shall be kept by the MHCB that did not admit the inmate-patient, and will include at least the following information:

- Date of referral
- Inmate-patient identification
- Reason for referral
- Reason for not being admitted
- Deciding clinician

Procedure

The MHCB shall accept inmates who meet the criteria for care and treatment and shall continue to house only those inmates for whom care is appropriate. No inmate shall be admitted to the MHCB until a provisional diagnosis or valid reason for admission has been stated and the appropriateness determined. When clinical differences of opinion exist regarding the appropriateness for admission and the clinicians involved cannot reach an agreement at the institutional level, the cases shall be referred to the HCPOP and/or Mental Health Services at headquarters central office for assistance.
Admissions to the MHCB shall be made on a "Psychiatric and Return" basis. A psychiatrist or a psychologist with admitting privileges in the MHCB may admit an inmate to the MHCB. Inmates shall be admitted only upon the written or verbal order of a MHCB psychiatrist or a psychologist.

Occasionally, crisis referrals require emergency and involuntary admission to the MHCB. An inmate-patient may, because of a psychotic episode, be confused, disoriented, disorganized and/or gravely disabled, or because of acute depression, may be dangerously suicidal. An inmate-patient in crisis who is explosive and assaultive may also be admitted involuntarily if a serious mental disorder also exists. Assaultiveness that is assessed by the clinician as resulting from an antisocial behavior, and not as a result of a serious mental disorder, is more appropriately dealt with by custody staff, per general institution policies.

Any inmate-patient admitted to the MHCB program because of suicidal threats or behavior shall receive a suicide risk assessment (including a SRAC) from a clinician, upon admission and prior to discharge.

After hours, weekends, and holidays, the Administrative Officers of the Day, MODs, POCs, and Watch Commanders shall be notified of an inmate who makes a serious suicide attempt or engages in self-injurious behavior requiring medical treatment.

Inmate-patients with multiple admissions to MHCB (three or more within a six-month period) shall be evaluated for referral to DMH.

An admission note shall be completed within 24 hours of admission to the MHCB by the admitting clinician and shall include the inmate-patient's condition at the time of admission, provisional diagnosis, and an initial treatment plan. This shall be documented on a CDCR 7230, *Interdisciplinary Progress Notes*, and filed in the UHR.

MHCB Nursing Evaluation

The nurse shall:

a. Interview and give an orientation to the inmate-patient.

b. Assess the inmate-patient and take vital signs.

c. Notify the physician of admission status including any admission problems.

d. Assemble the chart.

e. Initiate the Patient Care Plan.

f. Note and implement any admission orders, such as laboratory tests (for details refer to the Correctional Treatment Center Policy and Procedure Manual, Volume VIII, Mental Health), X-rays, medications, etc.

Physical Examination

For immediate care planning, a history and physical examination, including neurological screening, shall be completed, to the extent clinically possible, immediately before or within 24 hours of admission. If the inmate-patient is uncooperative or otherwise cannot be fully examined, a description of all possible observations and findings of the physical examination shall be documented. The complete physical examination shall be conducted as soon as clinically possible and documented in the UHR.

F. ASSESSMENT AND TREATMENT SERVICES

Intake Assessment

Upon admission to the MHCB unit, an assessment shall immediately be made on how best to meet the critical needs of the seriously mentally disordered inmate-patient. This is accomplished by reviewing and updating the CDCR 7386, *Mental Health Evaluation*, completed by the referring clinician at the time of referral. At a minimum, a provisional diagnosis is determined and an initial plan in the "Recommended Follow Up/Initial Treatment Plan" section of the CDCR 7386, *Mental Health Evaluation*, shall be formulated within 24 hours for immediate care planning and to rule out medical conditions that may be a cause of presenting symptoms. Serious medical conditions that are a significant cause of the crisis may warrant acute care medical hospitalization.

Interdisciplinary Treatment Team and Individualized Treatment Planning

The IDTT is composed of, at a minimum:

- Assigned MHCB psychiatrist
- Assigned MHCB Primary Clinician (PC)
- Nursing staff
- Correctional Counselor
- Inmate-patient (if clinically and custodially appropriate)

Other staff who have direct knowledge of the inmate-patient are encouraged to attend or provide information, such as:

- Custody officers

- RNs
- Licensed Vocational Nurses (LVN)
- Recreational Therapists

The IDTT is chaired by a licensed mental health clinician. The inmate-patient shall be included in the IDTT, if clinically and custodially appropriate as determined by the IDTT, unless the inmate-patient refuses to participate. If the inmate-patient refuses to participate, the PC shall document the reason for refusal on the CDCR 7230, *Interdisciplinary Progress Notes*. Inmate-patients shall not be disciplined for refusing to participate in IDTT. Attempts shall be made to gather input from the inmate-patient, such as talking to and observing the inmate-patient at the cell door.

The IDTT shall meet within 72 hours of an inmate-patient's admission and at least weekly thereafter. The IDTT shall begin discharge planning at the initial IDTT meeting.

An individual treatment plan shall be developed and implemented at the initial IDTT meeting. The treatment plan, which is to be filed in the inmate-patient's UHR, shall be individualized and based on a comprehensive assessment, including, at a minimum, a mental status exam and the inmate-patient's legal, criminal, psychiatric, medical, and developmental history, and psychosocial evaluations. Psychosocial evaluations shall include personal and family history, inmate-patient's strengths and weaknesses, and evaluation of support system.

The individualized treatment plan shall:

1. Provide a primary diagnosis and identify the main presenting problems targeted for treatment. The diagnosis may be provisional.
2. For every identified target problem, document the goals, interventions, and measurable objectives of treatment.
3. Specify the types, frequencies and providers of prescribed therapies and adjunct activities.
4. Document the success or failure in achieving stated objectives
5. Evaluate the factors contributing to the inmate-patient's progress or lack of progress toward recovery.

6. Document prescribed medication, dosage, and frequency of administration, as well as medication compliance.

7. Be reviewed at each IDTT meeting, at least weekly, and updated accordingly.

8. Designate appropriate medications, therapies, and custody follow-up in an aftercare plan to be followed after the inmate-patient's release from the MHCB. See MHSDS Program Guide, *Chapter 10, Suicide Prevention and Response*, for specific follow-up requirements for inmate-patients admitted for suicide prevention.

Case Reviews And Treatment Plan Update (CCR, Title XXII, Section 79747)

An inmate-patient's condition shall be assessed and monitored daily by the treating clinician, either a psychiatrist or psychologist. On weekends or holidays, a mental health clinician on call or the MOD shall make daily rounds. The Chief of Mental Health is responsible to ensure that all physicians serving as MOD or POC are trained in the use of the SRAC.

Documentation of daily contacts shall be made within 24 hours in the UHR by the updating clinician.

The IDTT shall review each crisis case as often as necessary, but at least every seven days, and update the treatment plan accordingly. Each treatment plan update shall include the following:

1. Documentation of the inmate-patient's response to treatment and his/her progress or lack of progress towards the goals of treatment.

2. Evaluation of factors that hinder progress and the interventions planned by the team to facilitate progress.

3. The most recent diagnoses and descriptions of the main presenting problems.

4. Evaluation of risk factors.

5. Review of release or discharge plans.

Treatment Services

The MHCB Clinical Director or designee shall be responsible for the prompt care and treatment of each inmate-patient admitted to the MHCB, development and implementation of a treatment plan, completeness and accuracy of the UHR, necessary special instructions, and transmitting reports of the inmate-patient's condition. Whenever these responsibilities are

delegated to another staff member, continuity shall be ensured [CCR, Title XXII, Section 79741 (b)] by the MHCB Clinical Director.

An inmate-patient admitted to the MHCB shall be provided the following services and treatment:

Medication Evaluation and Management

The assigned psychiatrist shall evaluate each MHCB inmate-patient individually at least twice weekly to address psychiatric medication issues.

Refer to Inmate Medical Services Policies and Procedures, *Volume 4, Chapter 11, Medication Management,* regarding procedures for administration of medication, medication refusals, Directly Observed Therapy, and other aspects of medication administration.

Nursing Care

Twenty-four hour nursing care is provided in the MHCB to administer and supervise medication, provide assistance for activities of daily living, observe and monitor inmate-patients, obtain all physician-ordered laboratory studies, and provide counseling or inmate-patient supervision as needed.

Therapy and Counseling

One-to-one intervention is often necessary in a crisis case. Usually, brief, intensive therapy is helpful if it focuses on issues that precipitated the admission and explores changes in behaviors, perceptions and expectations that facilitate coping with the crisis. Group therapy may be provided to MHCB inmate-patients, consistent with clinical needs.

Rehabilitation Therapy

Inmate-patients may participate in rehabilitation therapy activities, consistent with clinical needs. Rehabilitation therapy may include activities such as indoor or outdoor recreation. These activities provide a setting for additional observation of inmate-patients, allowing for the evaluation of exaggerated symptoms or severe symptoms that are masked [see CCR, Title XXII, Section 79749 (c) (1) for Rehabilitation Treatment Plan requirements].

Inmate-patients who are awaiting transfer to DMH and remain in a MHCB beyond ten days, shall be offered additional rehabilitation therapy and other treatment activities, as clinically indicated.

Aftercare Planning and Referral

Planning for follow-up services is a critical component of the care an inmate-patient needs upon release from the MHCB. This planning may lead to a referral to a program or other appropriate placement to ensure continuity of care. An inmate-patient who clearly requires longer-term hospital care may be referred and transferred to an inpatient hospital program operated by the DMH. Aftercare plans shall include:

1. The diagnosis and psychiatric problems continuing to require treatment.

2. Any other unique mental health or physical conditions that could affect treatment (e.g., allergies, special dietary needs, chronic diseases).

3. Recommendations for follow-up treatment, including medications and specific psychotherapies.

4. Referrals to other treatment programs and institutional services, including vocational or educational programs, substance abuse programs and job programs (CCR, Title XXII, Section 79749 [d]).

5. The aftercare plan shall consider the inmate-patient's potential in-custody housing, proximity to release from incarceration, probable need for community treatment and social services, and the need for continued mental health care. If an inmate-patient requires continued care upon paroling, the Parole Outpatient Clinic shall be contacted.

G. INVOLUNTARY TREATMENT

An inmate-patient in crisis who does not consent for treatment with medication may be involuntarily treated to control symptoms which constitute:

- A danger to self, or
- A danger to others, or
- Grave disability on the basis of a serious mental disorder.

Involuntary medication administration refers to the administration of any psychotropic or antipsychotic medication or drug by use of force, or restraint.
The reasoning for the determination that an inmate-patient is a danger to self or others, or is gravely disabled, and is incompetent to render an informed consent shall be documented in the inmate-patient's UHR.

If in the clinical judgment of a psychiatrist or other physician, an emergency exists, the physician or psychiatrist may order involuntary medication for a period not to exceed 72 hours. An emergency exists when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others and it is impractical to first obtain consent.
An inmate-patient shall be afforded due process rights if involuntary treatment is necessary beyond 72 hours.

Refer to Correctional Treatment Center Policy Manual, Volume VIII, Section 16, Involuntary Treatment, for detailed procedures.

H. CLINICAL RESTRAINT AND SECLUSION

Restraint and/or seclusion are special treatment procedures used to protect the safety of inmate-patients who pose an immediate danger to themselves or others, by restricting their ability to inflict injury by limiting body movement or by containing them in a safe environment. While utilization of restraint and/or seclusion is clearly effective in saving lives and preventing serious injury, it is also a procedure with inherent risks. In rare cases inmate-patients who have been restrained or secluded have suffered injury or death as a result of improper procedure or monitoring.

Restraints and/or seclusion shall be used only as a last resort and in response to an emergency to protect the inmate-patient and/or others from imminent harm, after less- intrusive and non-physical interventions have been attempted or ruled out. Staff shall strive to minimize or eliminate the use of seclusion or restraint whenever possible, through proper training, thorough assessment, effective treatment planning, and continuous quality improvement efforts. This policy restricts the use of restraints for mental health purposes generally to MHCBs. The use of restraints, for mental health purposes, in areas other than a MHCB unit shall be restricted to the amount of time required for transfer to a MHCB unit. Inmate-patients in need of restraints shall be transferred, in an expedited timeframe, to a MHCB unit.

The form of restraint and/or seclusion selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior. The determination of the presence of an emergent situation rests upon the clinical judgment of staff. It does not require the staff to defer restraint or seclusion until dangerous behavior occurs but may be based upon knowledge of the inmate-patient and its predictive value.

Restraint and/or seclusion shall never be used as punishment or for the convenience of staff. Threatening inmate-patients with restraint and/or seclusion is considered psychological abuse

and is prohibited. It may be appropriate to inform an inmate-patient when behavior may necessitate the use of restraints or placement into seclusion.

This policy expressly prohibits any form of as needed (PRN) or standing order for restraint or seclusion.
For the purpose of this policy, authorized clinician means a psychiatrist, licensed psychologist, (and at Pelican Bay State Prison only, a psychiatric nurse practitioner) or (on weekends or after normal business hours) the POC or psychiatrist on call, or the POD or MOD.

Per Title 22 Regulations, a "qualified RN" is a RN who has received training in the administration of restraints and placement into seclusion, and who has passed a competency examination, which includes assessment of clinical issues relevant to the use of restraint and/or seclusion.

RESTRAINT

Initial and Subsequent Orders

Restraints shall only be used on a written or verbal order of an authorized clinician. When an authorized clinician is present, the authorized clinician shall evaluate the need for restraints, and if appropriate, write an order and provide sufficient and adequate justification in the inmate-patient's UHR.

In an emergency circumstance, when no authorized clinician is available, a qualified RN may authorize initiation of restraints. An emergency circumstance exists when there is a sudden marked change in the inmate-patient's behavior so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to self or others, and it is impractical to first obtain an order from an authorized clinician.

When no authorized clinician is present, a qualified RN shall evaluate the need for restraints and implement restraints if appropriate. If a RN is not present, a RN shall be notified immediately and shall respond within 15 minutes of notification to evaluate the need for restraints and initiate restraints, if appropriate. When a RN initiates restraints, an authorized clinician shall immediately be notified. Within one hour of notification, an authorized clinician shall give a verbal or written orders (with justification) to either continue or discontinue restraints.

If the authorized clinician is not available for the initial assessment, a phone order will be secured to cover the restraint use and the nurse will do an initial assessment within one hour.

The initial order for restraint shall not exceed four hours. Subsequent orders for continuation of restraint shall not exceed four hours. Each order must specify the behavioral conduct requiring restraint and the type of restraint used. While a restraint order is valid for four hours, no inmate-patient shall be in restraint for longer than the time necessary to contain the dangerous behavior. Removal from restraints is an authorized clinician or RN determination, and does not require a physician's order unless otherwise specified.

Assessment by Authorized Clinicians and Qualified RNs

Prior to expiration of the initial order, an authorized clinician or qualified RN shall conduct a face-to-face evaluation to determine whether continued placement into restraints is clinically justified. If the clinician performing the initial face-to-face assessment is not a psychiatrist/physician, within four hours of the initial order a psychiatrist/physician shall be contacted/consulted by the RN to review current medications and any contraindications to continued restraint.

An authorized clinician or a qualified RN shall conduct a face-to-face evaluation at least every 8 hours during the period an inmate-patient is in restraints. An authorized clinician shall evaluate the inmate-patient face-to-face at least every 24 after the first four hours. If the authorized clinician is not a physician, the authorized clinician should consult with a physician after the face-to-face assessment. A psychiatrist shall conduct a face-to face evaluation at least every 24 hours while the inmate-patient is in clinical restraint.

A physician or nurse practitioner shall perform a brief physical examination of the inmate-patient as soon as possible but no more than four hours after the initiation of restraint use and document the evaluation on a progress note in the UHR. The physician/nurse practitioner's assessment will include inquiring into any history of physical disability or any other condition which would place the inmate-patient at greater physical or psychological risk during the restraint procedure. If the use of restraints is discontinued prior to the physician's arrival, the physician shall conduct a brief physical examination no more than 24 hours after the episode of restraint use.

Documentation

Documentation of an order for the use of restraints shall include the name of the authorized clinician giving the order, the time the order was received, the duration of the order, which is not to exceed four hours, the type of restraint to be used, and the name and signature of the RN receiving the order.

The Initial Telephone orders for restraint shall be received only by licensed nursing staff, who shall record them immediately. The ordering authorized clinician shall sign them within

24 hours. Likewise, subsequent telephone orders for restraint shall be signed within 24 hours of the time the orders were given.

This policy requires the clinician ordering the restraint to provide a written order authorizing the use of restraint even if such use is discontinued prior to the authorized clinician's arrival.

Each time a verbal order for restraint is written, the nurse shall complete a CDCR 7230, *Interdisciplinary Progress Note,* documenting the need for initiation/continuation of restraint and shall specify the elements for the emergency that necessitated the use of restraint and behavior changes that may indicate the inmate-patient no longer presents a danger to self or others. The note shall describe any less restrictive measures that were implemented prior to this order.

Results of face-to-face evaluations shall be documented on CDCR 7316, *Restraints/Seclusion Record.*

When a qualified RN initiates restraint, the RN shall document the need for the initiation of restraint on a CDCR 7316, *Restraint/Seclusion Record.* The documentation shall include a description of the inmate-patient's behavior including any precursor/antecedent behaviors and other relevant factors upon which the inmate-patient was determined to be a danger to self or others, staff actions taken to utilize alternatives to restraint, information given to the inmate-patient about the reasons for restraint, the conditions of release, the inmate-patient's response, and injuries to the inmate-patient.

The use of restraints requires the inmate-patient's treatment plan be modified to include a sufficiently detailed description of the emergency and the rationale for the use of the specific degree of restraint. The inmate-patient's nursing care plan shall be modified to provide for the special needs of the inmate-patient while in restraint and/or seclusion. The criteria for establishing termination should be described in operational, objective terms comprehensible to the inmate-patient.

Types of Restraint

- Five-point: All four extremities and waist (note below on use of five-point restraints)
- Four-point: All four extremities
- Two-point: Upper extremities only

Application

The inmate-patient shall be protected from injury during restraint application and use. Staff shall use the least physical force necessary to protect inmate-patient and yet exercise sufficient force to control the inmate-patient.

The dignity and well-being of the inmate-patient shall be preserved at all times during the period of restraint.

Inmate-patients shall be placed on their backs when restraints are applied unless clinically contraindicated. When an inmate-patient is medically compromised or disabled, all necessary steps to safeguard the inmate-patient during the procedure need to be taken. Inmate-patients who are considered medically compromised/disabled consist of, but are not limited to, the following: morbidly obese, known history of cardiac or respiratory disease, history of spinal injury, amputee, fractured or injured extremity, recent history of emesis, pregnancy, or seizure disorder. RNs must contact a physician either prior to, or immediately after, the placement of a medically compromised inmate-patient in restraints to notify the physician of the restraint and the inmate-patient's medical condition. Upon notification of the restraint of a medically compromised/disabled inmate-patient, the physician will either order the RN to discontinue the restraint or order the restraint as well as any special measures/treatments that need to be taken to safeguard the inmate-patient's medical condition. If the inmate-patient is an amputee or otherwise lacks one or more limbs, two or three point restraints should be used. Generally, restraints should be applied to the upper extremities first.

Four-, five-, or two-point leather restraints shall be used by clinical staff when ordered by an authorized clinician. Inmate-patients shall only be restrained with the least amount of restraints necessary to contain the unsafe behavior. Each period of restraint must be assessed individually to determine the level of restraint required at the time of the application of the restraint. Five-point restraints will only be used after the inmate-patient has been unsuccessfully restrained in four-point restraints or a determination is made by the RN that a fifth restraint is needed to ensure the safety of the inmate-patient. The physician on-call and the Nursing Supervisor must be notified anytime five-point restraints are utilized. The restraint key shall be carried by nursing staff after restraints have been applied to an inmate- patient until the procedure is discontinued.

Generally, four-point restraints should be used unless there are compelling reasons to the contrary.

A soft cloth or bandage shall be applied to the extremity before applying the leather restraints to protect the skin.

Nursing staff shall notify the watch commander and Chief Psychiatrist or designee of an order to place an inmate-patient in restraints. When restraints are applied to an inmate- patient, CTC staff shall have at least three custody personnel present for the application of these restraints, but the RN shall be in charge of the actual application of restraints. The RN is responsible to ensure that the restraints are applied properly, and are not restricting the inmate-patient's circulation.

In emergency situations, custody staff may use metal restraints (handcuffs) on inmates in order to gain control. Metal restraints shall be replaced with leather restraints by the RN as soon as possible.

Monitoring and Evaluation by Nursing Staff

All inmate-patients placed into restraint shall remain under constant direct, in-person visual observation by trained nursing staff (CNA, psychiatric technician, LVN, or RN) until restraint is discontinued.

Immediate Nursing Evaluation

A RN shall perform a mental status and physical assessment of the inmate-patient immediately upon the initiation of restraint use. The RN assessment will include the identification of techniques, methods and tools which can help the inmate-patient control their behavior, and will identify pre-existing medical conditions and physical disabilities that place the inmate-patient at greater risk during the restraint procedure.

Assessment at 15 minute Intervals

In order to continue adequate circulation, nursing staff monitoring the inmate-patient shall physically check each extremity every 15 minutes. Each 15 minute assessment period shall be documented on the CDCR 7316, *Restraint/Seclusion Record.*

The nursing staff shall provide fluids and nourishments every 15 minutes as needed and as practicable except during hours of sleep. The inmate-patient's head and shoulders shall be elevated, if needed, while being fed or receiving fluids to reduce the risk of aspiration. The nurse shall document meals and fluids on CDCR 7316, *Restrain/Seclusion Record.*

Hourly Assessments

The RN will conduct hourly assessments of the inmate-patient during the entire period of restraints. Subsequent to the initial assessment conducted by the RN, the hourly assessments will document current physical, mental, and behavioral status of the inmate-patient, any indicated interventions performed, and the inmate-patient's readiness for release from

restraints. The assessment includes noting the condition of skin and circulation, need for toileting, personal hygiene procedures, and proper application of restraint. Documentation of the one hour evaluations shall summarize the inmate-patient's overall physical condition, general behavior, and response to counseling/interviews.

Every hour the nursing staff, with the assistance of custody staff, shall perform 2 minute range of motion exercises on each limb unless the inmate-patient is too agitated or assaultive to safely remove the restraints. For range of motion exercises, restraints on each extremity shall be removed, one at a time. Performance of range of motion exercises shall be clearly documented on the CDCR 7316, *Restraint/Seclusion Record,* and shall include the inmate- patient's behavior, respiration, and responsiveness. If range of motion exercises are not performed, nursing staff shall clearly document the reason on the CDCR 7316, *Restraint/Seclusion Record.*

A RN may suspend restraints for short periods of time in order to transfer inmate-patients from place to place to attend to necessary or personal needs (i.e., feeding, bathing, or other treatment needs as necessary). A RN shall decide whether release from restraint is necessary in order to attend to necessary nursing or personal needs. Custody staff shall provide adequate security to prevent assaults or self-injurious behavior during suspension of restraints. If an inmate-patient has been released from restraints for more than one hour, a new order shall be obtained. Inmate-patients shall not be returned to the previous, or any state of restraint without continuing evidence of dangerousness to self or others.

Restraint Renewal

The RN shall contact an authorized clinician and provide a description of current behavior, attitudes, or other indicators of present dangerousness; PRN/emergency medication usage; change in vital signs, including pain assessment; changes in mental or physical status; and side effects (e.g., confusion, akathisia, or extrapyramidal) at least every four hours. The authorized clinician shall then either give an order to discontinue restraint or give an order to continue or modify restraint for a period not to exceed four hours.

Termination

Restraint shall be terminated when:

1. The emergency or dangerous behavior no longer exists based on previously established criteria for release; or

2. The inmate-patient's identified precursor behaviors indicating imminent danger to self or others are not longer present; or

3. Due to the presence of medical contraindications, it would be harmful for the inmate-patient to remain in restraints.

Removal from restraints is an authorized clinician or RN determination that the inmate- patient has reached the behavioral criteria for release and no longer presents an imminent danger. Release does not require a physician's order unless otherwise specified.

Upon termination of the restraint use, an entry shall be made in the CDCR 7230, *Interdisciplinary Progress Note,* describing the condition and response of the inmate-patient.

In accordance with Health and Safety Code 1180, a clinical and quality review shall be conducted for each episode of the use of restraints.

Seclusion

Seclusion is a behavioral treatment procedure used to prevent injury to self or others by containment of the inmate-patient in a specially designed room. Seclusion will typically take place in safety cells in a MHCB facility. Seclusion rooms shall be designed or modified to: provide for sufficient space for freedom of movement of staff; be free from hazardous objects or fixtures; have adequate light and ventilation; be maintained at an appropriate temperature; have secure, lockable doors; and have windows that permit visual observation of the inmate-patient by staff. Each MHCB facility shall set aside and equip a specific room to be used for the purpose of seclusion.

Placement of inmate-patients in single cells located in housing units, CTC's, or MHCB's for custodial reasons does not constitute seclusion for the purposes of this section.

Initial and Subsequent Orders

Seclusion shall only be used on a written or verbal order of an authorized clinician. When an authorized clinician is present, the authorized clinician shall evaluate the need for seclusion and if appropriate, write an order and provide sufficient and adequate justification in the inmate-patient's UHR. The initial order for seclusion shall not exceed four hours.

In an emergency circumstance when there is no authorized clinician present, a qualified RN may authorize initiation of seclusion after evaluating the need for seclusion. An emergency circumstance exists when there is a sudden marked change in the inmate-patient's behavior so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to self or others, and it is impractical to first obtain an order from an authorized clinician. If a RN is not present, a RN shall be notified immediately and shall respond within 15 minutes of notification to evaluate the need for seclusion and initiate seclusion, if appropriate. When a RN initiates seclusion, an authorized clinician shall

immediately be notified, and within one hour of notification write or give a verbal order with justification to either continue or discontinue seclusion.

Subsequent orders for continuation of seclusion shall not exceed four hours.

Documentation

Documentation of an order for seclusion shall include the name of the authorized clinician giving the order, the time the order was received, the duration of the order, and the name and signature of the RN receiving the order.
Telephone orders for seclusion shall be received only by licensed nursing staff, shall be recorded immediately, and shall be signed within 24 hours. Initial telephone orders for seclusion shall be followed with written orders within 24 hours of the time the seclusion was first ordered. The ordering clinician will follow subsequent telephone orders for seclusion with written orders within 24 hours.

A written order authorizing the use of seclusion is required even if such use is discontinued prior to the authorized clinician's arrival.

Each time an order for seclusion is written, the authorized clinician or RN shall complete a CDCR 7230, *Interdisciplinary Progress Note,* documenting the need for initiation/continuation of seclusion and shall specify the elements of the emergency that necessitated the use of seclusion and behavior changes that may indicate the inmate-patient no longer presents a danger to self or others. The note shall describe what least restrictive measures were tried prior to this order.

Results of face-to-face evaluations shall be documented on CDCR 7316, *Restraint/Seclusion Record.*

When a qualified RN initiates seclusion, the RN shall document the need for the initiation of seclusion on a CDCR 7316, *Restraint/Seclusion Record.* The documentation shall include a description of the inmate-patient's behavior including any precursor/antecedent behaviors and other relevant factors upon which the inmate-patient was determined to be a danger to self or others, staff actions taken to utilize alternatives to seclusion, information given to the inmate-patient about the reasons for seclusion, the conditions of release, the inmate-patient's response, and injuries to the inmate-patient.

The inmate-patient's treatment plan must be modified to include a sufficiently detailed description of the emergency and the rationale for the use of seclusion. The inmate-patient's nursing care plan shall be modified to provide for the special needs of the inmate-patient while in seclusion. The criteria for establishing termination should be described in operational, objective terms comprehensible to the inmate-patient.

Monitoring and Evaluation by Nursing Staff

During the entire period of seclusion, the inmate-patient shall remain on direct one on one nursing observation. Nursing staff will document their observations at least every 15 minutes on a CDCR 7316, *Restraints/Seclusion Record.* Nursing staff shall ensure that the inmate-patient is safely secluded. The direct one on one nursing observation shall also include verbal interaction when the inmate-patient is awake.

A RN shall perform a mental status and physical assessment of the inmate-patient within 15 minutes of the initiation of seclusion. A physician or nurse practitioner shall perform a brief physical examination of the inmate-patient as soon as possible but no more than four hours after the initiation of seclusion and document the evaluation in the patient's UHR. If seclusion is discontinued prior to the physician's arrival, the physician shall conduct a brief physical examination no more than 24 hours after the episode of seclusion.

Prior to the expiration of the initial order an authorized clinician or qualified RN shall conduct a face-to-face evaluation to determine whether continued placement in seclusion is clinically justified. If the clinician performing the initial face-to-face assessment is not a psychiatrist/physician, within four hours of the initial order a psychiatrist/physician shall be consulted by the RN to review current medications and any contraindications to continued seclusion. The authorized clinician shall either give an order to discontinue seclusion or give an order to continue seclusion for a period not to exceed four hours.

After the initial face-to-face evaluation, an authorized clinician or a qualified RN shall conduct a face-to-face evaluation at least every eight hours during the period an inmate- patient is in seclusion and evaluated for continued dangerousness by an authorized clinician at least daily. The authorized clinician shall then either give an order to discontinue seclusion or give an order to continue seclusion for a period not to exceed four hours.

An authorized clinician shall evaluate the inmate-patient face-to-face at least every 24 after the first four hours. If the authorized clinician is not a physician, the authorized clinician should consult with a physician after the face-to-face assessment. A psychiatrist shall conduct a face-to-face evaluation at least every 24 hours while the inmate-patient is in clinical seclusion.

Every hour the RN will perform an assessment of the inmate-patient including need for toileting; exercise; personal hygiene procedures; and room environment, temperature, and cleanliness. Fluids and nourishment shall be offered every 15 minutes by the nursing staff assigned to the direct observation of the inmate-patient, except during hours of sleep. In documentation of hourly evaluations, the nurse shall summarize the inmate-patient's overall physical condition, general behavior, and response to counseling/interviews.

A RN may suspend seclusion for short periods of time in order to transfer inmate-patients from place to place to attend to necessary nursing or personal needs (i.e., feeding, bathing, or other treatment needs as necessary). A RN shall decide whether release from seclusion is necessary in order to attend to necessary nursing or personal needs. Custody staff shall provide adequate security to prevent assaults or self-injurious behavior during suspension of seclusion. If an inmate-patient has been released from seclusion for more than one hour, a new order shall be obtained. Inmate-patients shall not be returned to the previous, or any state of seclusion without continuing evidence of dangerousness to self or others.

Termination

Seclusion shall be terminated when:

1. The emergency or dangerous behavior no longer exists based on previously established criteria for release; or

2. The inmate-patient's identified precursor behaviors indicating imminent danger to self or others are no longer present; or

3. Due to the presence of medical contraindications, it would be harmful for the inmate-patient to remain in restraints.

Removal from the seclusion is an authorized clinician or RN determination that the inmate-patient has reached the behavioral criteria for release and no longer presents an imminent danger. Release does not require a physician's order unless otherwise specified.

Upon termination of the seclusion use, an entry shall be made on a CDCR 7230, *Interdisciplinary Progress Note,* describing the condition and response of the inmate-patient.

In accordance with Health and Safety Code 1180, a clinical and quality review shall be conducted for each episode of the use of seclusion.

I. DISCHARGE

It is the responsibility of the MHCB to provide for continuity of inmate-patient care upon discharge to another level of care, another facility, or self-care.

The inmate-patient has a right to information regarding discharge on an ongoing basis during his or her stay in the MHCB.

Discharge Plan

a. The discharge plan is initiated at the time of admission.

b. The IDTT shall assess the inmate-patient's need for further medical, psychiatric, psychological, social work, and rehabilitative services; nursing services; education services; and transportation when developing the discharge plan. The plan ensures that needed services are available at the appropriate level of care.

c. The plan shall include participation by the inmate-patient to facilitate inmate-patient responsibility for his or her care and treatment.

d. The plan reflects appropriate coordination with and utilization of MHCB custody staff.

e. The plan includes documentation of contact with the Chief of Mental Health at the institution where the inmate-patient is being transferred.

f. Once the discharge plan is completed, referrals for appropriate aftercare placement shall be documented by an MHCB clinical staff member in the inmate-patient's treatment plan.

g. The assigned CCM or PC at the institution where the inmate-patient is being transferred is responsible for implementing the discharge plan.

h. Treatment shall continue for all inmate-patients clinically discharged until transferred.

Discharge Criteria

Criteria for discharge from the MHCB to an EOP or CCCMS program include:

- stabilization of the crisis behavior; and
- the ability to function in a less clinically structured environment.

Discharge criteria do not necessarily include complete resolution of symptoms but a resolution sufficient to allow continuation of treatment at a less intensive level of care.

Discharge to DMH inpatient care requires the clinical need for inpatient services of a duration greater than ten days.

Procedure

a. Upon completion of MHCB inpatient treatment, cases transferred to the MHCB as "Psychiatric and Return" shall be returned to the sending institution, unless the sending institution does not provide the level of care that the inmate-patient currently requires or the inmate-patient has any other case factor(s) that preclude return to the sending

institution. In those cases, the MHCB will transfer the inmate-patient to an institution that provides the appropriate level of care and security.

b. The MHCB discharge summary shall be completed by the attending psychiatrist or psychologist prior to release from the MHCB. This should include specific recommendations regarding follow-up visits with the CCM or PC and custody staff. The discharge summary, either handwritten or dictated, includes, but is not limited to, the MHCB course of treatment, current medications, response to treatment, condition at time of discharge, and detailed information regarding follow-up care needs. The inmate-patient's participation, which supports inmate-patient responsibility, shall also be included.

c. An inmate-patient shall be discharged only on the written order of the MHCB psychiatrist or psychologist.

d. Each institution with an MHCB shall appoint a Discharge Coordinator who is responsible for notifying the Chief of Mental Health or designee at the institution where the inmate-patient is being transferred of the pending discharge. The notification shall occur prior to discharge and shall include the inmate-patient's discharge summary, custody level, treatment needs, and any significant medical conditions. The Discharge Coordinator shall document the notification in the inmate-patient's discharge plan.

e. The Chief of Mental Health or designee at the institution where the inmate-patient is being transferred shall notify the assigned CCM or PC. If the inmate-patient does not have an assigned CCM or PC, one shall be assigned. If the inmate-patient was admitted to the MHCB for Suicide Precaution or Watch, the Chief of Mental Health shall also notify the mental health clerical staff responsible for the tracking system, clinical staff responsible for weekend or holiday coverage, and the Facility Captain of the housing unit to which the inmate-patient is being transferred so that the required clinical and custody evaluation can be scheduled.

f. No inmate-patient shall be discharged from the MHCB without an IDTT review, or in the event a new IDTT cannot be convened, a consultation with an IDTT member, such as a nurse.

g. At the time of discharge, the original inpatient record is retained at the MHCB institution. The inmate-patient's UHR shall be transferred to the receiving institution at the time of discharge. Certain documents from the Inpatient Record are copied and filed in the Inpatient section of the UHR. This includes copies of the Admission Record, History and Physical, Operative Reports, Physician Orders, Discharge Summary, Consultations, Progress Notes, and Diagnostic Reports.

h. Prior to discharge from the MHCB, a nurse shall advise the inmate-patient regarding medications and follow-up visits, and clear the inmate-patient for MHCB discharge.

i. Any inmate-patient admitted to the MHCB program because of suicidal threats or behavior shall not be discharged to their housing unit until a Suicide Risk Assessment Checklist has been completed and a follow-up plan developed.

- The PC shall provide follow-up treatment on an outpatient basis. This shall include daily contact with the inmate-patient for five consecutive days following discharge. On weekends and holidays, a Licensed Psychiatric Technician or mental health clinician other than the PC may conduct the daily contact; however, the PC is responsible for ensuring the contacts occur. The daily contact shall be documented on a CDCR 7230, *Interdisciplinary Progress Note,* or a CDCR 7230B-MH, *Follow Up to MHCB/MH-OHU Discharge for Suicidal Issues* template. The note shall include the inmate-patient's current mental status and suicide risk.

- The contact shall occur in the inmate-patient's regular housing unit.

- Custody staff shall conduct an hourly check of inmate-patients admitted to the MHCB for suicidality for the first 24 hours after discharge. A mental health clinician shall then discuss the inmate-patient's behavior with the custody staff and evaluate the inmate-patient to determine if the custody checks should be continued or discontinued. If the custody checks are retained, the mental health clinician shall determine whether the checks are to be every hour, every 2 hours, or every 4 hours for the next 24 - 48 hours. Custody staff shall maintain a log of checks on inmates.

- If after any evaluation the mental health clinician believes the inmate-patient has not stabilized, the inmate-patient shall be returned to the MHCB for further treatment. Careful consideration by the IDTT should be given to releasing inmates on a Friday, during the weekend, or the day before a holiday. The mental status and stability of the inmate-patient should be documented in detail on a CDCR 7230, *Interdisciplinary Progress Note.* A mental health clinician must be available every day (including weekends and holidays), either on duty or on call, to monitor inmate-patients who are discharged from a MHCB.

Quality Management for Implementation of Discharge Planning

Concurrent with the implementation of the discharge plan or within 21 days of the inmate-patient's discharge from the MHCB, the Chief of Mental Health at the institution where the inmate-patient was transferred will audit the implementation of the discharge plan and follow-up care.

For inmate-patients who were admitted to the MHCB for Suicide Precaution or Watch, the Chief of Mental Health shall review the SRAC that was completed prior to discharge from the MHCB to ensure the discharge plan is appropriate. The Chief of Mental Health shall document the review in the UHR and forward a copy of the SRAC to the local Suicide Prevention Committee. A copy will also be retained by the mental health clerical staff.

J. MENTAL HEALTH PATIENTS IN OUTPATIENT HOUSING UNITS

When an inmate-patient requires observation and evaluation of behaviors that may be indicative of mental illness, a licensed mental health professional may document the need for placement of the inmate-patient into an Outpatient Housing Unit (OHU).

A physician, psychiatrist, or licensed psychologist shall order placement and release of inmate-patients into and out of the OHU for mental health care and shall be in charge of the inmate-patients' care while housed there. The placement into the OHU shall be made using the CDCR 7221, *Physician's Order.*

Psychologists ordering placement of inmate-patients into the OHU shall refer the inmate-patient to a physician for a physical examination and to a psychiatrist for a medication evaluation.

The physician's or psychologist's placement orders may be transmitted verbally or by telephone to the RN or LVN. The ordering physician or psychologist shall sign all verbal placement orders within 24 hours.

A physician or psychologist shall document the need for placement on a CDCR 7230, *Interdisciplinary Progress Note*, within 24 hours of placement. Within 24 hours after placement each inmate-patient shall have an evaluation, including admission history and physical examination, for immediate care planning. The Mental Health Evaluation shall be documented on a CDCR 7386, *Mental Heath Evaluation.*

The patient shall receive an additional face-to-face evaluation by a mental health clinician or other qualified medical staff within 48 hours. This contact shall be documented on a CDCR 7230, *Interdisciplinary Progress Note.* If at any time during this observation/evaluation period it is determined that the inmate-patient requires inpatient care, arrangements shall be made to transfer the inmate-patient within 24 hours of the determination to a MHCB. If evaluation of the inmate-patient's mental health need continues beyond 48 hours, arrangements shall be made to transfer the inmate-patient to a MHCB or inpatient facility. Inmate-patients shall not remain in OHU for more than 72 hours.

The only exception to this 72-hour limit shall occur, on a case-by-case basis, only if both of the following criteria are met:

1. The inmate-patient has been determined to need EOP level of care and is awaiting placement, and

2. An IDTT determines that the inmate-patient may be at risk if returned to any of the housing units available at that institution while awaiting transfer.

When both of the above criteria are met, the inmate-patient may be held in OHU until transferred to an EOP level of care program. The timeline for transfer from OHU to EOP shall not exceed 30 days from EOP endorsement. This timeline for transfer shall include any days that the inmate-patient is in a MHCB following endorsement, and shall not be restarted if the inmate-patient returns to the OHU.
When it is determined that inpatient care is necessary and the institution staff are unable to expeditiously find a MHCB, they will contact the HCPOP for assistance to ensure placement within the required timelines. If it is determined that an order for Suicide Precaution or Watch is necessary, observation by clinical and/or custody staff, consistent with the MHSDS Suicide Prevention policy (see Chapter 10 for details), shall be provided.

When an inmate is placed in the OHU for being potentially suicidal, a mental health clinician shall administer a SRAC at the times of placement and release. On weekends, holidays, or after hours, the SRAC shall be administered by the MOD, POD, or RN trained on administration of the SRAC. Inmate-patients housed in OHU for suicide observation, who do not require MHCB level of care and who were discharged from the OHU before 24-hours, may be seen by clinicians and custody staff for follow-up care utilizing the process and timeframes described for MHCB suicide discharges, if clinically indicated.

When emergency circumstances exist, clinical restraint or clinical seclusion may be applied in OHU, subject to the requirements for clinical restraint or clinical seclusion in the MHCB. Emergency circumstances exist when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others, and it is impractical to first transfer the inmate-patient to a MHCB. The MHCB transfer process (See Section D, *Referral and Transfer, MHCB Transfer*) shall be immediately initiated upon determination that an inmate-patient requires clinical restraint or clinical seclusion, and transported when clinically safe to do so.

HCPOP shall be notified when an inmate-patient has been placed in clinical restraint or clinical seclusion. HCPOP shall expedite MHCB placement of inmate-patients in clinical restraint or clinical seclusion.

Mental Health Conditions Appropriate for Placement into an OHU

1. Observation for Suicide Precaution or Suicide Watch consistent with the CDCR Suicide Prevention and Response Project.

2. Inmates who engage in behaviors that might be indicative of a mental disorder that interferes with daily living and requires further observation and evaluation.

3. Inmate-patients who have been referred to an EOP or MHCB who are too ill or too vulnerable to be placed in the general population while waiting for transfer.

If at any time the mental health clinician determines that the inmate-patient has improved and does not require a higher level of care, the clinician may discharge the inmate-patient back to the General Population at the appropriate level of care.

K. STAFFING

The MHCB is designed to provide 24-hour care and is subject to State licensing requirements (CCR, Title XXII, Section 79739). Consequently, it must comply with the staffing standards of the CTC license under which it operates. MHCB staff shall provide acute mental health services for inmate-patients admitted to MHCB. In programs with six or fewer beds, acute mental health services may be provided by the MHCB Clinical Director. Through contracts or temporary reassignment of mental health staff from other program areas, staffing shall be augmented as needed.

The MHCB shall have a Clinical Director who shall direct the clinical program and be responsible for the quality of clinical services (CCR, Title XXII, Section 79741 (b)). The Clinical Director shall be a psychiatrist, licensed clinical psychologist, licensed clinical social worker, or a psychiatric mental health nurse operating within his or her scope of licensure with at least three years of direct clinical experience with seriously mentally disordered individuals after completion of his or her last year of graduate education (CCR, Title XXII, Section 79755 (a)). Each inmate-patient admitted as a patient to the MHCB is under the treatment of Staff Psychiatrists, Psychologists and/or Licensed Clinical Social Workers. Nursing services are provided by RN, LVN, Recreational or Occupational Therapists or Licensed Psychiatric Technicians. Clerical services are provided by an Office Technician and a Medical Transcriber.

Administrative Staff

The MHCB is subject to the same medical staff organization, bylaws, and policies and procedures that govern the other licensed beds of the facility (CCR, Title XXII, Sections 79775, 79777). Staff serving in these positions shall meet the minimum

qualifications specified in the CCR, Title XXII. All MHCB staff are responsible to the Clinical Director.

Clinical Staff

Individual therapy or counseling, aftercare planning and referral services, and the clinical lead role in treatment plan development and modification shall be performed by the Staff Psychiatrist, Staff Psychologist, or Licensed Clinical Social Worker. A Chief or Senior Psychiatrist or a Chief or Senior Psychologist may also provide these clinical services in addition to his or her other supervisory or management responsibilities, as directed. Supervising clinical staff may assist in these services if required by workload, staffing considerations or unusual complexity of an individual case. Staff Psychiatrists, Staff Psychologists, Licensed Clinical Social Workers, Senior Psychiatrists and Senior Psychologists serve as PCs and report to the Clinical Director.

Nursing Staff (CCR, Title XXII, Section 79629)

Two Supervising RNs positions oversee all nursing services delivered in the CTC: one for medical services and one for mental health services (CCR, Title XXII, Section 79755 (d)). Although the latter includes the MHCB, the use of one Supervising RN per shift may mean that MHCB nursing functions may be supervised by the medical Supervising RN for part of each 24-hour day.

Supervising RN are responsible for functional supervision of CTC line nursing staff and nursing administration, which includes the MHCB. Twenty-four hour registered nursing coverage and availability of a Supervising Psychiatric RN forty hours a week are necessary in the MHCB. There are sufficient nurses within a 24-hour period to provide at least 2.5 hours per inmate-patient (CCR, Title XXII, Section 79759). An inmate-patient with higher acuity needs receives additional nursing and professional care as symptoms require. RNs may co-manage selected inmate-patients assisting PCs with group therapies but will not function independently as PCs.

Mental Health Rehabilitation Services Staff

Mental health rehabilitation therapy services shall evaluate social, recreational, and vocational needs in accordance with the interests, abilities and needs of the inmate-patient; shall develop and prepare related therapies; and shall include such evaluation, and documentation of therapy development and preparation, in the inmate-patient's treatment plan (CCR, Title XXII, Section 79749).

Mental health rehabilitation therapy services shall be designed by and provided under the direction of a licensed mental health professional, a Recreational Therapist, an Occupational Therapist, or a Licensed Psychiatric Technician (CCR, Title XXII, Section 79749 (c) (2)).

In the Department, appropriately trained Correctional Officers (COs) and Correctional Counselors may be counted to meet licensing ratios. COs also assist in managing, observing and escorting the assaultive or suicidal inmate-patients.

Clerical Staff

Clerical support in the MHCB is provided by an Office Technician, who reports to the Clinical Director, and a Medical Transcriber, who is placed in the institutional transcriber pool and reports to the pool's Supervising Medical Transcriber.

L. UNIT HEALTH RECORDS

1. Confidentiality

   Mental health records generally have a higher standard of confidentiality than other medical records. All staff with possible access to such records shall sign an oath of confidentiality to keep any information they learn from the records strictly confidential (CCR, Title XXII, Section 79807).

2. Access

   All MHCB clinicians and nursing staff must have access to the inmate-patient's records 24 hours per day. Records shall be brought as needed from the records storage area, kept in the MHCB treatment area or clinician offices while needed, and returned to the storage area when no longer needed. If records are required outside the MHCB treatment area or clinician's offices, the records shall be hand carried by escorting staff and returned to the MHCB with escorting staff as soon as the outside business is completed (CCR, Title XXII, Section 79807).

3. The Clinical Director shall:

   a. Ensure the History and Physical is transcribed and delivered to the MHCB as soon as possible.

   b. Ensure that previous medical records are provided to the MHCB [Title XXII, Section 79803 (d)].

M. MENTAL HEALTH QUALITY MANAGEMENT SYSTEM

Ongoing assessment of the quality of clinical services will follow the Mental Health Quality Management System procedures.

EXHIBIT 25

Los Angeles Times

Tracking coronavirus vaccinations in California

By Los Angeles Times Staff

Updated Aug. 28 10:04 a.m. Pacific

45,823,123

doses administered

65%

of Californians have received at least one dose

Experts say about 85% of Americans will need to be vaccinated to bring the COVID-19 pandemic under control. This page tracks California's progress toward that goal using data from state and federal authorities.

Jump to a section

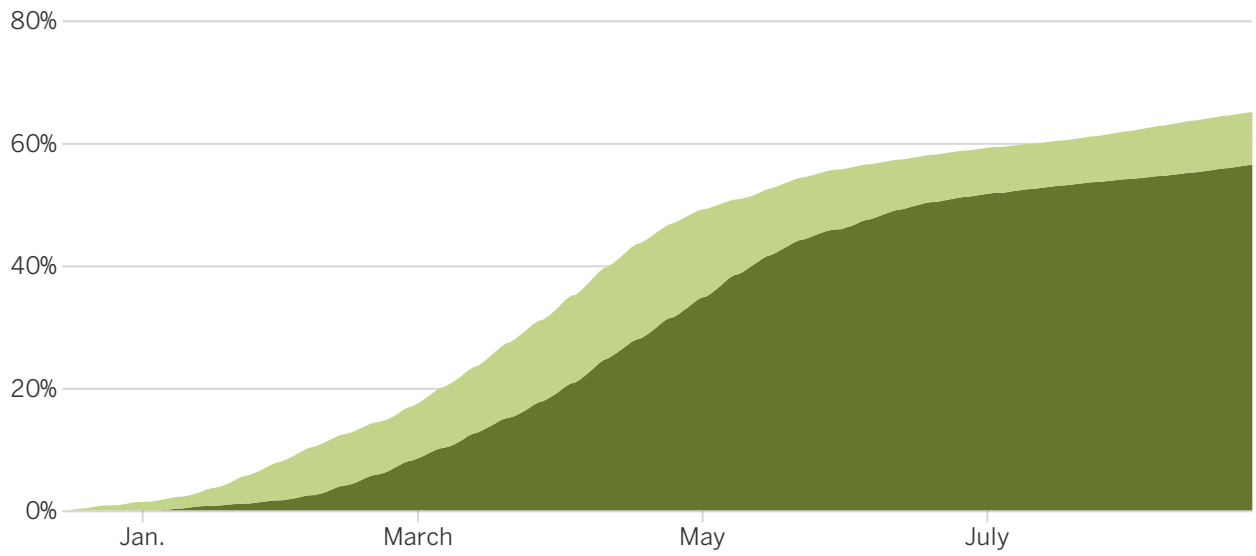
Totals By company By county By ZIP Code By demographic By state

Vaccination totals

So far, 65% of residents have received at least one dose, about 25.5 million people.

Among all Californians, 56.4% are fully vaccinated, meaning they have either received both shots of a two-dose regimen from Pfizer or Moderna, or the single-dose Johnson & Johnson vaccine.

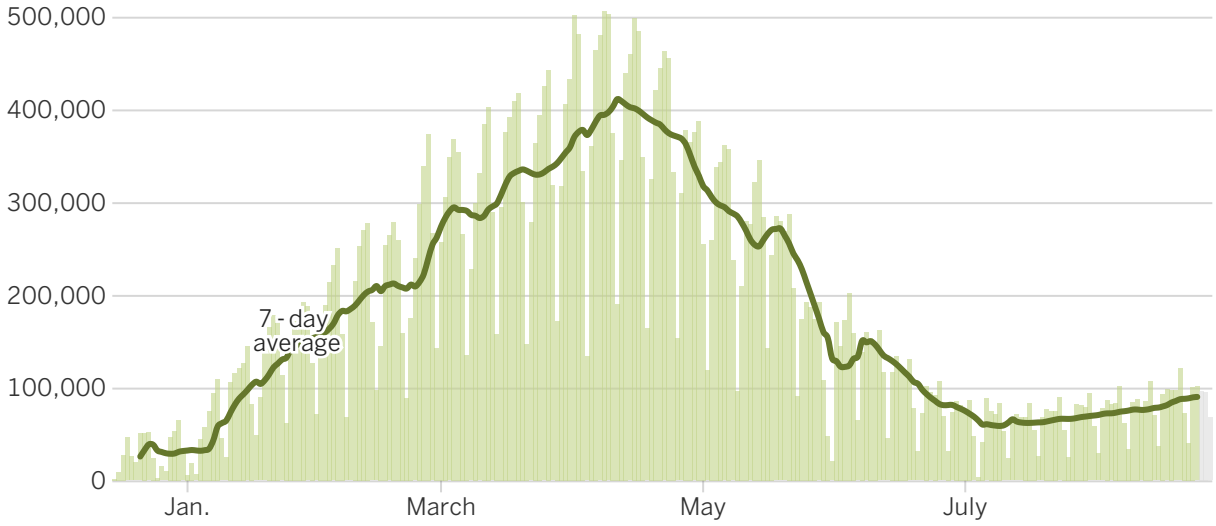
Percentage of Californians who are partially or fully vaccinated



California Department of Public Health

To date, 45,823,123 shots of have been given out to Californians across the state. Over the last seven days, an average of 82,075 doses per day have been administered.

Vaccine doses administered by day



Due to delays in data collection, totals for the most recent days are incomplete.

Track hospitals in California ↗

Follow the data and look up the latest patient numbers and beds at hundreds of hospitals across the state.

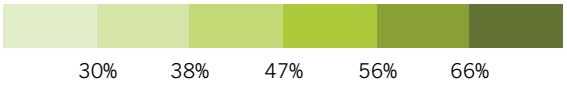
Vaccinations by county

The state health department publishes a breakdown of the number of residents fully and partially vaccinated in all 58 counties.

Progress

Fully vaccinated | At least one dose

Fully vaccinated



County	Doses administered	At least 1 dose	▼ Fully vaccinated
Marin »	397,039	80.7%	74.8%
San Francisco »	1,278,040	78.9%	72.6%
Santa Clara »	2,801,058	77.8%	72.3%
San Mateo »	1,094,079	76.8%	70.1%
Contra Costa »	1,574,439	74.1%	68.5%
Alameda »	2,244,059	74.3%	68.0%
Napa »	188,532	73.1%	64.1%
Sonoma »	660,965	71.0%	63.9%
Imperial »	237,311	77.6%	62.1%

County	Doses administered	At least 1 dose	▼ Fully vaccinated
Santa Cruz »	351,007	69.1%	61.5%
San Diego »	4,195,367	80.0%	61.5%
Alpine »	1,518	72.5%	59.9%
Orange »	3,882,078	66.3%	59.3%
Ventura »	1,021,700	65.5%	58.3%
Mono »	17,127	64.5%	58.1%
Yolo »	258,956	65.5%	58.0%
Los Angeles »	11,990,212	65.3%	57.2%
San Benito »	70,424	66.3%	56.6%
Monterey »	505,046	64.5%	56.3%
Santa Barbara »	516,455	64.3%	56.3%
Placer »	443,331	62.8%	56.2%
Mendocino »	100,730	63.6%	54.5%
Sacramento »	1,694,250	61.0%	53.8%
San Luis Obispo »	311,546	60.5%	53.4%
Humboldt »	147,404	60.1%	53.1%
Nevada »	109,368	60.0%	52.3%
El Dorado »	201,178	59.0%	52.2%
Solano »	493,528	62.9%	52.1%
Sierra »	2,939	52.1%	49.2%
Inyo »	17,885	53.5%	48.0%
Riverside »	2,378,204	55.2%	47.1%
Plumas »	17,431	51.8%	46.8%
San Joaquin »	749,676	58.6%	46.6%
Fresno »	954,592	54.9%	46.0%
Sutter »	91,693	53.8%	45.4%
San Bernardino »	1,979,452	51.1%	44.1%

County	Doses administered	At least 1 dose	▼ Fully vaccinated
Lake »	58,255	50.8%	43.8%
Stanislaus »	524,722	56.4%	43.5%
Colusa »	19,522	51.0%	43.3%
Glenn »	24,157	47.9%	42.9%
Tuolumne »	49,709	50.9%	42.7%
Amador »	37,070	59.0%	42.4%
Calaveras »	41,808	52.4%	42.3%
Butte »	190,860	46.3%	40.6%
Madera »	132,178	48.4%	40.4%
Tulare »	385,774	46.7%	39.1%
Siskiyou »	35,896	45.6%	38.9%
Kern »	723,014	46.2%	38.8%
Trinity »	9,790	43.4%	37.5%
Merced »	225,277	49.6%	36.7%
Yuba »	56,647	43.1%	36.3%
Del Norte »	20,718	43.1%	36.0%
Shasta »	132,545	42.5%	34.9%
Modoc »	6,133	38.2%	34.7%
Tehama »	43,073	37.6%	32.6%
Mariposa »	13,728	49.2%	32.1%
Kings »	101,050	38.8%	31.8%
Lassen »	12,578	23.1%	20.4%

Show less

The sum of doses administered by county is less than the statewide total. Officials say this is because the grand total includes residents of other states who have been given doses while working or quarantining in California.
California Department of Public Health

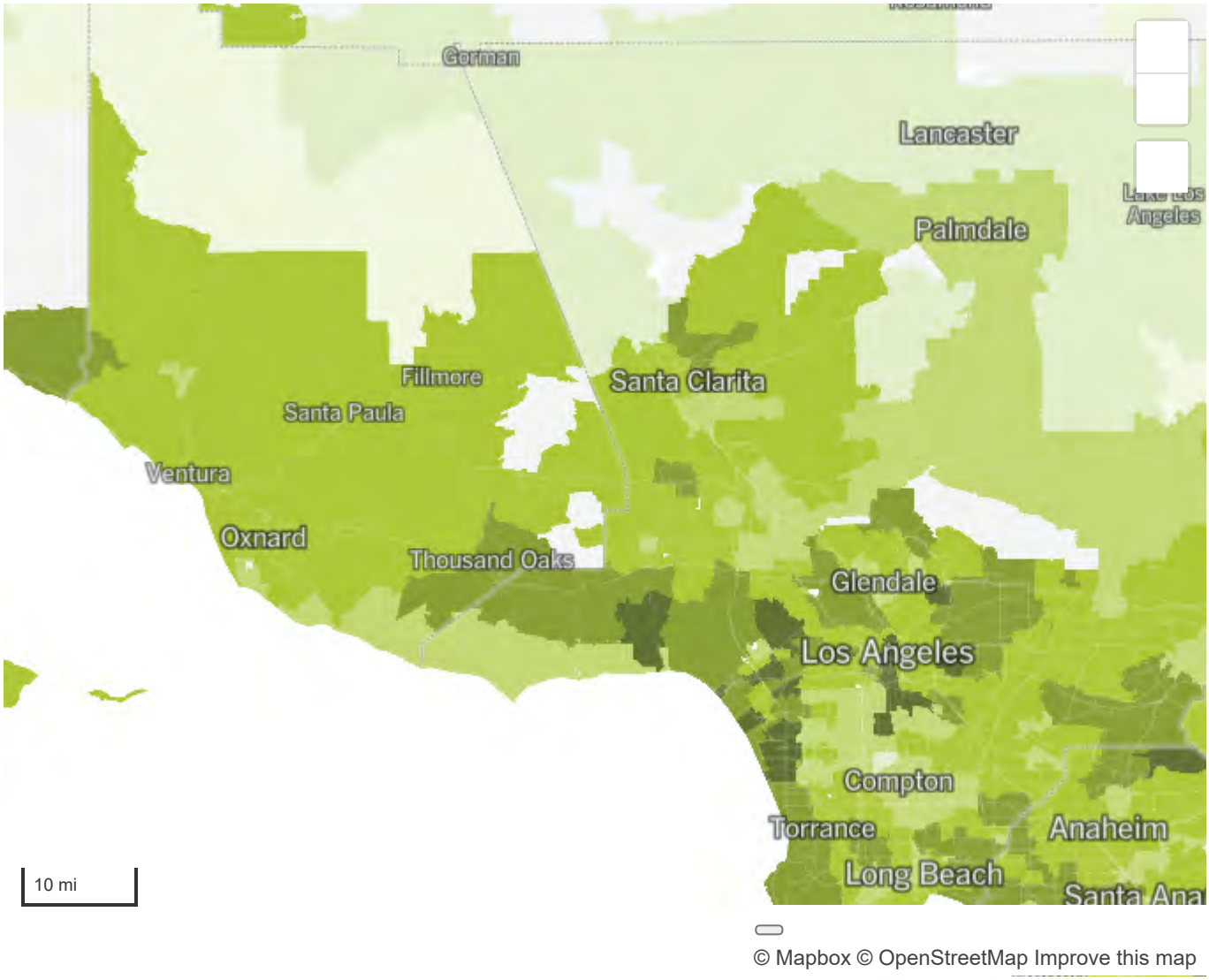
Vaccinations by ZIP Code

Each week, the state public health department publishes the latest vaccination numbers for 1,611 ZIP Codes statewide.

Percentage of residents with at least one dose

30% 50% 60% 70% 80%

Find a ZIP Code



A small number of areas show more vaccinations than residents. State officials said this could be due to data entry errors by the vaccine provider or underestimated population figures. New data is released weekly. Last updated Aug. 24.

California Department of Public Health

Tracking the coronavirus outbreak ↗

Follow the latest data on the spread of COVID-19 in California with our coronavirus tracker.

Vaccinations by company

According to federal data that updates at a slower pace, the shot manufactured by Pfizer-BioNTech represents the lion's share of vaccinations in the state.

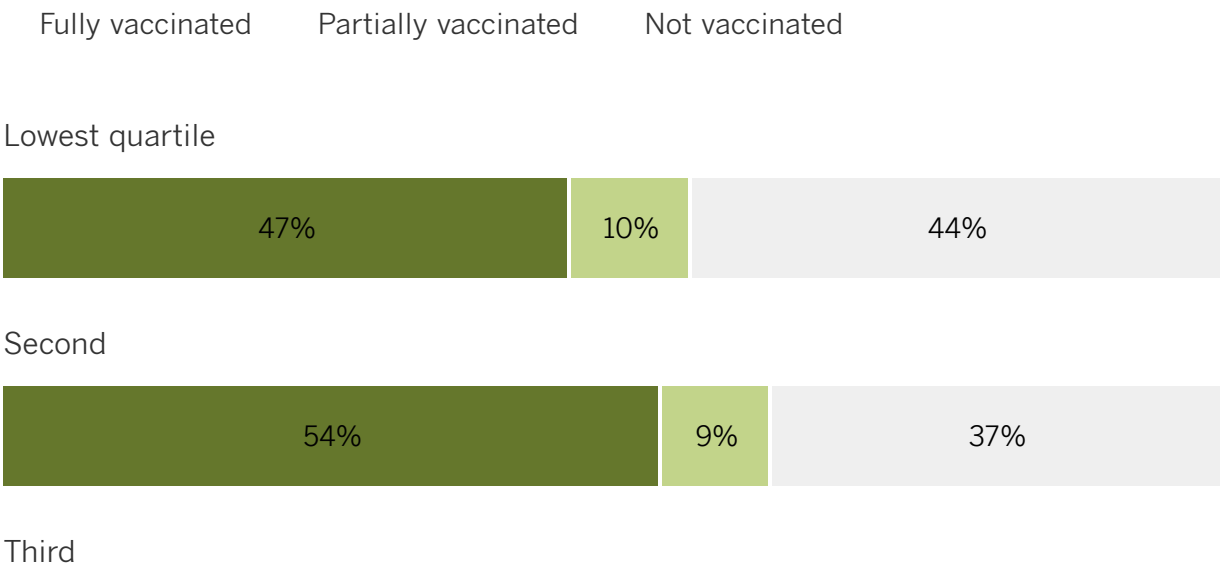
Share of completed vaccinations by Pfizer, Moderna or Johnson & Johnson

Vaccinations by demographic

Officials have assigned every California ZIP Code a community health score by combining a variety of economic and social indicators.

Comparing the health of communities against vaccination rates shows a wide gap, with the most disadvantaged areas 20 percentage points behind the highest ranking areas.

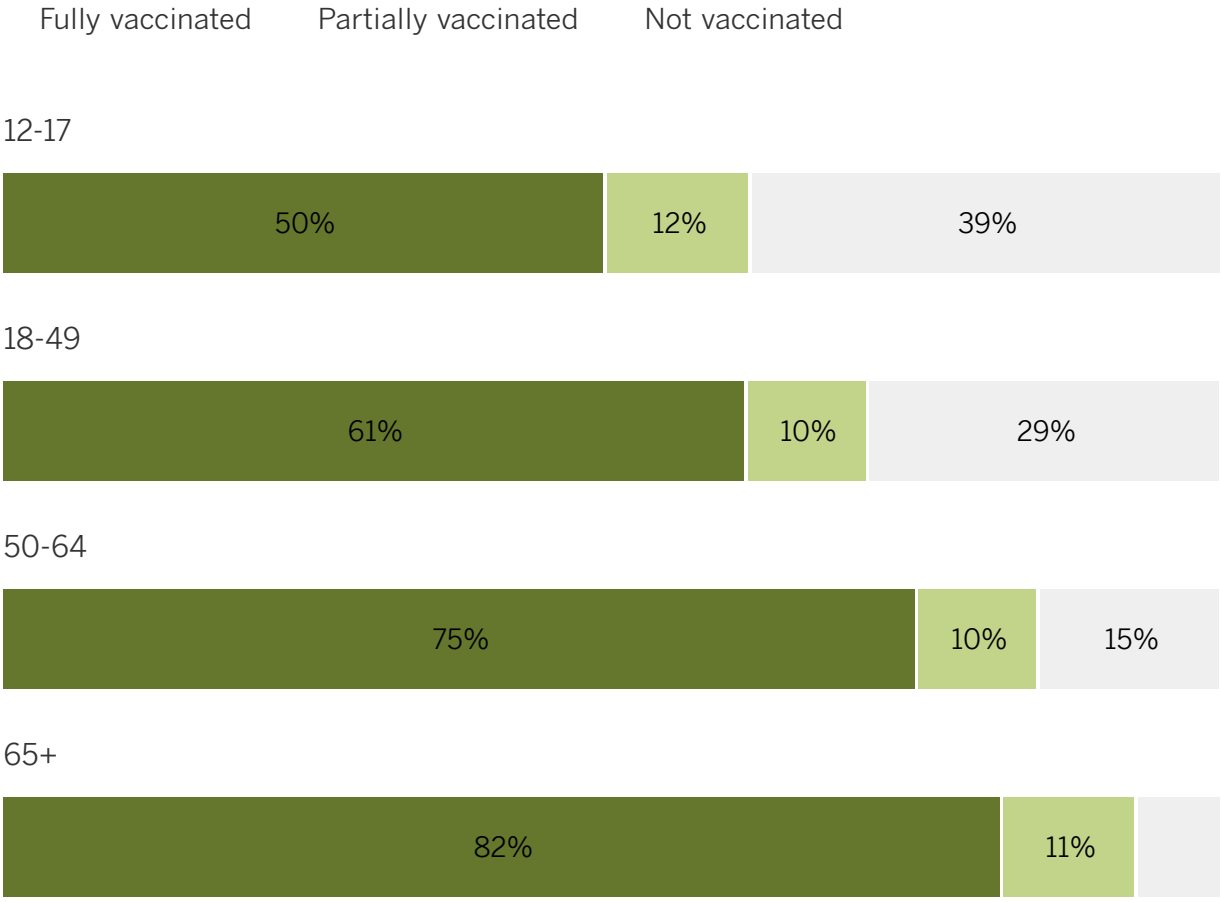
Vaccinations in communities ranked by community health score



California Department of Public Health

About 93% of California seniors have received at least one dose. Vaccinations among younger adults so far trail behind older people by 22 percentage points.

Vaccinations by age group

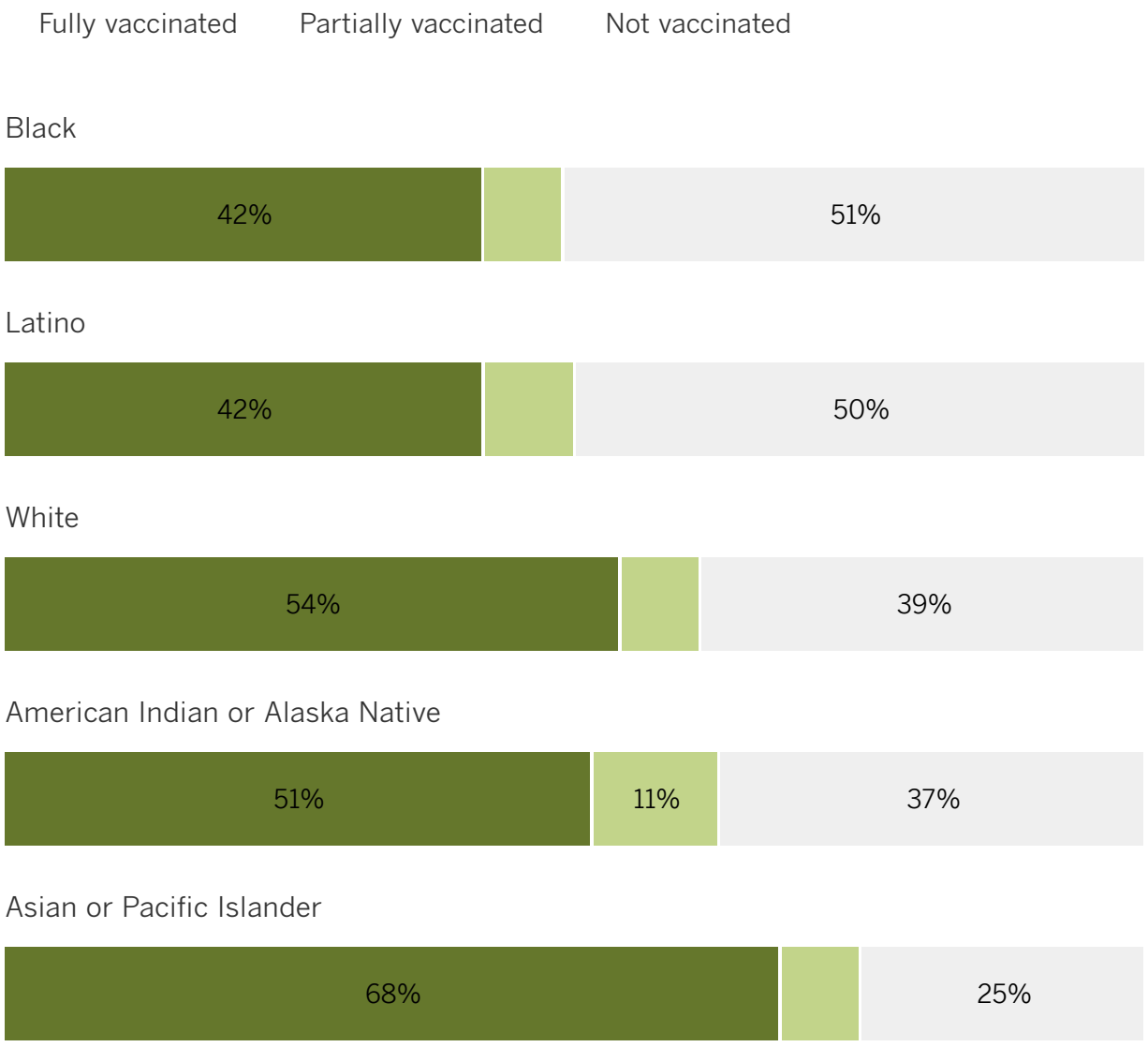


California Department of Public Health

Native American, Black, Latino and white residents have seen lower vaccination rates than the rest of the state.

These numbers are an undercount. The race of about 15.3% of people who have been vaccinated is unknown.

Vaccinations by race



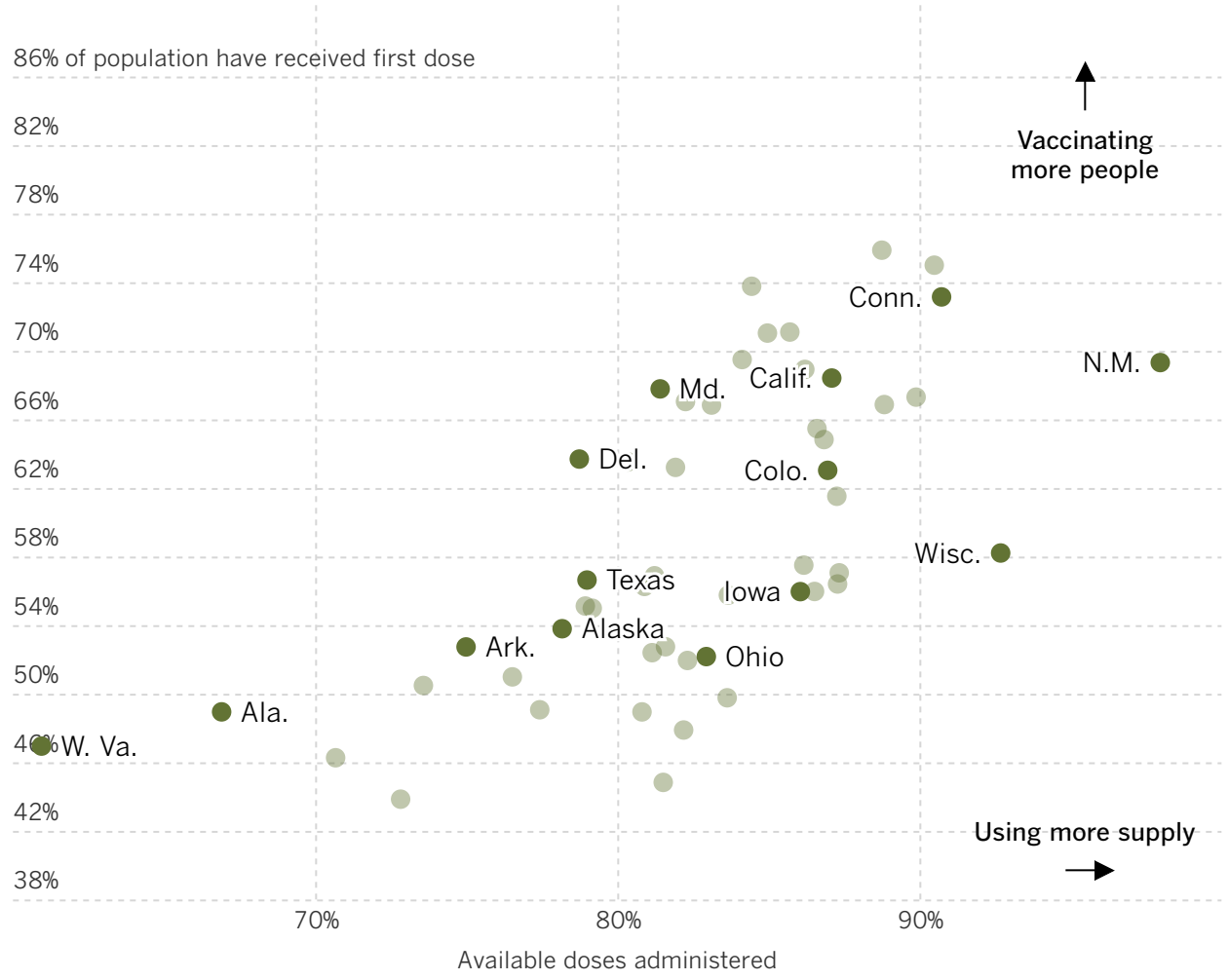
California Department of Public Health

Vaccinations by state

Data from the U.S. Centers for Disease Control and Prevention show how the vaccine rollout is progressing nationwide. The numbers vary slightly from those reported by the state of California.

In California, 68.4% of the population has received at least one dose, which ranks 13th out of all states and territories. Nationwide, 366,838,484 doses have been administered, with 61.3% of Americans receiving a first dose.

Vaccine distribution by state



Centers for Disease Control and Prevention

	Doses	People vaccinated	
Name	**Used**	**▼ At least 1 dose**	**Fully vaccinated**
Republic of Palau	98.7%	90.6%	68.7%
Vermont	88.8%	75.9%	61.2%
Massachusetts	90.5%	75.0%	61.0%
Hawaii	84.4%	73.8%	51.8%
Puerto Rico	96.1%	73.2%	58.7%
Connecticut	90.7%	73.1%	60.1%
Maine	85.7%	71.1%	57.3%
Rhode Island	85.0%	71.0%	59.5%
New Jersey	84.1%	69.5%	56.3%

	Doses	People vaccinated	
Name	**Used**	**▼ At least 1 dose**	**Fully vaccinated**
New Mexico	98.0%	69.3%	55.2%

Show all

Data are updated on weekdays, excluding federal holidays.
Centers for Disease Control and Prevention

Tracking the coronavirus

California counties

Alameda
Alpine
Amador
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Lassen
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz

Shasta
Sierra
Siskiyou
Solano
Sonoma
Stanislaus
Sutter
Tehama
Trinity
Tulare
Tuolumne
Ventura
Yolo
Yuba

Other trackers

Statewide totals
Schools
Hospitals
Nursing homes
State prisons
Housing homeless people
Lives lost
Unemployment and economic fallout
Following the curve
Which counties are open
Which beaches are closed
Frequently asked questions

More coverage

How to get vaccinated
Coronavirus symptoms
How coronavirus spreads
Get our newsletter

About the numbers

This page was created by Sean Greene, Vanessa Martínez, Casey Miller, Rahul Mukherjee, Ryan Murphy and Matt Stiles.

State vaccination data come from the California Department of Public Health and are updated daily. The department's count of vaccines administered includes both first and second doses. Percentages of the population receiving the first and second shot are calculated from the U.S. Centers for Disease Control and Prevention data, which updates

on weekdays. The totals for doses administered and distributed vary slightly between datasets.

The complete Times database on COVID-19 is available to the public on Github, a popular website for hosting data and computer code. The files will be updated daily at github.com/datadesk/california-coronavirus-data.

Learn more about The Times count by reading this list of frequently asked questions or by reading this interview with members of our team.

Change log

Aug. 18 The unemployment tracker has been retired.

Aug. 18 Due to a lack of government data, the Project Roomkey tracker will no longer be updated.

July 10 The regional ICU metric was removed from the hospital tracker since the state has stopped providing it.

July 9 A new method for estimating recoveries was added to the site.

June 15 The state ended its tier-based restriction system and our reopening tracker was retired.

Show all

More coverage

The pandemic's toll: Lives lost in California

It's easier than ever to get a vaccine. Here's how

EXHIBIT 26

California Institution for Men (CIM)

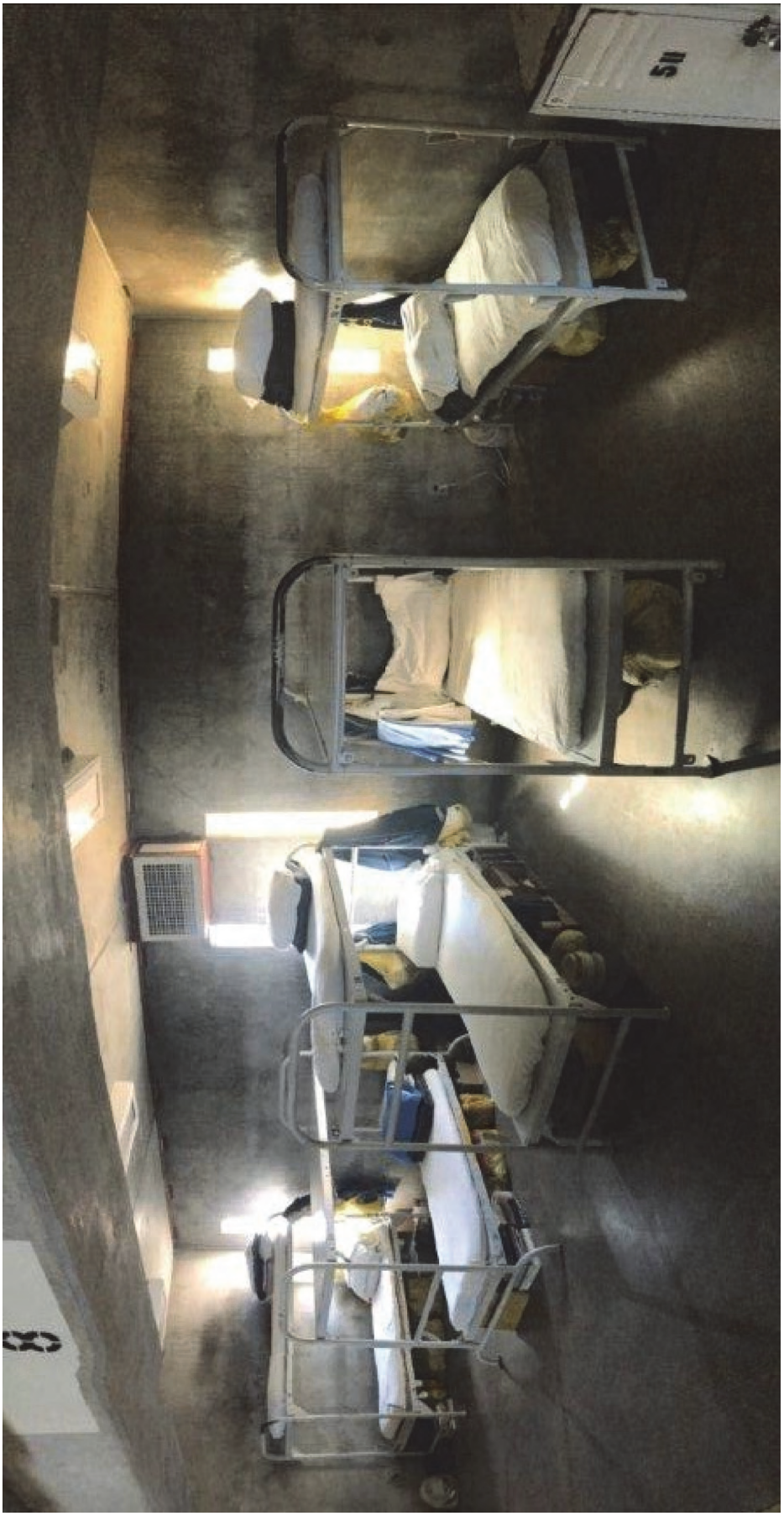
California Institution for Women (CIW)

DORM #2

California Medical Facility (CMF)

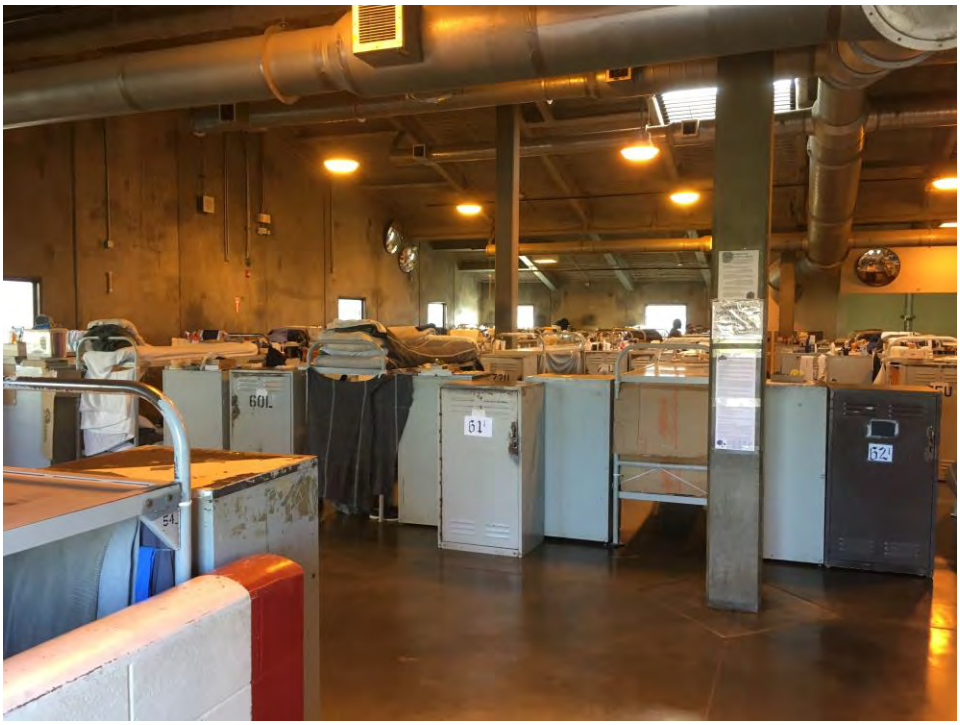

105

Chuckawalla Valley State Prison (CVSP)



Correctional Training Facility (CTF)

FACILITY D, DORM 2 – 6ft. Distance Bunk Design



North Kern State Prison (NKSP)

NORTH KERN STATE PRISON FACILITY C DORM

Salinas Valley State Prison (SVSP)


017

EXHIBIT 27

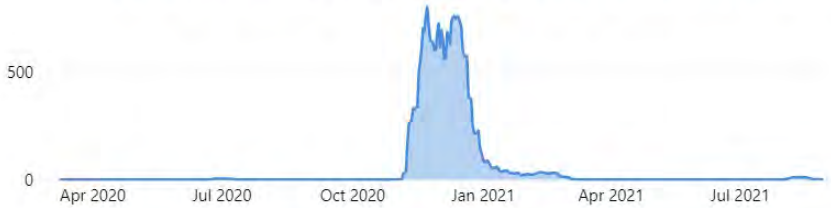
CDCR PATIENTS: COVID-19 BY INSTITUTION

Institution: High Desert State Prison

CONFIRMED CASES: Cumulative Count

NEW IN LAST 14 DAYS	ACTIVE		RESOLVED	DEATHS
	CUSTODY	RELEASED		
1	1	5	2,035	2

NEW IN THE LAST 14 DAYS OVER TIME



*New case count by date may be delayed 2-3 days while awaiting test results.

TESTING: Institution Count

CURRENT POPULATION	PATIENTS TESTED IN LAST 14 DAYS	% OF POPULATION TESTED IN LAST 14 DAYS
3,267	644	20%

PATIENTS TESTED BY DAY

*Released or transfered patients are in the 'Tested By Day' graph but not included in the 'Last 14 Days' count if no longer at the selected institution. Counts may be delayed 2-3 days while awaiting results.

CONFIRMED CASES : Rate Comparison

Cumulative Per 1,000 People

Institution: HDSP	CDCR	County: Lassen	California	United States
625.3	499.8	201.7	108.7	116.4

ROADMAP TO REOPENING: Facility Phases

Summary *(By Facility)*

PHASE 1 *Outbreak*	PHASE 2 *Modified*	PHASE 3 *Normal*
2	0	5

Data Last Updated: Aug 28 2021 11:15AM

Confirmed | Confirmed Table View | Vaccination | Testing | Trended | Reopening | Institution View | Definitions | Version History

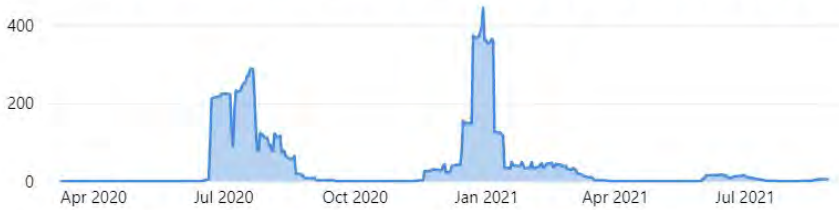
CDCR PATIENTS: COVID-19 BY INSTITUTION

Institution: CA Correctional Center

CONFIRMED CASES: Cumulative Count

NEW IN LAST 14 DAYS	ACTIVE		RESOLVED	DEATHS
	CUSTODY	RELEASED		
5	5	33	1,367	0

NEW IN THE LAST 14 DAYS OVER TIME



*New case count by date may be delayed 2-3 days while awaiting test results.

TESTING: Institution Count

CURRENT POPULATION	PATIENTS TESTED IN LAST 14 DAYS	% OF POPULATION TESTED IN LAST 14 DAYS
2,139	1,261	59%

PATIENTS TESTED BY DAY

*Released or transfered patients are in the 'Tested By Day' graph but not included in the 'Last 14 Days' count if no longer at the selected institution. Counts may be delayed 2-3 days while awaiting results.

CONFIRMED CASES : Rate Comparison

Cumulative Per 1,000 People

Institution: CCC	CDCR	County: Lassen	California	United States
656.8	499.8	201.7	108.7	116.4

ROADMAP TO REOPENING: Facility Phases

Summary *(By Facility)*

PHASE 1 *Outbreak*	PHASE 2 *Modified*	PHASE 3 *Normal*
1	0	17

Data Last Updated: Aug 28 2021 11:15AM

Confirmed | Confirmed Table View | Vaccination | Testing | Trended | Reopening | Institution View | Definitions | Version History

EXHIBIT 28

Prison Law Office (PLO) Inquires

Institution	Inquiry	Response
CCWF	CCWF has had three patients recently test positive. It appears they were each housed in different buildings (507, 514, and 515). 1.) What is known about the source of exposure for each patient? According to the update we received last Friday (8/6), CCWF had 28 staff members out with active cases of COVID-19. 2.) How many correctional officers are out due to a positive COVID test? How many medical staff? 3.) How many correctional officers are out due to a COVID exposure and/or contact tracing? How many medical staff? 4.) How many patients are currently on quarantine due to exposure to a positive staff member?	1.) 507 – indeterminate 514 – traced to positive staff 515 – indeterminate 2.) Correctional Officers – 7 Medical Staff – 5 3.) Corr. Officers out due to exposure – 18 Medical staff out due to exposure – 3 4.) 6
COR	According to the update we received last Friday (8/6), COR had 25 staff members out with active cases of COVID-19. 1.) How many correctional officers are out due to a positive COVID test? How many medical staff? 2.) How many correctional officers are out due to a COVID exposure and/or contact tracing? How many medical staff? 3.) How many patients are currently on quarantine due to exposure to a positive staff member? The 8/10 OMT reports: "Nursing requested additional registry staff due to increased workload with frequent testing and rounds; recruitment ongoing. 2 nursing staff out COVID positive." 4.) When was the request for additional nursing staff made? 5.) What is the status of this request?	1.) 20 correctional officers and 5 medical staff. 2.) 14 correctional officers and 2 medical staff. 3.) Possible exposure to positive staff 58 (HUA, HUB & HUC). 4.) The request was made on 6/25/21. 5.) On August 23, 2021, 3 LVNs and 5 C.N.As will start working at COR as contract/registry staff.
SAC	According to the 8/10/21 OMT, "High custody vacancy rates continue. Starting 05/24/21, the institution is now under PSR SAC-CUS-21-005 until further notice. To address the staffing shortage, 25 Officers from FOL started on 06/28/2021 and 25 Officers from MCSP started on 08/02/2021."	1.) **804.2 C/O positions and 73.2 vacancies** 2.) **19 officers out due to positive COVID test.** 3.) 1 officer out due to COVID exposure and/or contract tracing. 4.) 2 officers out due to long term medical condition on account of COVID

Prison Law Office (PLO) Inquires

	1.) How many officers should SAC have and what is the current vacancy rate among officers at SAC? 2.) How many officers are out due to a positive COVID test? 3.) How many officers are out due to a COVID exposure and/or contact tracing? 4.) How many officers, if any, are out due to long term medical condition on account of COVID? 5.) What does it mean for daily programming operations, including medical operations, that the institution is under PSR SAC-CUS-21-005? Are all buildings under modified program? If not, which buildings remain on modified program and when are they expected to come off ? 6.) Is the PSR in effect at all related to the staff shortages? Please explain. According to the most recent OMT, SAC is in a Phase 3 nursing shortage. 7.) In practical terms, how many nurses is SAC allocated and how many of those positions are filled? 8.) How many nurses, if any, are out due to COVID or exposure to COVID? 9.) How is SAC filling the vacant position? 10.) Have any nursing functions been curtailed due to the shortages? Please explain. 11.) In the past two weeks, how many units at SAC have gone on, or are currently on quarantine, due to a COVID positive staff exposure?	5.) **CSP-SAC is not on PSR currently.** 6.) **No, CSP-SAC is not on a PSR currently** 7.) Per recent Pars/Mar Psychiatric Technician - total of 106 post- 81 post filled. RN - 86 total posts with 72 posts filled (not included: LTL, Sick leave, etc.) LVNs - a total of 25 posts and 18 post filled. 8.) We have 1 nurse out on COVID at the moment 9.) SAC is utilizing services of Registry/Contractors through Management solutions to cover vacant posts. SAC also use VOR process to cover vacancies on a daily basis. SAC use monthly OT BID to cover vacant post. SAC hired LIE and Part Time staff to help cover vacant post 10.) No. SAC continues to allow nurses to perform all nursing functions to full extent. 11.) Currently, we have one unit (B7) on Quarantine dues to (+) staff exposure and one due to (+) patients exposure. Multiple IPs placed on quarantine in various units due to the (+) staff exposure, but not necessarily the entire unit.
SQ	The 8/10/21 OMT is unclear regarding post-transfer quarantine, and we have received an anonymous report that sometime in the last two weeks incarcerated people were transferred into the prison who said they were not vaccinated against COVID-19 and who were not quarantined. 1.) How many people transferred into San Quentin between July 25, 2021 and August 10, 2021, and how many of them were not fully vaccinated?	1.) **Between July 25, 2021 and August 10, 2021, San Quentin received 125 inmates transferring in from other institutions or the RC. All of the 125 inmates were vaccinated. However, if we received a patient that was unvaccinated, they would be housed in the Adjustment Center. As requested, attached are the CDCR 135's (Transfer Record) of the patients that transferred into SQ during the above timeframe.**

Prison Law Office (PLO) Inquires

	2.) Where were was each unvaccinated person housed, and was all housing of unvaccinated transferees in accord with the latest Movement Matrix (please explain)? 3.) Please also provide a list of all who transferred into San Quentin between July 25 and August 10, 2021, and the COVID vaccination status of each.	
SATF	According to the update we received last Friday (8/6), SATF had 27 staff members out with active cases of COVID-19. 1.) How many correctional officers are out due to a positive COVID test? How many medical staff? 2.) How many correctional officers are out due to a COVID exposure and/or contact tracing? How many medical staff? 3.) How many patients are currently on quarantine due to exposure to a positive staff member?	1.) **For staff out due to a positive COVID-19 test, CSATF has:** **Custody – 14** **Medical – 7** 2.) For staff out due to COVID exposure and/or contract tracing, CSATF has: Custody – 12 Medical – 3 3.) For patients on quarantine due to exposure to a positive staff member, CSATF has 29.
SCC	The answers received from CDCR on 8/10/21 indicated that some incarcerated persons exposed to COVID were not being housed in solid door single door cells for their quarantine period. However, the number of people so housed, the circumstances of such housing, and why solid door single door cells were not being used was not clear. 1.) Since 7/15/21 to and including 8/10/21, how many people at SCC exposed to COVID-19 were not housed in a solid door single cell? 2.) For those people, why were they not housed in a solid door single cell? 3.) Where were they housed? 4.) For each such housing location, were the people on quarantine for exposure not housed in a dorm with those not known to be exposed? If no, please explain. 5.) Also, were they housed in cohorts as small as possible, no more than 2-4 persons? If no, please explain.	1.) **Although SCC noticed a spike in staff positives at the end of June; the first positive inmate/patient resulted on 7/19/2021. The data below represents from 7/20/2021 through and including 8/10/2021 which correlates to the daily OMT reporting.** **7/20/2021: 28 (.17%*) 7/28/2021: 243 (1.60)** **7/31/2021: 290 (2.38) 8/3/2021: 326 (2.87)** **8/6/2021: 346 (2.79) 8/9/2021: 339 (2.99)** **7/26/2021: 203 (1.44) 7/29/2021: 251 (2.4)** **8/1/2021: 290 (3.06) 8/4/2021: 338 (2.70)** **8/7/2021: 347 (3.31) 8/10/2021: 339 (2.34)** **7/27/2021: 212 (1.57) 7/30/2021: 230 (2.0)** **8/2/2021: 284 (3.02) 8/5/2021: 368 (2.44)** **8/8/2021: 219 (3.19)** *** Testing positivity rate** **Average number of patients on quarantined in a dorm setting: 273.7**

		Average positivity rate for SCC from 7/20/2021-8/10/2021: 2.36% **In comparison to what one finds in the community: (CDC COVID Data Tracker)** **Even given the limitations of SCC's dorm setting our transmission levels and positivity rates are in the low transmission statistical range.** 2.) **SCC's Plant has 5 units with single cell layout on C Facility. C1 is reserved for inmates who may return from camp (various reasons, not COVID related), C2 is ASU, C3 is designated as Quarantine Unit and C4&5 contain inmates with a higher custodial need who cannot be housed in a dorm setting.** **Additionally, lessons learned during our December 2020 outbreak were that excessive movement, compactions, etc. led to increased infectivity across the institution and, while this is a much more virulent variant, we have managed to moderate the spread much more effectively through limiting movement as compared to our previous experience.** 3.) **They were/are housed in their primary assigned dorm(s) within A Facility depending upon whether an index positive case was removed from that dorm. There are a total of 38 dorms on Facility A, of which SCC is currently utilizing 8 dorms for quarantine housing due to limited space in the celled housing.** 4.) **No. When an inmate who lives in a dorm tests positive for COVID, that inmate (the index case) is removed from the dorm and placed in Isolation. The remainder of the inmates within that dorm, which could range from 1 to 31, are placed on quarantine. If we do not have enough available housing in our Facility C, Building 3 celled living (designated contact**

		quarantine space), the inmates remain in their dorm for their quarantine period until the celled living becomes available. Therefore, all inmates within the dorm on quarantine have been exposed to the index case and remain on quarantine together. This process prevents the potential risk of cross exposing inmates from other dorms. 5.) **As explained above, we do not remove quarantined inmates from the exposed dorms in order to prevent cross contamination among other dorms. In addition, the population on Facility A does not allow for numbers as low as 10 inmates within a dorm. However, we are proactive in ensuring quarantine dorms with large numbers of inmates are housed into celled quarantine as quickly as the vacancies permit.**

EXHIBIT 29

FOR IMMEDIATE RELEASE

Contact: Colorado Department of Corrections
Annie Skinner, Public Information Officer
719-322-8228
annie.skinner@state.co.us

Colorado Department of Human Services
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State Agencies with 24/7 Facilities to Require COVID-19 Vaccinations for Staff Members

STATEWIDE - The Colorado Department of Corrections (CDOC), the Colorado Department of Human Services (CDHS), and the Colorado Department of Public Health and Environment (CDPHE), announced that agency staff members and other state employees that interact with vulnerable populations and populations living in congregate living settings will be required to be vaccinated against COVID-19. The Delta variant is increasing COVID-19 cases and hospitalizations in our state like in the rest of the country and data shows that unvaccinated people are at a higher risk of getting the COVID-19 virus and spreading it to others.

The Centers for Disease Control and Prevention, and state public health officials concur that the best way to protect Coloradans is for individuals to be fully vaccinated against COVID-19.

"We have a responsibility to protect the health and safety of our staff and the incarcerated individuals in our custody to the best of our ability. Some people will say that it is a personal choice whether or not they want to get vaccinated, but it is very difficult to socially distance in congregate settings, and inmates do not have a choice regarding where they live and who they come in contact with," said CDOC Executive Director Dean Williams. **An individual who can get the vaccine and yet is avoiding it, is potentially putting the lives of the people around them at risk and individuals incarcerated at risk. Our dedicated staff have a responsibility to protect public safety and that includes protecting their loved ones, co-workers, inmates, parolees, and communities from this potentially deadly virus."**

"We are in the health care business. It is our ultimate responsibility to do everything we can to protect and provide for the wellbeing of our clients, and one another," said CDHS

Executive Director Michelle Barnes. **“Our clients are in congregate care settings. This virus and its variants have hit these environments hard. It is incumbent upon us to do the right thing for our clients, staff, loved ones and community."**

"The vaccine is the most powerful tool we have to end this pandemic, but it’s only effective when people get it. We are continuing to make the vaccine as accessible as possible, and more than 3 million Coloradans are already fully vaccinated. By requiring the vaccine for people who work in congregate settings and with high-risk populations, we can make even more of a difference. We simply cannot allow the delta variant to jeopardize the progress we have achieved in protecting Coloradans," said Jill Hunsaker Ryan, executive director, CDPHE.

The staff members included in the mandate for CDOC and CDPHE will have until September 30th to receive the first dose of the vaccine and are required to be fully vaccinated by October 31. CDHS staff will be on a staggered rollout by facility with fully vaccinated dates between October 31 and November 14. Staff members can either receive their vaccine through clinics hosted by their department, or can receive their vaccine at any of the numerous public options around the state, their provider, and provide proof of that vaccination to their department. Colorado has a digital verified vaccine card in the form of the myColorado mobile app, which empowers Coloradans to access their own information when and where they want it.

For CDOC: all CDOC employees that interface with the public, interact with inmates or parolees, or who enter into facilities as part of their job assignment will be required to receive the vaccine. CDOC will also require other state employees, contract employees, visitors, volunteers and vendors who enter a prison facility to be vaccinated (with some accommodations made for extenuating circumstances).

For CDHS: all CDHS direct care and support staff who regularly enter CDHS facilities, including all leadership positions at CDHS and other state employees who may interact with facility staff, will be required to receive the vaccine. CDHS will also require proof of vaccination for contractors who regularly enter facilities and interact with clients. This includes but is not limited to providers of OT/PT, education providers, security personnel, and temporary staff.

For CDPHE: all CDPHE employees, temporary staff, and contractors who go in-person to health facilities to perform a job duty (e.g., long-term care facility inspectors); staff and contractors who are on-site administering or managing vaccine or testing events; staff and contractors in the Disease Control and Public Health Response Division (DCPHR), including from the State Lab and Office of Emergency Preparedness and Response; and staff and contractors who could come in face-to-face contact with moderate-to-severe immunocompromised Coloradans through the regular course of their duties, as defined by the CDC’s additional dose recommendations.

Additional Information:

Employees of CDOC and CDHS have had access to receive the COVID-19 vaccine since January of 2021. The Departments have held numerous vaccine clinics in order to provide continued

access to the vaccine for staff as well as inmates and clients. The Departments also provided other incentive programs to encourage vaccination.

Currently 58.7% of all DOC staff are fully vaccinated (both doses of Moderna/Pfizer or the one dose Johnson and Johnson). Amongst the inmate population, 64% are fully vaccinated and another 8% have received at least their first dose.

The current vaccination rate for all of CDHS direct care staff is 77%, and 73% for residents and clients.

More information on where to find a vaccine and the safety of the COVID-19 vaccine can be found here.

EXHIBIT 30

Read Gov. Pritzker's Full Remarks on New COVID Mitigations for Illinois

Published August 4, 2021 • Updated on August 4, 2021 at 4:53 pm

Gov. J.B. Pritzker on Wednesday announced that all students and teachers in schools will be required to wear masks while indoors, as state officials take steps to try to slow the spread of the delta variant of COVID-19.

Gov. J.B. Pritzker announced new COVID-19 mitigations Wednesday as cases surge throughout Illinois, including a mask mandate for students and teachers in schools, as well as vaccine requirements for state-run congregant care facilities.

Read his full remarks on the new state orders below:

Good afternoon everyone. I'm here with Illinois Department of Public Health Director Dr. Ngozi Ezike to address the growing threat of the Delta variant of the COVID-19 virus.

Since we reached our lowest case numbers earlier this summer, we've seen COVID-19 cases soar by a factor of nearly 10. Hospitalizations and ICU rates have doubled in a month. And since the middle of July, the number of COVID patients requiring a ventilator has multiplied nearly 2.5 times over.

This upward movement has occurred almost entirely among those who are unvaccinated. In the month of June, 96 percent of people hospitalized in Illinois with COVID-19 were unvaccinated or only partially vaccinated – the majority of which are UNDER 60 years old.

Every time we think we know where this virus is headed, it changes and shifts. For example, unlike before, people 29 years old and younger accounted for 12 percent of hospitalizations. All across the nation, we are seeing young people with no other underlying conditions now on ventilators. I want to say specifically to young adults: please do not think the worst case scenario can't happen to you. It can happen. It is happening. Get vaccinated. To parents of minors who are eligible to get the shot, please get your children vaccinated as soon as possible.

This isn't just happening to young people. To everyone listening, I wish we could avoid having COVID interfere with our summer. But the virus and its effects are increasing once again, and the largest group affected who are being hit especially hard are the unvaccinated.

Local

21 MINS AGO
Jesse Jackson in Rehab Facility, Wife Moved From ICU as COVID Battle Continues

28 MINS AGO
Proof, Testing, Religious Exemptions: What to Know About COVID Vaccine Mandates

As your governor, it's my duty to say that we all must take immediate and urgent action to slow the spread of this Delta variant. People are dying who don't have to die. It's heartbreaking, and it impacts us all.

Given our current trajectory, we have a limited amount of time right now to stave off the highest peaks of this surge going into the fall. We need to act now or risk what we're starting to see in places like Florida, which has once again set a new record for COVID hospitalizations.

Unlike last year at this time, we now have an extremely effective tool to save lives and keep our hospital systems from being overwhelmed with COVID19 patients. It will allow is to support kids' FULL return to in-person learning. It will keep businesses open. And it's easy to get.

It's the vaccine.

For those of you who are still sitting on the fence about getting vaccinated, I urge you to talk to your own doctor about your concerns. Or listen to Dr. Ezike and the world class medical professionals I've invited here over the past year and a half, all of whom will tell you that the vaccine is safe, effective and prevents serious illness or death even from the Delta variant.

Every Illinoisan who is eligible should get vaccinated as soon as possible. In the meantime, we cannot delay taking action. Today I am announcing our initial actions to combat the fast-moving Delta variant.

We are taking three key steps to protect our state's 1.8 million unvaccinated children under 12 and their families, residents and staff of long-term care facilities, and those highly vulnerable people who rely upon state employees for their daily care.

First, far too few school districts have chosen to follow the federal Centers for Disease Control's prescription for keeping students and staff safe, though I want to commend the districts of Edwardsville, Champaign,

Peoria, Springfield, Elgin, Chicago and others for already doing the right thing by their students.

Given the CDC's strong recommendation, I had hoped that a state mask requirement in schools wouldn't be necessary. But it is. The Delta variant is highly transmissible, more so than any of the previous forms of the virus. Because of the lower rates of vaccination among teens aged 12 to 17, because the vaccine has not yet been approved for children under 12, and because of the reluctance of some districts to adopt the CDC's guidance, effective immediately, all P-12 schools and day cares in Illinois must follow the CDC guidance of universal masking inside, regardless of vaccine status.

My goal has always been to safely bring all kids into the classroom at the start of the school year and, crucially, keep them there. Without these measure, we would likely see many more outbreaks than in the latter half of the last school year. Preventing outbreaks from the start also prevents kids from having to stay home because they're sick, or in quarantine.

This requirement extends to P-12 sports: face coverings will be required for all indoor recreation, whereas outdoors, where transmission risks and rates are lower, athletes and coaches will not be required to mask. We will continue to encourage school districts to make sure their athletes are tested regularly to catch any potential outbreaks early.

And to ensure that schools have what they need to adhere to the new mask requirement, my administration is ready to supply masks to any school districts that need them. That's on top of the FREE COVID-19 testing supplies we've providing to all our public schools statewide.

Throughout this pandemic, we've shifted public health protocols as circumstances change, and we'll continue to do so. We'll continue to watch for things like a significant reduction in transmission, the availability and utilization of vaccines for school-aged children under 12, and additional guidance from the CDC – and, as we see developments in those areas, we will adjust our requirements for schools accordingly. Again, our goal has

always been to make sure every child can go to school this fall and that the school environment is safe for everyone.

Today I'm also announcing that Illinois will require vaccinations for ALL state employees who work in congregate facilities, such as our veteran's homes, corrections facilities, and Department of Human Services developmental centers and psychiatric hospitals.

Our most vulnerable residents – such as veterans who can't live on their own and adults living with developmental disabilities – have no choice but to live amongst these workers. By and large, residents of these state-run facilities have done what they can to protect themselves by getting vaccinated. For example, residents at our state veterans' homes have vaccination rates of 96%, 98%, even 100%.

And yet many of the long-term care facilities' employees have themselves not yet been vaccinated. The run the risk of carrying the virus into work with them – and then it's the residents who are ending up seriously sick, hospitalized, or worse. It's a breach of safety, it's fundamentally wrong, and in Illinois, it's going to stop. We already require masks for everyone entering state facilities, but if we're going to fully protect our vulnerable populations, the most effective infection control measure is vaccination. It's our obligation to exercise due care in protecting of the health of the residents, so we will.

We've notified the unions about this necessary safety measure, requesting that they come to the negotiating table to work out the details. Our state agencies will continue to make the vaccine readily available to employees, including hosting vaccination drives at worksites and offering paid time off for receiving the vaccine.

This directive takes effect October 4th, two months from today, leaving ample time for employees to get fully vaccinated. If I could do it sooner I would. Until then, all employees will remain be masked up.

Finally, I'm announcing a universal mask mandate in all long-term care facilities across Illinois, including those that are privately owned and operated. This means everyone, vaccinated or not, must wear a mask when in a facility with long term care patients and residents. This is already standard practice in much of the industry, but while the Delta variant rages on, I want to leave no doubt on the need for compliance.

I will continue to listen to IDPH and other experts to evaluate any and all necessary action to protect children, prevent death, and support our healthcare systems. I'm asking private employers to do the same. Already, we've seen companies with Illinois operations, like Tyson and Google, announce vaccine requirements for employees. I applaud those employers who have taken steps to protect their employees, their customers and the public from the virus and I hope to see others join them.

Most crucially, I'm putting this call out to ALL long-term care facilities and nursing homes in the state of Illinois. Your workers are on the frontlines of protecting thousands of our elderly loved ones – but across the state, staff vaccination rates are dramatically lower than those of your residents. At a troubling number of facilities, staff vaccination rates are below 25 percent.

I want to end with a message for our vaccinated residents.

I know this is hard. You did the right thing for yourself, for your family, for your community, and now, because of the new Delta variant and the high number of unvaccinated people in the U.S. it feels like we're going backwards in this journey.

Please remember that the vast majority of vaccinated people are safe. No vaccine is 100 percent effective, and hearing about breakthrough cases on the news can feel scary, even when breakthroughs are rare and mild. But the likelihood of a vaccinated person testing positive for COVID-19 remains extremely low – and, most importantly, these vaccines are doing what they're designed to do: essentially eliminate the risk of hospitalization and death.

Again to all those who are already vaccinated, I'm going to ask one more thing of you: Talk to someone in your life who could get the vaccine, but hasn't yet. Please: share your story. Share why you got vaccinated. Let them know the vaccine is free. Let them know they can go to their doctor, to a pharmacy, to the clinic – and if they're homebound, someone can come and vaccinate them. Let them know they'll still be eligible for the $1 million Illinois vaccine lottery – and most important, that they'll receive the lifesaving benefits of the vaccine.

We'll get through this as Illinoisans always have come through crises: working together. Thank you.

EXHIBIT 31

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COMMONWEALTH OF MASSACHUSETTS
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CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

By His Excellency

CHARLES D. BAKER
GOVERNOR

EXECUTIVE ORDER NO. 595

IMPLEMENTING A REQUIREMENT FOR COVID-19 VACCINATION FOR THE COMMONWEALTH'S EXECUTIVE DEPARTMENT EMPLOYEES

WHEREAS, vaccination is the most effective tool for combating the 2019 novel Coronavirus ("COVID-19") and the executive department of the Commonwealth, as the largest employer in the State, can lead in promoting policies to ensure the health and safety of all Massachusetts workers and residents;

WHEREAS, widespread vaccination is the only means the Commonwealth has over the long-term to ensure protection from COVID-19 in all its variations and to end the many negative consequences COVID-19 produces in our daily lives;

WHEREAS, COVID-19 vaccines are safe and effective, as evidenced by the fact that COVID-19 vaccines have satisfied the U.S. Food and Drug Administration's rigorous scientific standards for safety, effectiveness, and manufacturing quality needed to permit widespread use and distribution, and to date, more than 357 million doses of COVID-19 vaccines have been safely administered in the United States, with more than 9 million safely administered in the Commonwealth, and negative side effects have proven exceedingly rare;

WHEREAS, the Commonwealth leads the nation in nearly every measure of progress in vaccinating its residents, with over 64 percent of the Commonwealth's population fully vaccinated and over 74 percent of persons 18 and older fully vaccinated, both as reported by the Centers for Disease Control;

WHEREAS, the COVID-19 vaccine is a proven measure at preventing hospitalization and severe disease;

WHEREAS, achieving full vaccination among the executive department workforce is necessary to ensure that the executive department can provide the full measure of public services due to the residents of the Commonwealth;

NOW, THEREFORE, I, Charles D. Baker, Governor of the Commonwealth of Massachusetts, by virtue of the authority vested in me by the Constitution, Part 2, c. 2, § 1, Art. 1, do hereby order as follows:

Section 1. It is the policy of the Commonwealth that all executive department employees shall be required to demonstrate that they have received COVID-19 vaccination and maintain full COVID-19 vaccination as a condition of continuing employment.

For the purposes of this executive order, the executive department includes the office of the Governor, any executive office of the Commonwealth, as defined by section 2 of chapter 6A of the General Laws, and any agency, bureau, department, office, or division of the Commonwealth within or reporting to such an executive office of the commonwealth.

For the purposes of this executive order, the definition of employee shall mean any person who performs services for a Commonwealth executive department agency, bureau, department, office, or division of the Commonwealth for wage, remuneration, or other compensation, including full-time, part-time, seasonal, intermittent, temporary, post-retiree and contract employees, and interns.

Section 2. The Human Resources Division ("HRD") shall within 60 days of this order establish and issue a written policy for all executive department employees to require proof of COVID-19 vaccination, and the heads of all executive department agencies, bureaus, departments, offices, and divisions shall then implement the terms of the HRD policy. The HRD policy shall include the elements listed below:

1. a requirement that all executive department employees demonstrate no later than October 17, 2021 to their employing agency, bureau, department, office, or division that they have received COVID-19 vaccination and, going forward, that they demonstrate they are maintaining full COVID-19 vaccination;
2. a procedure to allow limited exemptions from the vaccination requirement where a reasonable accommodation can be reached for any employee who is unable to receive COVID-19 vaccination due to medical disability or who is

unwilling to receive COVID-19 vaccination due to a sincerely held religious belief;

3. a method for documenting and verifying vaccination status among executive department employees that ensures all information will be maintained confidentially and separately from any employee's personnel files;
4. appropriate allowance for use of Commonwealth-provided sick leave or other time off for employees in order to obtain COVID-19 vaccination; and
5. appropriate enforcement measures to ensure compliance, which shall include progressive discipline up to and including termination for non-compliance and termination for any misrepresentation by an employee regarding vaccination status.

Section 3. Independent agencies and authorities, public institutions of higher education, elected officials, other constitutional offices, the Legislature, and the Judiciary are encouraged to adopt policies consistent with this Executive Order.

Section 4. This Executive Order shall continue in effect until amended, superseded, or revoked by subsequent Executive Order.

Given at the Executive Chamber in Boston this 19th day of August in the year of our Lord two thousand twenty-one and of the Independence of the United States of America two hundred forty-five.

CHARLES D. BAKER
GOVERNOR
Commonwealth of Massachusetts

WILLIAM FRANCIS GALVIN
Secretary of the Commonwealth

GOD SAVE THE COMMONWEALTH OF MASSACHUSETTS

EXHIBIT 32

Governor Kate Brown Announces New Statewide Measures to Address Rising COVID-19 Hospitalizations

August 10, 2021

All State of Oregon executive branch employees required to be fully vaccinated

Salem, OR—Governor to hold press conference tomorrow, August 11, to announce new statewide indoor mask requirements

Governor Kate Brown today announced she will be issuing two new health and safety measures to address the spike in COVID-19 hospitalizations being driven by the spread of the highly contagious Delta variant: a vaccination requirement for state employees and statewide indoor mask requirements.

New modeling from the Oregon Health Authority and Oregon Health & Science University (OHSU) projects that, without new health and safety interventions in place, COVID-19 hospitalizations will far exceed Oregon's health system capacity in the next several weeks. According to modeling from OHSU, without these additional mitigation measures, Oregon could be as many as 500 staffed hospital beds short of what will be needed to treat patients hospitalized for any reason by September.

"Oregon is facing a spike in COVID-19 hospitalizations––consisting overwhelmingly of unvaccinated individuals––that is quickly exceeding the darkest days of our winter surge," said Governor Brown. "When our hospitals are full, there will be no room for additional patients needing care––whether for COVID-19, a heart attack or stroke, a car collision, or a variety of other emergency situations. If our hospitals run out of staffed beds, all Oregonians will be at risk.

"There are two keys to saving lives. Vaccination is the best way to protect yourself and your family against severe illness, hospitalization, and death. And, by wearing masks, all of

us––vaccinated and unvaccinated––can help ensure that a hospital bed staffed by health professionals is available for our loved ones in their time of need. If we all do our part, we can beat COVID-19 once and for all, keep our economy open and thriving, and return our kids to the classroom with minimal disruptions in a few weeks."

All State of Oregon executive branch employees required to be fully vaccinated

Governor Brown announced today that all State of Oregon executive branch employees will be required to be fully vaccinated on or before October 18, or six weeks after a COVID-19 vaccine receives full approval from the U.S. Food and Drug Administration, whichever is later.

The requirement will apply to all executive branch employees, including employees working for all Oregon state agencies, and in consultation with Oregon's statewide elected officials, employees of the Oregon State Treasury and the Oregon Secretary of State's Office, as well as employees of the Oregon Bureau of Labor & Industries and the Oregon Department of Justice. Employees will be required to show proof of vaccination by the deadline. Individuals unable to be vaccinated due to disability or sincerely held religious belief may be able to qualify for an exception, as required by state and federal law. State of Oregon employees will not have the option of weekly testing instead of showing proof of vaccination.

"Vaccines are safe and effective, and they are the surest way to prevent Oregonians from ending up in intensive care units," said Governor Brown. "I am taking action to help ensure State of Oregon workplaces are safe for employees and customers alike, and I am strongly encouraging all public and private employers to follow suit by requiring vaccination for their employees. The only way we can stop the spread of COVID-19 for good is through vaccination."

The vaccination requirement does not apply to employees of Oregon's legislative and judicial branches of government, though the Governor is encouraging the leadership of both branches to consider a similar requirement.

Governor to hold press conference tomorrow, August 11, to announce new statewide indoor mask requirements

Governor Brown also announced she will be holding a press conference tomorrow, August 11, to announce new statewide indoor mask requirements. The Governor's Office will send a media advisory with RSVP information for the media later this afternoon.

"The latest science is clear: although unvaccinated individuals are more likely to contract the disease, both vaccinated and unvaccinated people can spread the Delta variant. Masks are a simple and effective way to make sure you are not unknowingly infecting your friends, family members, neighbors, and colleagues. After a year and a half of this pandemic, I know Oregonians are tired of health and safety restrictions. This new mask requirement will not last forever, but it is a measure that can save lives right now. It will help to protect all of us, including people who are immunocompromised, and our children under 12 who are not yet eligible to get vaccinated. Masks are a simple and effective tool that will keep our schools, businesses, and communities open."

EXHIBIT 33

STATE OF WASHINGTON
OFFICE OF GOVERNOR JAY INSLEE

PROCLAMATION BY THE GOVERNOR
AMENDING PROCLAMATION 20-05, et seq.

21-14

COVID-19 VACCINATION REQUIREMENT

WHEREAS, on February 29, 2020, I issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout Washington State as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State; and

WHEREAS, as a result of the continued worldwide spread of COVID-19, its significant progression in Washington State, and the high risk it poses to our most vulnerable populations and our health care system, I have subsequently issued several amendatory proclamations, exercising my emergency powers under RCW 43.06.220 by prohibiting certain activities and waiving and suspending specified laws and regulations, including issuance of Proclamations 20-25, et seq., which limit Washingtonians' ability to participate in certain activities unless certain conditions are met; and

WHEREAS, during early stages of the COVID-19 pandemic, health professionals and epidemiological modeling experts indicated that the spread of COVID-19, if left unchecked, threatened to overwhelm portions of Washington's public and private health-care system; and

WHEREAS, to protect some of our most vulnerable populations – persons in health care facilities, long-term care facilities (which includes nursing homes), and similar congregate care facilities – and to protect our health and congregate care systems themselves, I issued several proclamations imposing heightened protections on workers, residents and visitors in those facilities; and

WHEREAS, although COVID-19 continues as an ongoing and present threat in Washington State, the measures we have taken together as Washingtonians over the past 18 months, including the willingness of most Washingtonians to take advantage of the remarkable, life-saving vaccines being administered throughout the state, have made a difference and have altered the course of the pandemic in fundamental ways; and

WHEREAS, after months of improving COVID-19 epidemiological conditions in Washington State, the emergence of highly contagious COVID-19 variants, including the "delta variant" that is at least twice as transmissible as the virus that emerged in late 2019, coupled with the continued significant numbers of unvaccinated people, have caused COVID-19 cases and hospitalizations to rise sharply among unvaccinated populations and have resulted in breakthrough infections in some fully vaccinated individuals; and

WHEREAS, COVID-19 vaccines are effective in reducing infection and serious disease, widespread vaccination is the primary means we have as a state to protect everyone, including persons who cannot be vaccinated for medical reasons, youth who are not eligible to receive a vaccine, immunocompromised individuals, and vulnerable persons including persons in health care facilities, long-term care facilities and other congregate care facilities from COVID-19 infections; and

WHEREAS, widespread vaccination is also the primary means we have as a state to protect our health care system, to avoid the return of stringent public health measures, and to put the pandemic behind us; and

WHEREAS, COVID-19 vaccinations have been available in Washington State from December 2020 to the present, and since April 15, 2021, all Washingtonians over the age of 16 have been eligible to receive free COVID-19 vaccinations from a wide variety of providers at many locations; and

WHEREAS, as of August 4, 2021, nearly 4.4 million Washingtonians, about 70% of those eligible and 58% of the total population, had initiated their vaccine series, leaving 2.1 million eligible Washingtonians who were unvaccinated; and

WHEREAS, according to the CDC, as of August 1, 2021, approximately 67% of staff in Washington state nursing homes were fully vaccinated; and

WHEREAS, healthcare workers face COVID-19 exposures in a variety of healthcare settings, with those involving direct patient care likely at higher risk; and

WHEREAS, COVID-19 vaccines are safe and effective. COVID-19 vaccines were evaluated in clinical trials involving tens of thousands of participants and met the U.S. Food & Drug Administration's rigorous scientific standards for safety, effectiveness, and manufacturing quality needed to support emergency use authorization; and, to date, more than 346 million doses of COVID-19 vaccines have been given in the United States with 8.2 million of those doses administered in Washington, and serious safety problems and long-term side effects are rare; and

WHEREAS, on July 6, 2021, the Office of Legal Counsel of the United State Department of Justice issued a legal opinion stating that federal and state governments were not prohibited by federal law

from imposing vaccination mandates, even when the only vaccines available are those authorized under U.S. Food and Drug Administration Emergency Use Authorizations; and

WHEREAS, on July 26, 2021, approximately 60 medical groups, including the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Physicians, the American Nurses Association, the American Academy of Physician Assistants, the Association of Professionals in Infection Control and Epidemiology, the American Public Health Association, the Infectious Diseases Society of America LeadingAge, the National Hispanic Medical Association, the National Medical Association, and the Society of Infectious Disease Pharmacists, issued a memorandum supporting mandatory, universal vaccination of all public and private health care and long-term care workers, noting that such a requirement is the "fulfillment of the ethical commitment of all health care workers to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being"; and on August 2, 2021, the Washington State Society of Post-Acute and Long-Term Care Medicine submitted a letter in support of the above noted July 26, 2021 memorandum; and

WHEREAS, on July 15, 2021, the American College of Obstetricians and Gynecologists, together with the Society for Maternal-Fetal Medicine, posted a formal opinion stating that medical professionals have an ethical obligation to be vaccinated against COVID-19 to prevent the spread of harmful infectious diseases, and that women who are or may become pregnant should be vaccinated against COVID-19; and

WHEREAS, it is the duty of every employer to protect the health and safety of employees by establishing and maintaining a healthy and safe work environment and by requiring all employees to comply with health and safety measures; and

WHEREAS, state employees live in and provide services to the public in every county in our state, and many interact with the public on a regular basis, and they all interact with some portion of the community at large to varying degrees before and/or after state work hours; and

WHEREAS, to further our individual and collective duty to reduce the spread of COVID-19 in our communities, I am requiring all employees, on-site independent contractors, volunteers, goods and services providers, and appointees of designated state agencies to be fully vaccinated against COVID-19 on or before October 18, 2021; and

WHEREAS, the worldwide COVID-19 pandemic and its persistence in Washington State continue to threaten the life and health of our people as well as the economy of Washington State, and remain a public disaster affecting life, health, property or the public peace; and

WHEREAS, the Washington State Department of Health continues to maintain a Public Health Incident Management Team in coordination with the State Emergency Operations Center and other supporting state agencies to manage the public health aspects of the incident; and

WHEREAS, the Washington State Military Department Emergency Management Division, through the State Emergency Operations Center, continues coordinating resources across state government to support the Department of Health and local health officials in alleviating the impacts to people, property, and infrastructure, and continues coordinating with the state Department of Health in assessing the impacts and long-term effects of the incident on Washington State and its people; and

NOW, THEREFORE, I, Jay Inslee, Governor of the state of Washington, as a result of the above noted situation, and under Chapters 38.08, 38.52 and 43.06 RCW, do hereby proclaim and order that a State of Emergency continues to exist in all counties of Washington State, that Proclamation 20-05, as amended, remains in effect, and that, to help preserve and maintain life, health, property or the public peace pursuant to RCW 43.06.220(1)(h), and (3), I hereby prohibit, subject to the conditions, exceptions, and circumstances set forth below, the following activities:

1. Prohibitions. This order prohibits the following:

    a. Any Worker from engaging in work for a State Agency after October 18, 2021 if the Worker has not been fully vaccinated against COVID-19;
    b. Any State Agency from permitting any Worker to engage in work for the agency after October 18, 2021 if the Worker has not been fully vaccinated against COVID-19 and provided proof thereof to the agency;
    c. Any Health Care Provider from failing to be fully vaccinated against COVID-19 after October 18, 2021; and
    d. Any individual or entity that operates a Health Care Setting from permitting a Health Care Provider to engage in work for the individual or entity as an employee, contractor, or volunteer after October 18, 2021 if the Health Care Provider has not been fully vaccinated against COVID-19 and provided proof thereof to the individual or entity. Providers who do not work in a Health Care Setting must provide proof of vaccination to the operator of the facility in which the Provider works, if any, or, if requested, to a lawful authority. A lawful authority includes, but is not limited to, law enforcement, local health jurisdictions, and the state Department of Health.

2. Exemptions from Vaccine Requirement.

    a. Health Care Providers and Workers for State Agencies are not required to get vaccinated against COVID-19 if they are entitled under the Americans With Disabilities Act (ADA), Title VII of the Civil Rights Act of 1964 (Title VII), the Washington Law Against Discrimination (WLAD), or any other applicable law to a disability-related reasonable accommodation or a sincerely held religious belief accommodation to the requirements of this order. Nothing herein precludes individuals or entities for which Health Care Providers work as employees, contractors, or volunteers and State Agencies from providing disability-related reasonable accommodations and religious accommodations to the requirements of this order as required by the laws noted above. As provided in the ADA, Title VII, and the WLAD, individuals or entities for which Health Care Providers work as

employees, contractors, or volunteers and State Agencies are not required to provide such accommodations if they would cause undue hardship.

b. To the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, individuals or entities for which Health Care Providers work as employees, contractors, or volunteers and State Agencies must obtain from the individual requesting the accommodation documentation from an appropriate health care or rehabilitation professional authorized to practice in the State of Washington stating that the individual has a disability that necessitates an accommodation and the probable duration of the need for the accommodation.

c. To the extent permitted by law, before providing a sincerely held religious belief accommodation to the requirements of this Order, individuals or entities for which Health Care Providers work as employees, contractors, or volunteers and State Agencies must document that the request for an accommodation has been made and the document must include a statement regarding the way in which the requirements of this order conflict with the religious observance, practice, or belief of the individual.

3. Acceptable Proof of Full Vaccination Against COVID-19: Where required above, Workers for State Agencies and Health Care Providers must provide proof of full vaccination against COVID-19 by providing one of the following:
   a. CDC COVID-19 Vaccination Record Card or photo of the card;
   b. Documentation of vaccination from a health care provider or electronic health record; or
   c. State immunization information system record.

   Personal attestation is not an acceptable form of verification of COVID-19 vaccination.

4. Public and Private Entities and Employers May Exceed These Requirements: Nothing in this order prohibits individuals or entities employing or using the services of Health Care Providers and State Agencies from implementing requirements that exceed the requirements of this Order.

5. Definitions.
   a. "Worker":
      - For purposes of this order, "worker" includes:
        - A person engaged to work as an employee, independent contractor, service provider, volunteer, or through any other formal or informal agreement to provide goods or services, whether compensated or uncompensated, but does not include a visitor or patron;
        - The director, secretary, or other executive officer of a State Agency;
        - A person appointed to serve on a board, commission, or similar body that is an executive cabinet agency listed at https://www.governor.wa.gov/office-governor/office/executive-cabinet or

a small cabinet agency listed at https://www.governor.wa.gov/office-governor/office/small-cabinet.

- The following exceptions apply to the definition of "worker":
  - Independent contractors, and any of their workers, are exempt from this order unless any provision of the contract to provide goods or services requires work to be performed in person and on site, regardless of frequency, whether other workers are present, or any contingent nature of that requirement.
  - For any State Agency that is listed as an agency under the authority of a board, council, or commission at https://ofm.wa.gov/sites/default/files/public/publications/2021_State_Org_Chart.pdf and that is not also listed as an executive cabinet agency at https://www.governor.wa.gov/office-governor/office/executive-cabinet or a small cabinet agency at https://www.governor.wa.gov/office-governor/office/small-cabinet, only the State Agency's compensated employees are "workers" subject to the requirements of this proclamation.

b. "Health Care Provider" includes:
   - Individuals with credentials listed in the Healthcare Professional Credentialing Requirements list;
   - Individuals who are permitted by law to provide health care services in a professional capacity without holding a credential;
   - Long-term care workers unless specifically excluded in this order; and
   - Workers in any Health Care Setting, as defined herein.

   "Health Care Provider" does not include, for purposes of this order:
   - Individual providers, as defined in RCW 74.39A.240;
   - Providers of personal care in a person's home, such as home care, home health or hospice care;
   - Providers who are not actively practicing or providing services; and
   - Providers who provide services only at one or more of the settings that are expressly excluded from the list of Health Care Settings under this order.

c. "Health Care Setting" is any public or private setting that is primarily used for the delivery of in-person health care services to people, except as specifically exempted below. If located at a facility that is primarily used for the delivery of health-care services, such as a hospital, then the entire facility is a Health Care Setting. If located at a facility that is primarily used for another purpose, such as a pharmacy within a grocery store, school nurse's office, or vaccination clinic within a business establishment, the Health Care Setting includes only the areas that are primarily used for the delivery of health care and the areas regularly occupied by Health Care Providers and people seeking care, but not the other areas of the facility.

"Health Care Setting" includes, but is not limited to:

- Acute care facilities, including, but not limited to, hospitals;
- Long-term acute care facilities;
- Inpatient rehabilitation facilities;
- Inpatient behavioral health facilities, including, but not limited to, evaluation and treatment facilities, residential treatment facilities, secure detox facilities;
- Residential long-term care facilities, including, but not limited to, nursing homes, assisted living facilities, adult family homes, settings where certified community residential services and supports are provided, and enhanced services facilities;
- Mobile clinics or other vehicles where health care is delivered;
- Outpatient facilities, including, but not limited to, dialysis centers, physician offices, and behavioral health facilities (including offices of psychiatrists, mental health counselors, and substance use disorder professionals);
- Dental and dental specialty facilities;
- Pharmacies (not including the retail areas);
- Massage therapy offices (this includes designated areas where massage is administered within non-health care settings like spas and wellness/fitness centers);
- Chiropractic offices;
- Midwifery practices and stand-alone birth centers;
- Isolation and/or quarantine facilities;
- Ambulatory surgical facilities;
- Urgent care centers; and
- Hospice care centers.

"Health Care Setting" does not include:

- Settings where sports and spectator events or other gatherings are held (including when credentialed athletic trainers are providing care to players), other than areas primarily used for the delivery of health care services, such as designated first aid areas (which are Health Care Settings);
- Department of Children, Youth & Families (DCYF)-licensed foster homes that do not primarily provide health care services;
- Research facilities where no health care is delivered to people;
- Veterinary health care settings;
- Animal control agencies; and
- Non-profit humane societies.

d. "State Agency" includes:

- Every agency listed at https://www.governor.wa.gov/office-governor/office/executive-cabinet;
- Every agency listed at https://www.governor.wa.gov/office-governor/office/small-cabinet; and

- Every agency under the authority of a board, council, or commission listed at https://ofm.wa.gov/sites/default/files/public/publications/2021_State_Org_Chart.pdf except the State Board for Community and Technical Colleges and the governing boards of four-year institutions of higher education.

e. "Fully Vaccinated against COVID-19": A person is fully vaccinated against COVID-19 two weeks after they have received the second dose in a two-dose series of a COVID-19 vaccine authorized for emergency use, licensed, or otherwise approved by the FDA (e.g., Pfizer-BioNTech or Moderna) or two weeks after they have received a single-dose COVID-19 vaccine authorized for emergency use, licensed, or otherwise approved by the FDA (e.g., Johnson & Johnson (J&J)/Janssen.

ADDITIONALLY, the specific prohibitions in this Proclamation are severable and do not apply to the extent that compliance with a prohibition would violate (1) any U.S. or Washington constitutional provision; (2) federal statutes or regulations; (3) any conditions that apply to the state's receipt of federal funding; (4) state statutes; or (5) applicable orders from any court of competent jurisdiction.

ADDITIONALLY, nothing in this Proclamation limits otherwise applicable requirements related to personal protective equipment, personnel training, and infection control policies and procedures.

I again direct that the plans and procedures of the *Washington State Comprehensive Emergency Management Plan* be implemented throughout state government. State agencies and departments are directed to continue utilizing state resources and doing everything reasonably possible to support implementation of the *Washington State Comprehensive Emergency Management Plan* and to assist affected political subdivisions in an effort to respond to and recover from the COVID-19 pandemic.

I continue to order into active state service the organized militia of Washington State to include the National Guard and the State Guard, or such part thereof as may be necessary in the opinion of The Adjutant General to address the circumstances described above, to perform such duties as directed by competent authority of the Washington State Military Department in addressing the outbreak. Additionally, I continue to direct the Department of Health, the Washington State Military Department Emergency Management Division, and other agencies to identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.

Violators of this order may be subject to criminal penalties pursuant to RCW 43.06.220(5). Further, if people fail to comply with the required facial coverings, social distancing and other protective measures while engaging in this phased reopening, I may be forced to reinstate the prohibitions established in earlier proclamations.

This order is effective immediately. Unless extended or amended, upon expiration or termination of this amendatory proclamation the provisions of Proclamation 20-25, et seq., will continue to be in

effect until the state of emergency, issued on February 29, 2020, pursuant to Proclamation 20-05, is rescinded.

Signed and sealed with the official seal of the state of Washington on this 9th day of August, A.D., Two Thousand and Twenty-One at Olympia, Washington.

By:

/s/
Jay Inslee, Governor

BY THE GOVERNOR:

/s/
Secretary of State

EXHIBIT 34

County Administrator

County Administration Building
1025 Escobar Street, 4th Floor
Martinez, California 94553-1229
(925) 655-2075

Monica Nino
County Administrator

Contra Costa County

August 27, 2021

COVID 19 Update to Employees:

The County Board of Supervisors recognizes the continued threat to the health and safety of our staff and community posed by COVID-19. In light of the recent increase in cases and hospitalizations due to the Delta variant and following the recent FDA approval of the Pfizer-BioNTech COVID-19 vaccine, the Board of Supervisors has deemed it necessary to establish the attached **Mandatory Vaccination Policy** to protect the health and safety of employees and the community.

1. The Policy requires all employees to receive their final COVID-19 vaccine shot (second shot in a two shot series or single shot in a single shot series) by October 4, 2021. Employees must provide proof of their vaccination status to the County by this date.

2. No later than October 4, 2021, you must provide your departmental designee with one of the following:

   - A photocopy of the CDC Card or WHO Yellow Card. You should redact any other medical information that may appear, such as other vaccinations received; or
   - A photocopy of your COVID-19 Vaccine record, obtained through the following portal: https://myvaccinerecord.cdph.ca.gov/. You should redact any other medical information that may appear, such as other vaccinations received.

   Employees should contact their supervisors or departmental personnel officer with questions on submitting proof of vaccination.

3. Employees covered under the State Public Health Order from August 5, 2021 issued by the California Department of Public Health are still subject to the vaccination compliance deadline of September 30, 2021. Similar health orders or regulations requiring masking, testing, vaccination, or other measures still apply. Where any conflict exists between this Policy and another rule or regulation on the topic, the more restrictive measure applies. Employees should consult their supervisors if they are unsure which standard applies to their position.

4. Employees should use their COVID Leave to get vaccinated during work time. Employees who wish to be vaccinated during their normal work time but have exhausted their COVID Leave shall be provided sufficient time needed to get vaccinated during their normal work hours.

5. Employees with a qualifying medical condition or disability or a sincerely held religious belief that prevents them from being vaccinated may apply for an exemption on the attached exemption request form. Employees should submit this form to their departmental personnel contacts, who will transmit the form to central Human Resources for processing, determination, and retention. Employees granted an exemption to the vaccination requirement will be required to undergo mandatory COVID-19 testing on a weekly basis (or twice weekly for employees subject to more restrictive requirements). Employees with medical or religious exemptions should submit the exemption request form to their departmental personnel contact **as soon as possible** to ensure that the request is processed in a timely manner. Employees are still responsible for meeting the vaccination requirement by the established deadline if their request is denied.

6. Failure to comply with the terms of this Policy will result in discipline up to and including termination. It is the employee's responsibility to ensure they are following the requirements of this Policy by the October 4, 2021 deadline.

7. Over the coming weeks, the County will continue to meet and confer with its Labor Partners over the impacts of this Policy. As developments arise, some aspects of the policy may be subject to change.

Thank you for your continued work to support your fellow employees and the community we serve by getting vaccinated. We look forward to continued collaboration with our departmental staff as we make the County a safer and healthier place.

Sincerely,

Monica Nino
County Administrator

Enclosures: Mandatory Vaccination Policy
Mandatory COVID-19 Vaccination Exemption Request Form

EXHIBIT 35

EXECUTIVE ORDER OF THE CHAIR OF THE COUNTY OF LOS ANGELES BOARD OF SUPERVISORS FOLLOWING PROCLAMATION OF EXISTENCE OF A LOCAL EMERGENCY DUE TO NOVEL CORONAVIRUS – COVID-19

WHEREAS, on March 4, 2020, the Chair of the Los Angeles County Board of Supervisors ("Board") proclaimed, pursuant to Chapter 2.68 of the Los Angeles County Code ("LACC"), the existence of a local emergency because the County of Los Angeles ("County") was affected or likely to be affected by a public calamity due to conditions of disaster or of extreme peril to the safety of persons and property arising as a result of the novel coronavirus, COVID-19, in the County;

WHEREAS, on March 4, 2020, the Los Angeles County Health Officer issued a declaration of local health emergency due to the occurrence of COVID-19 in the County;

WHEREAS, Government Code Section 8634 and LACC Section 2.68.150 empower the Chair of the Board, during a proclaimed local emergency, to promulgate orders and regulations necessary to provide for the protection of life or property;

WHEREAS, COVID-19 vaccines have been developed to help combat the spread of COVID-19 and prevent people from getting seriously ill from COVID-19;

WHEREAS, the County is now experiencing increased spread due to the highly transmissible Delta variant, which now comprises more than 94% of sequenced cases in the County;

WHEREAS, there are many residents who are not fully vaccinated, including over three million vaccine-eligible residents and one million residents currently ineligible, who are especially vulnerable to the spread of the Delta variant;

WHEREAS, on July 26, 2021, the State of California announced a requirement that all State employees must provide proof of vaccination or submit to at least weekly testing, and encouraged localities and businesses to implement similar programs;

WHEREAS, on July 26, 2021, the California Department of Public Health ("CDPH") issued an order requiring workers in high-risk health care and congregate settings to provide proof of vaccination or submit to at least weekly testing;

WHEREAS, on July 30, 2021, the Los Angeles County Health Officer issued a Health Officer Order, which incorporated by reference, the July 26, 2021 CDPH order requiring workers in high-risk health care and congregate settings to provide proof of vaccination or submit to at least weekly testing;

WHEREAS, on July 26, 2021, the Department of Justice released a Memorandum Opinion stating that Section 564 of the Food, Drug, and Cosmetic Act does not prohibit public or private employers from imposing vaccination requirements for a vaccine that is subject to an emergency use authorization;

WHEREAS, on July 15, 2021, Los Angeles County led by example by being the first in the nation to reinstitute a masking requirement for public indoor settings, which would soon after be emulated in varying degrees by the Centers for Disease Control and Prevention (CDC), the State of California, and other localities across the country;

WHEREAS, on July 29, 2021, President Biden announced that he would direct the Department of Defense to look into how and when they will add the COVID-19 vaccination to the list of required vaccinations for members of the military;

WHEREAS, on July 29, 2021, President Biden announced every federal government employee and onsite contractor will be asked to attest to their vaccination status, and those who do not must comply with testing at least once per week, a masking requirement, physical distancing from other employees and visitors, and restrictions on official travel;

WHEREAS, on June 11, 2021, Governor Newsom issued Executive Order N-08-21, which set a date of October 1, 2021 for public agencies to transition back to public meetings held under the Brown Act;

WHEREAS, the County plans on reopening its buildings to the public on October 1, 2021, and the County has a strong interest in protecting its employees and the public from COVID; and

WHEREAS, pursuant to Government Code section 8634, and in the interest of public health and safety, it is necessary to issue the following order for the protection of life and property.

NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

1. The Chief Executive Officer, in consultation with the Office of County Counsel and the Departments of Human Resources and Public Health, establish a mandatory vaccination policy, effective immediately, which requires all County employees to provide proof of full vaccination by October 1, 2021; and

2. The Chief Executive Officer engage with the County's labor partners regarding the effects of the vaccination policy.

Date: August 4, 2021

Hilda L. Solis
Chair, Los Angeles County Board of Supervisors

Chair Hilda L. Solis' Statement on Issuing an Executive Order to Require All LA County Employees to Be Vaccinated Against COVID-19

LOS ANGELES – Chair Hilda L. Solis released the following statement after issuing an Executive Order requiring all Los Angeles County employees to be vaccinated against COVID-19:

"Today, the County is reporting another 3,734 new cases, 1,242 hospitalizations, and tragically, 16 deaths. When the County marked its re-opening on June 15, there were only 210 confirmed cases, fewer than 220 were hospitalized with COVID-19, and the positivity rate sat at an incredibly low 0.6%. However, with the rapid spread of the Delta variant, our daily cases have increased nearly eighteen-fold and hospitalizations more than five-fold. As vaccinations continue at a pace slower than what is necessary to slow the spread, the need for immediate action is great.

That is why today, as Chair of the Los Angeles County Board of Supervisors, I am issuing an Executive Order to require all County employees, regardless of the Department they serve, to be fully vaccinated no later than October 1, 2021, with exemptions for medical and religious purposes. This timeline gives our employees the time they need to consult with their healthcare providers, while moving expeditiously to protect the health and safety of our 110,000 workers.

Additionally, we are once again demonstrating to employers across the County that we are prepared to lead by example and set a standard for slowing the spread – just as we did when reinstating indoor masking, which has since been emulated by varying degrees by the CDC, the State, and localities across the country. We must all be prepared to come together and do our part to protect one another and get this virus under control once more. We cannot wait another day as this virus continues to upend and dramatically alter the lives of our residents. With today's Executive Order, the County is prepared to lead, and I am hopeful other employers across our great County do the same."

To view the Executive Order, click here.

The order was ratified by the Board of Supervisors on Tuesday, August 10th at the regularly scheduled board meeting.

August 4th, 2021 | COVID-19, In the news, Press Release

EXHIBIT 36

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

ORDER OF THE HEALTH OFFICER OF THE CITY AND COUNTY OF SAN FRANCISCO

ENCOURAGING COVID-19 VACCINE COVERAGE AND REDUCING DISEASE RISKS (Safer Return Together)

DATE OF ORDER: June 11, 2021, updated July 8, 2021, July 20, 2021, August 2, 2021, August 12, 2021, and August 24, 2021

Please read this Order carefully. Violation of or failure to comply with this Order is a misdemeanor punishable by fine, imprisonment, or both. (California Health and Safety Code § 120295, *et seq.*; California Penal Code §§ 69, 148(a)(1); and San Francisco Administrative Code § 7.17(b).)

Summary: As of August 25, 2021, this Order replaces the prior update of this health order, Health Officer Order No. C19-07y (issued August 12, 2021), in its entirety. Even though more people are vaccinated in San Francisco and the region against the virus that causes COVID-19, there remains a risk that people may come into contact with others who may have COVID-19 when outside their residence. San Francisco is currently experiencing a surge in new COVID-19 cases and an increase in hospitalizations, mostly among people who are not fully vaccinated, due to the highly contagious Delta variant. Future surges may occur due to other variants. In some instances, individuals who are fully vaccinated have been infected by breakthrough infections and are showing symptoms, though nearly no vaccinated individuals have required hospitalization. Most COVID-19 infections are caused by people who have no symptoms of illness. There are also people in San Francisco who are not yet fully vaccinated, including children under 12 years old, and people who are immuno-compromised and may be particularly vulnerable to infection and disease. We have also seen surges in other parts of the country and the world, increasingly impacting younger adults. Everyone who is eligible, including people at risk for severe illness with COVID-19—such as unvaccinated older adults and unvaccinated individuals with health risks—and members of their households, are urged to get vaccinated as soon as they can if they have not already done so.

The best way to address the current surge and future surges is for everyone who is eligible to get fully vaccinated as soon as possible. In the meantime, and consistent with CDC recommendations regarding indoor masking, the spread of the Delta variant necessitates imposing a face covering mandate for everyone, including people who are vaccinated, to help prevent transmission. Accordingly, this Order includes a "universal" face covering requirement for individuals in indoor public settings, with some exceptions. It also maintains face covering requirements in other settings, consistent with federal and state rules.

This Order adds a requirement for certain businesses to check proof of full vaccination of both patrons 12 years and older and staff for entering an indoor portion of the business's

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

facility, subject to limited exceptions. This Order also maintains the lifting of local capacity limits on business and other sectors, local physical distancing requirements, and many other previous health and safety restrictions that were removed in the prior health order as of June 15. Businesses are no longer required to prepare and post social distancing protocols or in most instances submit health and safety plans to the Health Officer. Nor are they strongly urged to allow office employees to continue to work remotely as much as possible. Also, except for schools, childcare, and out-of-school time programs, sector specific guidance under local health directives no longer apply.

And this Order maintains some requirements on businesses and government entities, such as a general requirement to report positive cases in the workplace and in schools, a new and much more limited requirement for signage, and a proof of vaccination requirement to admit people age 12 and older to attend indoor large or mega-events largely consistent with state rules with some additional rules and limitations, as well as for staff of such events. It also requires personnel working in certain high-risk settings, such as acute care hospitals, skilled nursing facilities, residential care facilities for the elderly, homeless shelters and jails, and certain other designated health care settings, as well as certain types of listed people (home health care workers and pharmacists) to be fully vaccinated, with limited exemptions and within specified timeframes. In light of the full approval of the Pfizer-BioNTech (Comirnaty) vaccine by the FDA on August 23, 2021, this Order extends for a limited period the original September 15, 2021 deadline for personnel working in certain high-risk settings to meet the vaccination requirements, consistent with State requirements, and imposes an individual mandate for vaccination on personnel working in those settings. Also, this Order includes proof of vaccination requirements for patrons to use certain indoor facilities, such as restaurants, bars, clubs and gyms. This Order includes recommendations to reduce COVID-19 risk, but not requirements, for individuals, businesses, and government entities.

UNDER THE AUTHORITY OF CALIFORNIA HEALTH AND SAFETY CODE SECTIONS 101040, 101085, AND 120175, THE HEALTH OFFICER OF THE CITY AND COUNTY OF SAN FRANCISCO ORDERS:

1. Definitions.

For purposes of this Order, the following initially capitalized terms have the meanings given below.

a. *Business*. A "Business" includes any for-profit, non-profit, or educational entity, whether a corporate entity, organization, partnership or sole proprietorship, and regardless of the nature of the service, the function it performs, or its corporate or entity structure.

b. *Cal/OSHA*. "Cal/OSHA" means the California Department of Industrial Relations, Division of Occupational Safety and Health, better known as Cal/OSHA.

c. *CDC*. "CDC" means the United States Centers for Disease Control and Prevention.

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

d. *Close Contact*. "Close Contact" means having any of following interactions with someone with COVID-19 while they were contagious: (i) being within six feet of them for a total of 15 minutes or more in a 24-hour period; (ii) living or staying overnight with them; (iii) having physical or intimate contact including hugging and kissing; (iv) taking care of them, or having being taken care of by them; or (v) having direct contact with their bodily fluids (*e.g.*, they coughed or sneezed on you or shared your food utensils). The person is considered contagious *either* if they had symptoms, from 48 hours before their symptoms began until at least 10 days after the start of symptoms, *or* if they did not have symptoms, from 48 hours before their COVID-19 test was collected until 10 days after they were tested.

e. *County*. The "County" means the City and County of San Francisco.

f. *COVID-19*. "COVID-19" means coronavirus disease 2019, the disease caused by the SARS-CoV-2 virus and that resulted in a global pandemic.

g. *DPH*. "DPH" means the San Francisco Department of Public Health.

h. *DPH Core Guidance*. "DPH Core Guidance" means the webpage and related materials titled *Core Guidance for COVID-19* that DPH regularly updates and includes health and safety recommendations for individuals and Businesses as well as web links to additional resources, available online at www.sfdph.org/dph/covid-19/core-guidance.asp.

i. *Face Covering Requirements*. "Face Covering Requirements" means the requirement to wear a Well-Fitted Mask (i) as required by federal or state law including, but not limited to, California Department of Public Health guidance and Cal/OSHA's rules and regulations; (ii) in indoor common areas of homeless shelters, emergency shelters, and cooling centers, except while sleeping, showering, engaged in personal hygiene that requires removal of face coverings, or actively eating or drinking; (iii) in indoor common areas of jails except while sleeping, showering, engaged in personal hygiene that requires removal of face coverings, or actively eating or drinking; and (iv) as required by Section 3(b), below and Appendix A, attached to the Order. If a separate state, local, or federal order or directive imposes different face covering requirements, including requirements to wear respirators or surgical masks in certain settings, the more health protective requirement applies.

j. *FDA*. "FDA" means the United States Food and Drug Administration.

k. *Fully Vaccinated/Full Vaccination*. "Fully Vaccinated" and "Full Vaccination" mean two weeks after completing the entire recommended series of vaccination (usually one or two doses) with a vaccine authorized to prevent COVID-19 by the FDA, including by way of an emergency use authorization, or by the World Health Organization (WHO). For example, as of the date of issuance of this Order, an individual would be fully vaccinated at least two weeks after receiving a second dose of the Pfizer-BioNTech (Comirnaty) or Moderna COVID-19 vaccine or two weeks

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

after receiving the single dose Johnson & Johnson's Janssen COVID-19 vaccine. A list of FDA-authorized vaccines is available at www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines. A list of WHO-authorized vaccines is available at https://extranet.who.int/pqweb/vaccines/covid-19-vaccines.

Unless otherwise specified, the following are acceptable as proof of Full Vaccination: (i) the CDC vaccination card, which includes name of person vaccinated, type of vaccine provided, and date last dose administered, or similar documentation issued by another foreign governmental jurisdiction, (ii) a photo of a vaccination card as a separate document, (iii) a photo of the a vaccination card stored on a phone or electronic device, (iv) documentation of vaccination from a healthcare provider, (v) written self-attestation of vaccination signed (including an electronic signature) under penalty of perjury and containing the name of the person vaccinated, type of vaccine taken, and date of last dose administered, or (vi) a personal digital COVID-19 vaccine record issued by the State of California and available by going to https://myvaccinerecord.cdph.ca.gov or similar documentation issued by another State, local, or foreign governmental jurisdiction, or by an approved private company (a list of approved companies offering digital vaccine verification is available at www.sfdph.org/dph/alerts/files/vaccine-verification-sites.pdf). If any state or federal agency uses a more restrictive definition of what it means to be Fully Vaccinated or to prove that status for specified purposes (such as Cal/OSHA rules for employers in workplaces), then that more restrictive definition controls for those purposes. Also, to the extent Cal/OSHA approves an alternate means of documenting whether an employee is "fully vaccinated," even if less restrictive than the definition contained here, employers may use the Cal/OSHA standard to document their employees' vaccination status.

l. *Health Officer*. "Health Officer" means the Health Officer of the City and County of San Francisco.

m. *High-Risk Settings*. "High-Risk Settings" means certain care or living settings involving many people, including many congregate settings, where vulnerable populations reside out of necessity and where the risk of COVID-19 transmission is high, consisting of general acute care hospitals, skilled nursing facilities (including subacute facilities), intermediate care facilities, residential care facilities for the elderly, homeless shelters, and jails.

n. *Household*. "Household" means people living in a single Residence or shared living unit. Households do not refer to individuals who live together in an institutional group living situation such as in a dormitory, fraternity, sorority, monastery, convent, or residential care facility.

o. *Qualifying Medical Reason*. "Qualifying Medical Reason" means a medical condition or disability recognized by the FDA or CDC as a contra-indication to COVID-19 vaccination.

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

p. *Large Indoor Event.* "Large Indoor Event" means an event with 1,000-4,999 people attending indoors. A Large Indoor Event may be public or private, may have either assigned or unassigned seating, and may be either general admission or ticketed events. A Large Indoor Event can also include an event without seating or without tickets.

q. *Mega-Event*. "Mega-Event" means an event with either more than 5,000 people attending indoors or more than 10,000 people attending outdoors, consistent with the definition of those events in the State's Post-Blueprint Guidance. As provided in the State's Post-Blueprint Guidance, a Mega-Event may have either assigned or unassigned seating, and may be either general admission or gated, ticketed and permitted events.

r. *Personnel*. "Personnel" means the following people who provide goods or services associated with a Business in the County: employees; contractors and sub-contractors (such as those who sell goods or perform services onsite or who deliver goods for the Business); independent contractors; vendors who are permitted to sell goods onsite; volunteers; and other individuals who regularly provide services onsite at the request of the Business. "Personnel" includes "gig workers" who perform work via the Business's app or other online interface, if any.

s. *Religious Beliefs*. "Religious Beliefs" means a sincerely held religious belief, practice, or observance protected by state or federal law.

t. *Residence*. "Residence" means the location a person lives, even if temporarily, and includes single-family homes, apartment units, condominium units, hotels, motels, shared rental units, and similar facilities. Residences also include living structures and outdoor spaces associated with those living structures, such as patios, porches, backyards, and front yards that are only accessible to a single family or Household.

u. *Schools*. "Schools" mean public and private schools operating in the County, including independent, parochial, and charter schools.

v. *State's Post-Blueprint Guidance*. The "State's Post-Blueprint Guidance" means the guidance entitled "Beyond the Blueprint for Industry and Business Sectors" that the California Department of Public Health issued on May 21, 2021 and that applies from June 15, 2021 through October 1, 2021, including as the State may extend, update or supplement that guidance in the future. (See www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Beyond-Blueprint-Framework.aspx.)

w. *Tested*. "Tested" means to have a negative test for the virus that causes COVID-19 within the prior 72 hours. Both nucleic acid (including polymerase chain reaction (PCR)) and antigen tests are acceptable. The following are acceptable as proof of a negative COVID-19 test result: a printed document (from the test provider or laboratory) or an email, text message, webpage, or application (app) screen displayed

on a phone or mobile device from the test provider or laboratory. The information should include person's name, type of test performed, negative test result, and date the test was administered. If any state or federal agency uses a more restrictive definition of what it means to be Tested for specified purposes (such as Cal/OSHA rules for employers in workplaces), then that more restrictive definition controls for those purposes.

x. *Ventilation Guidelines*. "Ventilation Guidelines" means ventilation guidance from recognized authorities such as the CDC, the American Society of Heating, Refrigerating and Air-Conditioning Engineers, or the State of California, including Cal/OSHA. The DPH Core Guidance also includes ventilation guidelines.

y. *Well-Fitted Mask*. A "Well-Fitted Mask" means a face covering that is well-fitted to an individual and covers the nose and mouth especially while talking, consistent with the Face Covering Requirements. DPH guidance regarding Well-Fitted Masks may be found at www.sfcdcp.org/maskingupdate. A non-vented N95 mask is strongly recommended as a Well-Fitted Mask, even if not fit-tested, to provide maximum protection. A Well-Fitted Mask does not include a scarf, ski mask, balaclava, bandana, turtleneck, collar, or single layer of fabric or any mask that has an unfiltered one-way exhaust valve.

2. Purpose and Intent.

a. Purpose. The public health threat of serious illness or death from COVID-19 is generally decreasing in the County, the Bay Area, and the State due to the vaccines. But COVID-19 continues to pose a risk especially to individuals who are not Fully Vaccinated, and certain safety measures continue to be necessary to protect against COVID-19 cases and deaths. Vaccination is the most effective method to prevent transmission and ultimately COVID-19 hospitalizations and deaths. It is important to ensure that as many eligible people as possible are vaccinated against COVID-19. Further, it is critical to ensure there is continued reporting of cases to protect individuals and the larger community. Accordingly, this Order allows Businesses, schools, and other activities to resume fully while at the same time putting in place certain requirements designed to (1) extend vaccine coverage to the greatest extent possible; (2) limit transmission risk of COVID-19; (3) contain any COVID-19 outbreaks; and (4) generally align with guidance issued by the CDC and the State relating to COVID-19 except in limited instances where local conditions require more restrictive measures. This Order is based on evidence of continued community transmission of SARS-CoV-2 within the County as well as scientific evidence and best practices to prevent transmission of COVID-19. The Health Officer will continue to monitor data regarding the evolving scientific understanding of the risks posed by COVID-19, including the impact of vaccination, and may amend or rescind this Order based on analysis of that data and knowledge.

b. Intent. The primary intent of this Order is to continue to protect the community from COVID-19 and to also increase vaccination rates to reduce transmission of COVID-

19 long-term, so that the whole community is safer and the COVID-19 health emergency can come to an end.

c. Interpretation. All provisions of this Order must be interpreted to effectuate the purposes and intent of this Order as described above. The summary at the beginning of this Order as well as the headings and subheadings of sections contained in this Order are for convenience only and may not be used to interpret this Order. In the event of any inconsistency between the summary, headings, or subheadings and the text of this Order, the text will control. Certain initially capitalized terms used in this Order have the meanings given them in Section 1 above. The interpretation of this Order in relation to the health orders or guidance of the State is described in Section 10 below.

d. Application. This Order applies to all individuals, Businesses, and other entities in the County. For clarity, the requirements of this Order apply to all individuals who do not currently reside in the County when they are in the County. Governmental entities must follow the requirements of this Order that apply to Businesses, unless otherwise specifically provided in this Order or directed by the Health Officer.

e. DPH Core Guidance. All individuals and Businesses are strongly urged to follow the DPH Core Guidance, containing health and safety recommendations for COVID-19.

f. Effect of Failure to Comply. Failure to comply with any of the provisions of this Order constitutes an imminent threat and menace to public health, constitutes a public nuisance, and is punishable by fine, imprisonment, or both, as further provided in Section 12 below.

3. General Requirements for Individuals.

a. Vaccination. Individuals are strongly urged to get Fully Vaccinated as soon as they are able to. In particular, people at risk for severe illness with COVID-19—such as unvaccinated older adults and unvaccinated individuals with health risks—and members of their Household, are urged to get Fully Vaccinated as soon as they can. Information about who is at increased risk of severe illness and people who need to take extra precautions can be found at www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. For those who are not yet Fully Vaccinated, staying home or choosing outdoor activities as much as possible with physical distancing from other Households whose vaccination status is unknown is the best way to prevent the risk of COVID-19 transmission. Fully Vaccinated individuals are subject to fewer restrictions as provided in this Order, and there are allowances for certain large gatherings where all the participants are Fully Vaccinated.

b. Face Coverings. Because of the recent surge in the Delta variant, everyone, including people who are Fully Vaccinated, must wear a Well-Fitted Mask in indoor public settings as described in Appendix A to this Order. That Appendix lists exceptions

when a Well-Fitted Mask is not required. All persons must also follow the Face Covering Requirements. People should be respectful of an individual's decision to wear face coverings even in settings where they are not required, such as crowded outdoor settings, and no Business or other person should take an adverse action against individuals who chose to wear a face covering to protect their health. Under current federal law, when riding or waiting to ride on public transit people who are inside the vehicle or other mode of transportation or are indoors at a public transit stop or station, must wear Well-Fitted Masks. This requirement extends to all modes of transportation other than private vehicles, such as airplanes, trains, subways, buses, taxis, ride-shares, maritime transportation, street cars, cable cars, and school buses. But any passenger who is outdoors or in open-air areas of the mode of transportation, such as open-air areas of ferries, buses, and cable-cars, is not required by federal law to wear a face covering. Personnel and passengers on public transit are urged to get Fully Vaccinated, and those who are not Fully Vaccinated are strongly urged to wear a Well-Fitted Mask or respirator when not otherwise required by the Face Covering Requirements. Under Cal/OSHA's rules and regulations, employers may also be required to ensure employees continue to wear Well-Fitted Masks or respirators, particularly in indoor settings.

c. Monitor for Symptoms. Individuals should monitor themselves for symptoms of COVID-19. A list of COVID-19 symptoms is available online at www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. Anyone with any symptom that is new or not explained by another condition must comply with subsections 3(d) and 3(e) below regarding isolation and quarantine.

d. Isolation. Anyone who (i) has a positive COVID-19 test result, (ii) is diagnosed with COVID-19, or (iii) has a COVID-19 symptom that is new or not explained by another condition must refer to the latest COVID-19 isolation health directive (available online at www.sfdph.org/directives) and follow the requirements detailed there.

e. Quarantine. Anyone who had Close Contact with someone with COVID-19 must refer to the latest COVID-19 quarantine health directive (available online at www.sfdph.org/directives) and follow the requirements detailed there.

f. Moving to, Traveling to, or Returning to the County. Everyone is strongly encouraged to comply with any State travel advisories and CDC travel guidelines (available online at www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html).

g. Indoor Private Gatherings. Individuals are urged to wear Well-Fitted Masks and maintain physical distance when they are in indoor private gatherings in Residences with members of other Households, regardless of the vaccination status of those individuals. Nothing in this section limits any requirements that apply under this Order to indoor public settings, indoor Mega-Events, Large Indoor Events, or that Cal/OSHA or other State authority may impose on any indoor setting involving gatherings.

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

4. General Requirements for Businesses and Governmental Entities.

   a. Vaccination. All Businesses and governmental entities are strongly urged to consider implementing measures to require Personnel and patrons to be Fully Vaccinated as soon as possible. Also, the following Businesses must require patrons and staff (as distinguished from the broader term "Personnel") to provide proof of Full Vaccination and comply with the other requirements detailed in Appendix B to this Order:

      - Operators or hosts of establishments or events where food or drink is served indoors—including, but not limited to, dining establishments, bars, clubs, theaters, and entertainment venues.

      - Gyms, recreation facilities, yoga studios, dance studios, and other fitness establishments, where any patrons engage in cardiovascular, aerobic, strength training, or other exercise involving elevated breathing.

   b. Encourage Activities that Can Occur Outdoors. All Businesses and governmental entities are urged to consider moving operations or activities outdoors, if feasible and to the extent allowed by local law and permitting requirements, because there is generally less risk of COVID-19 transmission outdoors as opposed to indoors.

   c. Personnel Health Screening. Businesses and governmental entities must develop and implement a process for screening Personnel for COVID-19 symptoms, but this requirement does not mean they must perform on-site screening of Personnel. Businesses and governmental entities should ask Personnel to evaluate their own symptoms before reporting to work. If Personnel have symptoms consistent with COVID-19, they should follow subsections 3(d) and 3(e) above.

   d. Businesses Must Allow Personnel to Stay Home When Sick. Businesses are required to follow Cal/OSHA rules and regulations allowing Personnel to stay home where they have symptoms associated with COVID-19 that are new or not explained by another condition or if they have been diagnosed with COVID-19 (by a test or a clinician) even if they have no symptoms, and to not to have those Personnel return to work until they have satisfied certain conditions, all as further set forth in the Cal/OSHA rules. Also, Businesses must comply with California Senate Bill 95 (Labor Code, sections 248.2 and 248.3), which provides that employers with more than 25 employees must give every employee 80 hours of COVID-related sick leave retroactive to January 1, 2021 and through September 30, 2021 (pro-rated for less than full time employees), including that employees may use this paid sick leave to get vaccinated or for post-vaccination illness. Each Business is prohibited from taking any adverse action against any Personnel for staying home in any of the circumstances described in this subsection.

   e. Signage. In addition to any signage otherwise required in this Order or any directives issued by the Health Officer for specific Business or other sectors, the following

general signage requirements apply.

i. Signage for Patrons. All Businesses and governmental entities are required to conspicuously post signage reminding individuals of COVID-19 prevention best practices to reduce transmission: Get vaccinated; Stay home if sick, and talk to your doctor; Masks are required indoors; Maximize fresh air; and Clean your hands. Sample signage is available online at https://sf.gov/outreach-toolkit-coronavirus-covid-19.

ii. Signage for Employees. All Businesses and governmental entities are required to post signs in employee break rooms or areas encouraging employees to get vaccinated and informing them how to obtain additional information. Sample signage is available online at https://sf.gov/outreach-toolkit-coronavirus-covid-19.

f. Ventilation Guidelines. All Businesses and governmental entities with indoor operations are urged to review the Ventilation Guidelines and implement ventilation strategies for indoor operations as feasible. Nothing in this subsection limits any ventilation requirements that apply to particular settings under federal, state, or local law.

g. Mandatory Reporting by Businesses and Governmental Entities. Consistent with Cal/OSHA rules and regulations, Businesses and governmental entities must require that all Personnel immediately alert the Business or governmental entity if they test positive for COVID-19 and were present in the workplace either (1) within the 48 hours before onset of symptoms or within 10 days after onset of symptoms if they were symptomatic; or (2) within 48 hours before the date on which they were tested or within 10 days after the date on which they were tested if they were asymptomatic. If a Business or governmental entity learns that three or more of its Personnel are confirmed positive cases of COVID-19 and visited the workplace during their high-risk exposure period at any time during a 14-day period (*i.e.*, three cases onsite within a 14-day period), then the entity must call DPH at 628-217-6100 immediately to report the cases and in any event no later than the next business day after learning of those positive cases. Businesses and governmental entities must also comply with all case investigation and contact tracing measures directed by DPH including providing any information requested within the timeframe provided by DPH, instructing Personnel to follow isolation and quarantine protocols specified by DPH, and excluding positive cases and unvaccinated close contacts from the workplace during these isolation and quarantine periods.

Schools and Programs for Children and Youth are subject to separate reporting requirements set forth in Health Officer Directive Nos. 2020-33 and 2020-14, respectively, including as those directives are updated in the future.

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

5. Schools and Programs for Children and Youth

   a. Schools. Based on the demonstrated low risk of transmission in school settings and the requirement for universal masking indoors, the Health Officer strongly believes that schools can and should reopen in full for in-person classes for all grades at the beginning of the 2021/2022 school year. Largely because not all children are eligible to be vaccinated against COVID-19 at this time, schools must follow the health and safety requirements set forth in Health Officer Directive No. 2020-33, including as it may be amended in the future, to ensure the safety of all students and Personnel at the school site.

   b. Programs for Children and Youth. Largely because not all children are eligible to be vaccinated against COVID-19 at this time, the following Programs for Children and Youth must operate in compliance with the health and safety requirements set forth in Health Officer Directive No. 2020-14, including as it may be amended in the future: (1) group care facilities for children who are not yet in elementary school—including, for example, licensed childcare centers, daycares, family daycares, and preschools (including cooperative preschools); and (2) with the exception of schools, which are addressed in subsection a above, educational or recreational institutions or programs that provide care or supervision for school-aged children and youth—including for example, learning hubs, other programs that support and supplement distance learning in schools, school-aged childcare programs, youth sports programs, summer camps, and afterschool programs.

6. Vaccination Requirements for Personnel in High-Risk Settings and Other Health Care Personnel.

   a. High-Risk Settings. Except for some Personnel as provided in subsections (a)(iii), (b), and (c) below, and for Personnel exempt under subsection (d) below, no later than September 30, 2021:

      i. Businesses and governmental entities with Personnel in High-Risk Settings must (1) ascertain vaccination status of all Personnel in High-Risk Settings who routinely work onsite, and (2) ensure that before entering or working in any High-Risk Setting, all Personnel who routinely work onsite have received their first dose of a one-dose COVID-19 vaccine regimen or their second dose of a two-dose COVID-19 vaccine regimen authorized to prevent COVID-19 by the FDA, including by way of an emergency use authorization, or by the World Health Organization, and as defined in subsection (a)(vii) below. Until such Personnel are Fully Vaccinated, they are subject to the requirements in subsection (a)(iv) below; and

      ii. Personnel who routinely work onsite in High-Risk Settings must have received their first dose of a one-dose COVID-19 vaccine regimen or their second dose of a two-dose COVID-19 vaccine regimen authorized to prevent COVID-19 by the FDA, including by way of an emergency use authorization,

or by the World Health Organization, and as defined in subsection (a)(vii) below. Until such Personnel are Fully Vaccinated, they are subject to the requirements in subsection (a)(iv) below; and

iii. For purposes of this Order, Personnel who are not permanently stationed or regularly assigned to a High-Risk Setting but who in the course of their duties may enter or work in High-Risk Settings even on an intermittent or occasional basis or for short periods of time are considered to routinely work onsite in High-Risk Settings. No later than October 13, 2021, Businesses and governmental entities with such Personnel are required to (1) ascertain vaccination status of all such Personnel and (2) ensure that before entering or working in any High-Risk Setting, all such Personnel are Fully Vaccinated with any vaccine authorized to prevent COVID-19 by the FDA, including by way of an emergency use authorization, or by the World Health Organization, unless exempt under subsection (d) below. Additionally, no later than September 29, 2021, all such Personnel must have received their first dose of a one-dose COVID-19 vaccine regimen or their second dose of a two-dose COVID-19 vaccine regimen authorized to prevent COVID-19 by the FDA, including by way of an emergency use authorization, or by the World Health Organization, and as defined in subsection (a)(vii) below. Until such Personnel are Fully Vaccinated, they are subject to the testing and face covering requirements in subsection (a)(iv) below; and

iv. All Businesses and governmental entities subject to this Section 6 must require any exempt Personnel who are not Fully Vaccinated to:

1. get tested for COVID-19 at least once a week (and at least twice a week for exempt Personnel who are not Fully Vaccinated in general acute care hospitals, skilled nursing facilities, and intermediate care facilities) using either a nucleic acid (including polymerase chain reaction (PCR)) or antigen test; and

2. at all times at the worksite in the High-Risk Setting wear a face covering in compliance with the State Public Health Officer Order of July 26, 2021 ("CDPH Vaccination Status Order"), available at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx.

   Because of the COVID-19 risks to any exempt Personnel who are not Fully Vaccinated, the High-Risk Setting must provide such Personnel, on request, with a well-fitting non-vented N95 respirator and strongly encourage such Personnel to wear that respirator at all times when working with patients, residents, clients, or incarcerated people; and

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

v. All Businesses and governmental entities subject to this Section 6 must, consistent with applicable privacy laws and regulations, maintain records of employee vaccination or exemption status; and

vi. All Businesses and governmental entities subject to this Section 6 must provide these records to the Health Officer or other public health authorities promptly upon request, and in any event no later than the next business day after receiving the request.

vii. Currently, a two-dose COVID-19 vaccine regimen includes the Pfizer-BioNTech (Comirnaty) or Moderna vaccines or a COVID-19 vaccine authorized by the World Health Organization. Currently, a one-dose vaccine regimen is the Johnson & Johnson Janssen COVID-19 vaccine.

viii. This mandated vaccination schedule allows Businesses, governmental entities, and affected Personnel adequate time to comply with this Order. In the interest of protecting residents of High-Risk Settings, Personnel, and their families, Businesses, governmental entities, and affected Personnel are strongly urged to meet these vaccination requirements as soon as possible.

For clarity, this requirement applies to Personnel in other buildings in a site containing a High-Risk Setting, such as a campus or other similar grouping of related buildings, where such Personnel do any of the following: (i) access the acute care or patient, resident, client, or incarcerated person areas of the High-Risk Setting; or (ii) work in-person with patients, residents, clients, or incarcerated people who visit those areas. All people in San Francisco who work in a clinical setting with a population that is more vulnerable to COVID-19 are strongly urged to be fully vaccinated against COVID-19.

b. Adult Care Facilities, Adult Day Programs, and Dental Offices. As soon as possible, but no later than October 13, 2021, Businesses and governmental entities with Personnel in adult care facilities, adult day programs licensed by the California Department of Social Services, and dental offices must, in relation to such settings, comply with the applicable requirements of this Section 6 and meet the timing requirements set forth in subsection (a)(iii) above. For clarity, Personnel of such Businesses or governmental entities in those settings are subject to subsection (a)(ii) above and must be Fully Vaccinated or qualify for an exemption under subsection (d) below and follow the precautions as set forth in this Order.

c. Home Health Care Workers and Pharmacists. As soon as possible, but no later than October 13, 2021, Businesses and governmental entities with Personnel who are home health care workers or pharmacists must, in relation to such Personnel, comply with the applicable requirements of this Section 6 and meet the timing requirements set forth in subsection (a)(iii) above. For clarity, all such Personnel are subject to subsection (a)(ii) above and must be Fully Vaccinated or qualify for an exemption under subsection (d) below and follow the precautions as set forth in this Order.

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

d. Limited Exemptions. Personnel covered by this Section 6 may be exempt from the vaccination requirements under this section only upon providing the requesting Business or governmental entity a declination form, signed by the individual under penalty of perjury stating either of the following: (1) the individual is declining vaccination based on Religious Beliefs or (2) the individual is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons. As to declinations for Qualifying Medical Reasons, to be eligible for this exemption Personnel must also provide to their employer or the Business a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and indicating the probable duration of the individual's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate). A sample ascertainment and declination form is available online at www.sfdph.org/dph/covid-19/files/declination.pdf. As to declinations based on Religious Beliefs, a Business or governmental entity may seek additional information as allowed or required by applicable law to determine whether Personnel have a qualifying Religious Belief. Personnel who qualify for and are granted by the employing Business or governmental entity an exemption due to Religious Beliefs or Qualifying Medical Reasons, as provided above, must still follow the requirements in subsection (a)(iv), above. Nothing in this Order is intended to limit any Business's or governmental entity's ability under applicable law to determine whether they are able to offer a reasonable accommodation to Personnel with an approved exemption.

e. Record Keeping Requirements. Businesses or governmental entities subject to this Section 6 must maintain records with following information:

i. For Fully Vaccinated Personnel: (1) full name and date of birth; (2) vaccine manufacturer; and (3) date of vaccine administration (for first dose and, if applicable, second dose). Nothing in this subsection is intended to prevent an employer from requesting additional information or documentation to verify vaccination status, to the extent permissible under the law.

ii. For unvaccinated Personnel: signed declination forms with written health care provider's statement where applicable, as described in subsection (d) above.

f. Compliance with CDPH Orders. In addition to the requirements set forth above:

i. Until the more health protective requirements in this section take effect, Businesses and governmental entities with Personnel in High-Risk Settings must comply with the requirements of the CDPH Vaccination Status Order; and

ii. Businesses and governmental entities with Personnel in adult care facilities and Other Health Care Settings—as that term is defined in the CDPH Vaccination

Status Order—must be in full compliance with the requirements of the CDPH Vaccination Status Order.

iii. Businesses and governmental entities with Personnel who provide services or work in facilities covered by the State Public Health Officer Order of August 5, 2021 ("CDPH Health Care Worker Vaccine Order"), must comply with the requirements of that order, including as that order may be amended in the future. See www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx.

g. Cooperation with Public Health Authorities. Businesses or governmental entities with Personnel subject to this Section 6 must cooperate with Health Officer or DPH requests for records, documents, or other information regarding the Business or governmental entity's implementation of these vaccination requirements. This cooperation includes, but is not limited to, identifying all jobs or positions within the organization and describing: (1) whether a given job or position is subject to the vaccination requirements of this Section 6, (2) how the Business or governmental entity determined a job or position is subject to vaccination requirements of this Section 6, and (3) how the Business or governmental entity is ensuring full compliance with the vaccination requirements set forth in this Section 6. Complete responses to these requests must be provided to the Health Officer or DPH promptly upon request, and in any event within three business days after receiving the request.

h. Chart. For convenience of reference, a chart summarizing which settings and Personnel are subject to which state and local vaccination requirements is available at https://www.sfdph.org/dph/alerts/files/C19-07-State-and-Local-Mandates-Chart.pdf.

i. Operative Date. This Section 6 becomes operative immediately and will continue, as updated, to be in effect until the Health Officer rescinds, supersedes, or amends it in writing.

7. Mega-Events and Large Indoor Events.

a. Compliance with State's Post-Blueprint Guidance. All Businesses, governmental entities, and other organizations hosting Mega-Events must comply with the requirements in the State's Post-Blueprint Guidance for indoor Mega-Events and are strongly urged to follow the recommendations in the State's Post-Blueprint Guidance for outdoor Mega-Events.

b. Vaccine Verification Requirements.

i. For indoor Mega-Events, Personnel and patrons age 12 and up are currently required to show proof, before entering the facility, that they are Fully Vaccinated or Tested.

ii. Except as provided below, as soon as possible, but no later than August 20, 2021, operators or hosts of indoor Mega-Events and Large Indoor Events must

require all patrons age 12 and up to show proof, before entering the facility, that they are Fully Vaccinated, subject to any applicable requirements of federal, state, or local laws requiring accommodation. Indoor Mega-Events and Large Indoor Event may not accept a written self-attestation as proof of Full Vaccination.

- Operators or hosts of indoor Mega-Events and Large Indoor Events that sold tickets or registered attendees before August 12, 2021, are not subject to the requirements in this subsection 7(b)(ii) until September 15, 2021. But beginning on August 20, 2021, and until September 15, 2021, operators or hosts of such indoor Mega-Events and Large Indoor Events must require all patrons age 12 and up to show proof, before entering the facility, that they are Fully Vaccinated or Tested.

iii. As soon as possible, but no later than October 13, 2021, operators or hosts of indoor Mega-Events and Large Indoor Events must require all staff to show proof, before entering the facility, that they are Fully Vaccinated, subject to any applicable requirements of federal, state, or local laws requiring accommodation.

For clarity, "staff" as used in this Section 7 does not include all individuals included in the broader term "Personnel." Performers or players who are not employed by the Business, governmental entity, or other organization hosting the event (*e.g.*, members of visiting teams and independent performers not employed by the host) are not covered by this Section, but are strongly encouraged to be Fully Vaccinated before playing or performing in San Francisco. If they are not, they are required to:

- Remain at least six feet away from members of the public for the entire duration of the event;
- Provide the Business, governmental entity, or other organization hosting the event with proof of a negative COVID-19 test (nucleic acid or antigen) taken within the 48 hours before the event; and
- Wear a Well-Fitted Mask at all times except while actively performing or playing as required by Appendix A of this Order.
- They will not be able to enter the indoor portion of any of the businesses covered in Appendix B of this Order except areas required for them to perform or play.

c. Health and Safety Plan Requirement.

The host or organizer of an indoor or outdoor Mega-Event, Large Indoor Event, or series of Mega-Events or Large Indoor Events must submit to the Health Officer a proposed plan detailing the procedures that will be implemented to minimize the risk of transmission among patrons and Personnel. Specifically, the proposed plan should include to following:

- Description of event details (date/time; expected capacity; location; and type of event).

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

- Contact name for the event (*i.e.*, a person who can be reached in the event of an outbreak and/or who can be contacted to discuss the proposed plan).
- An explanation of how the host or organizer will have attendees meet requirements for providing their vaccination status (required indoors, recommended outdoors).
- An explanation of how the host or organizer will communicate/message:
  - Information to ensure that guests are aware of vaccination requirements (indoors)/recommendations (outdoors); and
  - The safety measures being taken.
- If the event is being held indoors, an explanation of how the host or organizer will adhere to the Face Covering Requirements and Appendix A of this Order.
- A description of the strategies that will be implemented to avoid stagnant crowds (this can include traffic flow, advanced ticketing, touchless payment, etc.).

A template for plans for Large Indoor Events with 1,000-4,999 attendees is available at www.sfdph.org/dph/alerts/files/C19-07-HSP-over-1000.pdf.

Plans must be submitted by email to HealthPlan@sfcityatty.org at least ten business days before the planned event or, if earlier, ten business days before the date on which tickets will begin to be sold or offered to the public. If tickets for a Large Indoor Event are already on sale as of the date of this Order, the host or organizer must submit the plan within 30 days of the date of this Order or 48 hours before the event, whichever comes first. The host or organizer does not need advance written approval of the Health Officer or the Health Officer's designee to proceed with the Mega-Event or Large Indoor Event consistent with the plan. But in the event the Health Officer identifies deficiencies in the plan, DPH will contact the host or organizer, and the host or organizer is required to work with DPH to address any and all deficiencies.

d. Recommendations for Outdoor Events. All Businesses, governmental entities, and other organizations hosting outdoor events with between 5,000 and 9,999 attendees are strongly urged to (1) follow the recommendations in the State's Post-Blueprint Guidance for outdoor Mega-Events; and (2) require all patrons age 12 and up to show proof, before entering the event, that they are Fully Vaccinated, subject to any applicable requirements of federal, state, or local laws requiring accommodation.

e. For convenience of reference, a chart summarizing the requirements for Mega-Events and Large Events is available at www.sfdph.org/dph/alerts/files/C19-07-Mega-and-Large-Event-Chart.pdf.

8. COVID-19 Health Indicators. The City will continue to make publicly available on its website updated data on COVID-19 case rates, hospitalizations and vaccination rates. That information can be found online at https://sf.gov/resource/2021/covid-19-data-and-reports. The Health Officer will monitor this data, along with other data and scientific

evidence, in determining whether to modify or rescind this Order, as further described in Section 2(a) above.

9. Incorporation of State and Local Emergency Proclamations and Federal and State Health Orders. The Health Officer is issuing this Order in accordance with, and incorporates by reference, the emergency proclamations and other federal, state, and local orders and other pandemic-related orders described below in this Section. But this Order also functions independent of those emergency proclamations and other actions, and if any State, federal, or local emergency declaration, or any State or federal order or other guidance, is repealed, this Order remains in full effect in accordance with its terms (subject to Section 13 below).

   a. State and Local Emergency Proclamations. This Order is issued in accordance with, and incorporates by reference, the March 4, 2020 Proclamation of a State of Emergency issued by the Governor, the February 25, 2020 Proclamation by the Mayor Declaring the Existence of a Local Emergency, and the March 6, 2020 Declaration of Local Health Emergency Regarding Novel Coronavirus 2019 (COVID-19) issued by the Health Officer, as each of them have been and may be supplemented.

   b. State Health Orders. This Order is also issued in light of the various Orders of the State, including, but not limited to, those of the State's Public Health Officer and Cal/OSHA. The State has expressly acknowledged that local health officers have authority to establish and implement public health measures within their respective jurisdictions that are more restrictive than those implemented by the State Public Health Officer.

   c. Federal Orders. This Order is further issued in light of federal emergency declarations and orders, including, but not limited to, the January 20, 2021 Executive Order on Protecting the Federal Workforce and Requiring Mask-Wearing, which requires all individuals in Federal buildings and on Federal land to wear masks, maintain physical distance, and adhere to other public health measures, and the February 2, 2021 Order of the CDC, which requires use of masks on public transportation, as such orders are amended, extended or supplemented.

10. Obligation to Follow Stricter Requirements of Orders.

    Based on local health conditions, this Order includes a limited number of health and safety restrictions that are more stringent than those contained under State orders. Where a conflict exists between this Order and any state or federal public health order related to the COVID-19 pandemic, the most restrictive provision (*i.e.*, the more protective of public health) controls. Consistent with California Health and Safety Code section 131080 and the Health Officer Practice Guide for Communicable Disease Control in California, except where the State Health Officer may issue an order expressly directed at this Order and based on a finding that a provision of this Order constitutes a menace to public health, any more restrictive measures in this Order continue to apply and control in this County.

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

11. Obligation to Follow Health Officer Orders and Directives and Mandatory State Guidance.

    In addition to complying with all provisions of this Order, all individuals and entities, including all Businesses and governmental entities, must also follow any applicable orders and directives issued by the Health Officer (available online at www.sfdph.org/healthorders and www.sfdph.org/directives) and any applicable mandatory guidance issued by the State Health Officer or California Department of Public Health. To the extent that provisions in the orders or directives of the Health Officer and the mandatory guidance of the State conflict, the more restrictive provisions (*i.e.*, the more protective of public health) apply. In the event of a conflict between provisions of any previously-issued Health Officer order or directive and this Order, this Order controls over the conflicting provisions of the other Health Officer order or directive. And to the extent the continuing term of another order of the Health Officer is tied to the duration of the Stay-Safer-At-Home Order, this Order shall be deemed a continuation of the Stay-Safer-At-Home Order for those purposes only.

12. Enforcement.

    Under Government Code sections 26602 and 41601 and Health and Safety Code section 101029, the Health Officer requests that the Sheriff and the Chief of Police in the County ensure compliance with and enforce this Order. The violation of any provision of this Order (including, without limitation, any health directives) constitutes an imminent threat and immediate menace to public health, constitutes a public nuisance, and is punishable by fine, imprisonment, or both. DPH is authorized to respond to such public nuisances by issuing Notice(s) of Violation and ordering premises vacated and closed until the owner, tenant, or manager submits a written plan to eliminate all violations and DPH finds that plan satisfactory. Such Notice(s) of Violation and orders to vacate and close may be issued based on a written report made by any City employees writing the report within the scope of their duty. DPH must give notice of such orders to vacate and close to the Chief of Police or the Chief's designee to be executed and enforced by officers in the same manner as provided by San Francisco Health Code section 597. As a condition of allowing a Business to reopen, DPH may impose additional restrictions and requirements on the Business as DPH deems appropriate to reduce transmission risks, beyond those required by this Order and other applicable health orders and directives.

13. Effective Date.

    This Order becomes effective at 12:01 a.m. on June 15, 2021 and will continue, as updated, to be in effect until the Health Officer rescinds, supersedes, or amends it in writing.

14. Relation to Other Orders of the San Francisco Health Officer.

    As of the effective date and time in Section 13 above, this Order revises and entirely replaces the prior update to Health Officer Order No. C19-07y (issued August 12, 2021).

ORDER OF THE HEALTH OFFICER No. C19-07y (updated)

Leading up to and in connection with this Order, the Health Officer has rescinded or is rescinding a number of other orders and directives relating to COVID-19, including those listed in the Health Officer's Omnibus Rescission of Health Officer Orders and Directives, dated June 11, 2021. On and after the effective date of this Order, the following orders and directives of the Health Officer shall continue in full force and effect: Order Nos. C19-11 (Laguna Honda Hospital protective quarantine), C19-16 (hospital patient data sharing), C19-18 (vaccine data reporting), and C19-19 (minor consent to vaccination); and the directives that this Order references in Sections 3(e) and 5, as the Health Officer may separately amend or later terminate any of them. Also, this Order also does not alter the end date of any other Health Officer order or directive having its own end date or that continues indefinitely.

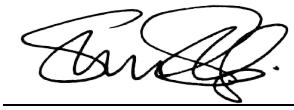
15. Copies.

The County must promptly provide copies of this Order as follows: (1) by posting on the DPH website (www.sfdph.org/healthorders); (2) by posting at City Hall, located at 1 Dr. Carlton B. Goodlett Pl., San Francisco, CA 94102; and (3) by providing to any member of the public requesting a copy.

16. Severability.

If a court holds any provision of this Order or its application to any person or circumstance to be invalid, then the remainder of the Order, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of this Order are severable.

IT IS SO ORDERED:



Susan Philip, MD, MPH,
Health Officer of the
City and County of San Francisco

Dated: August 24, 2021

Attachments:
- Appendix A – Face Covering Requirements (dated August 2, 2021)
- Appendix B – Proof of Vaccination Requirements (dated August 12, 2021)

Order No. C19-07y – Appendix A: Face Covering Requirements

[August 2, 2021]

1. General Requirement to Wear Well-Fitted Mask.

   Everyone, including people who are Fully Vaccinated, must wear a Well-Fitted Mask in indoor public settings at all times except as provided in Sections 4 and 5, below.

2. Ventilation.

   Businesses and operators of other public and private facilities where people are allowed to remove their Well-Fitted Masks indoors (under any of the exceptions provided in Section 5, below) may only allow people to remove their Well-Fitted Masks if they use at least one of the following ventilation strategies: (1) all available windows and doors accessible to fresh outdoor air are kept open as long as air quality and weather conditions permit; (2) fully operational HVAC system; or (3) appropriately sized portable air cleaners in each room.

3. Proof of Full Vaccination.

   Businesses and other entities are urged to require people to provide proof that they are Fully Vaccinated before allowing people to remove their Well-Fitted Mask to the extent allowed in Section 5, below. For clarity, even if a Business or other entity does verify that people are Fully Vaccinated, people still must wear a Well-Fitted Mask as required by this Order.

4. Status-Based Exemptions.

   a. Medical or Safety Exemption. A person does not need to wear a Well-Fitted Mask when they can show: (1) a medical professional has provided a written exemption to the Face Covering Requirement, based on the person's medical condition, other health concern, or disability; or (2) that they are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication; or (3) wearing a Well-Fitted Mask while working would create a risk to the person related to their work as determined by local, state, or federal regulators or workplace safety guidelines. In accordance with California Department of Public Health ("CDPH") and United States Centers for Disease Control and Prevention ("CDC") guidelines, if a person is exempt from wearing a Well-Fitted Mask under this paragraph, they still must wear an alternative face covering, such as a face shield with a drape on the bottom edge, unless they can show either: (1) a medical professional has provided a written exemption to this alternative face covering requirement, based on the person's medical condition, other health concern, or disability; or (2) wearing an alternative face covering while working would create a risk to the person related to their work as determined by local, state, or federal regulators or workplace safety guidelines.

   A Well-Fitted Mask should also not be used by anyone who has trouble breathing or is unconscious, incapacitated, or otherwise unable to remove the Well-Fitted Mask without assistance.

b. Children. In accordance with CDPH and CDC guidelines, any child younger than two years old must not wear a Well-Fitted Mask because of the risk of suffocation. Children age two to nine years must wear Well-Fitted Masks to the greatest extent feasible. Children age two to nine years may wear an alternative face covering (as that term is described in Section 2.a, above) if their parent or caregiver determines it will improve the child's ability to comply with this Order. Children age two to nine and their accompanying parents or caregivers should not be refused any essential service based on a child's inability to wear a Well-Fitted Mask (for example, if a four-year old child refuses to keep a Well-Fitted Mask on in a grocery store), but the parent or caregiver should when possible take reasonable steps to have the child wear a Well-Fitted Mask to protect others and minimize instances when children without Well-Fitted Masks are brought into settings with other people. Parents and caregivers of children age two to nine years must supervise the use of Well-Fitted Masks to ensure safety and avoid misuse.

c. Personal Protective Equipment. A person does not need to wear a Well-Fitted Mask when wearing personal protective equipment ("PPE") that is more protective than a Well-Fitted Mask, as required by (i) any workplace policy or (ii) any local, state, or federal law, regulation, or other mandatory guidance. When a person is not required to wear such PPE and in an indoor public setting, they must wear a Well-Fitted Mask unless otherwise exempted from this Order.

5. Activity- and Location-Based Exemptions.

To the extent allowed by state or federal rules requiring face coverings for unvaccinated people, wearing a Well-Fitted Mask is not required in any of the following situations:

a. Indoor Public Setting While Alone or with member of Household. A person does not need to wear a Well-Fitted Mask when they are alone or with a member of their Household in a public building or completely enclosed space such as an office, and people who are not part of their Household are not likely to be in the same space. If someone who is not part of a person's Household enters the enclosed space, both people must wear a Well-Fitted Mask for the duration of the interaction. For clarity, people must wear Well-Fitted Masks whenever they are in semi-enclosed spaces such as cubicles and common areas for shared living settings, such as hotels, shared rentals with multiple Households, dormitories, fire stations, lobbies, and elevators. A Well-Fitted Mask must be worn if the person is in an indoor public space where others who are not part of their Household routinely are present.

b. Active Eating and Drinking. People may remove their Well-Fitted Mask while actively eating or drinking. People are urged to be seated at a table or positioned at a stationary counter or place while eating or drinking. For clarity, Well-Fitted Masks may be removed while actively eating or drinking at events other than indoor dining, such as live performances and movies.

c. Personal Motor Vehicle. A person does not need to wear a Well-Fitted Mask when in a motor vehicle and either alone or exclusively with other members of the same Household. But a Well-Fitted Mask is required when alone in the vehicle if the vehicle is used as a taxi or for any private car service or ride-sharing vehicle. Persons sharing a personal motor vehicle with people outside of the same Household are strongly encouraged to roll down the vehicle's windows for ventilation.

d. Showering, Personal Hygiene, or Sleeping. People may remove their Well-Fitted Mask only while showering or actively engaging in personal hygiene that requires removal of the Well-Fitted Mask, including at a gym or other facility. People may remove their Well-Fitted Mask while sleeping in indoor public settings.

e. Live or Recorded Performance and Professional Sports. Performers at indoor live or recorded settings or events such as concerts, live music, film, television, recording studios, theater, opera, symphony, and professional sports may remove their Well-Fitted Masks while actively performing or practicing. If they remove their Well-Fitted Mask, performers must maintain at least six feet of distance from attendees and employees and are encouraged to maintain as much distance from other performers as possible. Performers are strongly urged to be Fully Vaccinated or regularly tested, and to wear their Well-Fitted Masks to the greatest extent possible. Attendees and employees must remain masked while attending or working at the performance except when another exception applies.

f. Religious Gatherings. Service leaders of indoor public religious gatherings, including by way of example but not limitation, choirs, may remove their Well-Fitted Mask while actively performing religious services. If they remove their Well-Fitted Mask, service leaders must maintain at least six feet of distance from participants except when another exception applies and are encouraged to maintain as much distance from other service leaders as possible. Service leaders are strongly urged to be Fully Vaccinated or regularly tested, and to wear their Well-Fitted Masks to the greatest extent possible. Participants in indoor religious gatherings may remove their Well-Fitted Masks to participate in religious rituals.

g. Personal Services. Patrons of personal services such as facials, beard trims, facial piercing and tattoos, and facial massages may remove their Well-Fitted Mask only while actively receiving a service or treatment that requires temporary removal of the Well-Fitted Mask. Where they cannot maintain at least six feet of distance, providers of personal services must wear a N-95 mask, respirator, or procedural/surgical mask while administering the service.

h. Recreational Sports. Participants in indoor recreational sports, gyms, and yoga studios may not remove their Well-Fitted Masks except while actively engaged in water-based sports (swimming, swim lessons, diving, water polo) and other sports where masks create imminent risk to health (e.g., wrestling, judo). Swim instructors who are not Fully

Vaccinated are required to wear a face shield at all times that they are in the water with other people.

6. Additional Recommendations.

   a. Outdoor Crowded Gatherings. People who are outdoors in close proximity to other people who are not part of their Household are strongly encouraged to wear a Well-Fitted Mask.

   b. Indoor Private Gatherings. People are strongly encouraged to wear a Well-Fitted Mask when present in an indoor private gathering at a Residence if someone who is not part of a person's Household is present in the Residence. For clarity, people must wear a Well-Fitted Mask in common areas of a Residence that is used as a shared rental with multiple Households.

   c. Providing a Well-Fitted Mask. Businesses and other entities subject to this Order are strongly encouraged to provide a Well-Fitted Mask at no cost to people who do not have one upon entry inside the facility.

7. Compliance with CDPH Vaccination Status Order's Mask Requirement.

   Businesses and governmental entities with Personnel in Acute Health Care Settings, Long-Term Care Settings, High-Risk Congregate Settings, and Other Health Care Settings—as those terms are defined in the CDPH Vaccination Status Order, available online at www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx—must provide appropriate face coverings as required by the CDPH Vaccination Status Order.

Order No. C19-07y – Appendix B: Proof of Vaccination Requirements

[August 12, 2021]

1. Covered Businesses and Events.

For purposes of this Appendix B, Covered Businesses include:

a. Operators/hosts of establishments or events where food or drink is served indoors—including, but not limited to, dining establishments, bars, clubs, theaters, and entertainment venues. For clarity, this does not include food or drink provided as part of a religious ceremony (*e.g.*, communion or kiddush).

b. Gyms, recreation facilities, yoga studios, dance studios, and other fitness establishments, where any patrons engage in cardiovascular, aerobic, strength training, or other exercise involving elevated breathing. For clarity, fitness establishments and activities that are part of a K-12 school or operate as a Program for Children and Youth are covered by separate sector-specific directives (available at www.sfdph.org/directives) and are not subject to the requirements of this Appendix B.

2. Vaccination Requirement for Patrons.

a. Requirement. As soon as possible, but no later than August 20, 2021, Covered Businesses must require all patrons age 12 and older to show proof that they are Fully Vaccinated before entering any indoor portion of a facility, subject only to the exceptions below and any applicable requirements of federal, state, or local laws requiring accommodation.

For purposes of this requirement, Covered Businesses may not accept a written self-attestation of vaccination proof of Full Vaccination. The following are the only acceptable proof of Full Vaccination:

(1) the CDC vaccination card, which includes name of person vaccinated, type of vaccine provided, and date last dose administered, or similar documentation issued by another foreign governmental jurisdiction;

(2) a photo or copy of a vaccination card as a separate document;

(3) a photo of a vaccination card stored on a phone or electronic device;

(4) documentation of vaccination from a healthcare provider; or

(5) a personal digital COVID-19 vaccine record issued by the State of California and available by going to myvaccinerecord.cdph.ca.gov or similar documentation issued by another state, local, or foreign governmental jurisdiction, or by an approved private company (a list of approved companies offering digital vaccine cards is available at www.sfdph.org/dph/alerts/files/vaccine-verification-sites.pdf).

Order No. C19-07y – Appendix B: Proof of Vaccination Requirements

[August 12, 2021]

Covered Businesses are required to cross-check proof of Full Vaccination for each patron against a photo identification, unless photo identification is integrated into the digital COVID-19 vaccine record.

b. Exceptions and Clarifications.

i. For clarity, individuals who do not provide proof of Full Vaccination may use the outdoor portions of Covered Business facilities (but not the indoor portions except solely as provided in subsections (ii), (iii), and (v) below).

ii. Covered Businesses may allow patrons wearing a Well-Fitted Mask to come indoors to use a restroom without requiring patrons to show proof they are Fully Vaccinated.

iii. Dining establishments and bars may require proof of Full Vaccination to be shown at the time of patrons' first in-person interaction with staff (*e.g.*, at the time of ordering) rather than at the entrance to the establishment, but only if all such patrons wear Well-Fitted Masks at all times after entering the indoor portion of the facility and before showing such proof. Dining establishments and bars are prohibited from serving any patron indoors who fails to provide this proof.

iv. Theaters where concessions are sold may require proof of Full Vaccination to be shown at the time of patrons' purchase of concessions rather than at the entrance to the establishment. Theaters are prohibited from selling food or beverages to any patron indoors who fails to provide this proof.

v. Dining establishments and bars that serve food may allow individuals wearing a Well-Fitted Mask to enter the indoor portion of the facility to order, pick up, or pay for food or drink "to go" without showing proof of Full Vaccination.

vi. Businesses may obtain proof of Full Vaccination in advance of a patron's arrival at a facility, *e.g.*, by email or through a reservation system, but must confirm identification at the time of entry into the facility.

vii. Businesses operating food courts in indoor shopping centers that offer seated dining are required to obtain proof of Full Vaccination before patrons enter into the food court unless those operators remove seating from the area.

viii. Individuals hosting private events in their homes are not subject to the requirements of this Appendix B but are strongly urged to require all guests age 12 and older to show proof that they are Fully Vaccinated.

3. Vaccination Requirement for Staff.

a. Requirements. Subject to the exceptions below and any applicable requirements of

federal, state, or local laws requiring accommodation:

i. As soon as possible, but no later than August 20, 2021, Covered Businesses must use their best efforts to ascertain the vaccination status of all staff who routinely work onsite. A sample Employee Vaccination Program Ascertainment Form is available at www.sfdph.org/dph/covid-19/files/declination.pdf.

ii. As soon as possible, but no later than October 13, 2021, Covered Businesses must ensure that all staff who routinely work onsite provide proof that they are Fully Vaccinated before entering or working in any indoor portion of the facility;

iii. Consistent with applicable privacy laws and regulations, Covered Businesses must maintain records of staff vaccination or exemption status, and provide these records to the Health Officer or other public health authorities promptly upon request, and in any event no later than the next business day after receiving the request.

b. Exceptions and Clarifications.

i. For clarity, "staff" as used in this order does not include all individuals included in the broader term "Personnel." Individuals who enter or work in a Covered Business facility on an intermittent or occasional basis or for short periods of time (*e.g.*, individuals who deliver goods or packages) are not covered by the requirements in this Appendix B.

4. Signage.

a. Signage for Patrons. As soon as possible, but no later than August 20, 2021, all Covered Businesses are required to conspicuously post at the entrance to the facility signage informing individuals that proof of Full Vaccination is required to enter the indoor portion of the facility. Sample signage is available at sf.gov/outreach-toolkit-coronavirus-covid-19.

b. Signage for Staff. As soon as possible, but no later than August 20, 2021, all Covered Businesses are required to post signs in employee break rooms or similar areas informing staff that they are required to provide proof of Full Vaccination by October 13, 2021, and informing them how to obtain additional information about getting vaccinated. Sample signage is available online at sf.gov/outreach-toolkit-coronavirus-covid-19.

EXHIBIT 37

OFFICE OF THE COUNTY EXECUTIVE
COUNTY OF SANTA CLARA

Jeffrey V. Smith
COUNTY EXECUTIVE

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70 West Hedding Street
East Wing, 11th Floor
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(408) 299-5105

OFFICE OF THE COUNTY COUNSEL
COUNTY OF SANTA CLARA

James R. Williams
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(408) 299-5900

MEMORANDUM

TO: All County of Santa Clara Personnel

FROM: Jeffrey V. Smith, County Executive
James R. Williams, County Counsel

DS JVS JRW

RE: **COVID-19 Vaccination Requirement for County Personnel**

DATE: August 5, 2021

Clinical trials, scientific research, and safety monitoring have demonstrated that the federally approved COVID-19 vaccines are safe and are the most effective method of preventing people from getting and spreading the virus that causes COVID-19 and from getting seriously ill, ending up hospitalized, or dying, even if they do get COVID-19.

To protect County personnel, the community members with whom County personnel interact, and all residents of the county, the County will require all County personnel to be fully vaccinated subject to the limited exceptions below. County departments are responsible for ensuring that their employees, interns, volunteers, and also any contractors who regularly work onsite for their department, comply with this policy. This policy is issued as an emergency measure based on the strong recommendation of the Health Officer that employers adopt such policies immediately and based on the significant rise of COVID-19 cases and hospitalizations among the unvaccinated due to the Delta variant.

County personnel may obtain the COVID-19 vaccine at a County Health System vaccination site or through another location of their choosing. County employees may take paid time off to obtain the COVID-19 vaccination, consistent with information previously provided to all County staff. Information on the COVID-19 vaccines and how to obtain vaccination is available at sccfreevax.org.

A. Definitions

County personnel, for purposes of this Memorandum and related requirements, includes: (1) County employees, interns, and volunteers; and (2) County contractors who regularly perform

services for the County onsite and interact with other individuals in person as part of their services for the County. County contractors who qualify as County personnel include, for example, contract physicians and contracted staff who consistently work within County facilities, but would not include, for example, a third-party that a department retains on occasion to pick up or deliver a package or documents.

COVID-19 vaccine means a vaccine authorized to prevent COVID-19 by the federal Food and Drug Administration, including by way of an emergency use authorization.

Fully vaccinated means (1) it has been at least two weeks since a person has completed the entire recommended series of a COVID-19 vaccine, and (2) the person has provided proof of vaccination in a form consistent with the requirements for verification of vaccine status in the State of California's July 26, 2021 Public Health Officer Order.

Partially vaccinated means (1) a person has received (i) one dose of a two dose recommended series of a COVID-19 vaccine or (ii) the complete recommended series of a COVID-19 vaccine but it has not been at least two weeks since the person has completed the entire recommended series, and (2) the person has provided proof of vaccination in a form consistent with the requirements for verification of vaccine status in the State of California's July 26, 2021 Public Health Officer Order.

B. Required Vaccination

- **By August 20, 2021** (*15 days from issuance of policy*) **all County personnel must be partially or fully vaccinated** or must have submitted a request for exemption.[1]
- **By September 30, 2021** (*8 weeks from issuance of policy*) **all County personnel must be fully vaccinated** or must have submitted a request for exemption.
- **Effective September 30, 2021** (*8 weeks from issuance of policy*) **all newly hired County employees and any new volunteers, interns, and/or contractors must be fully vaccinated** or must have submitted a request for exemption.

Requests for exemption must be submitted per Section C, below. If a person's request for exemption is not approved, they must be partially or fully vaccinated within 14 days and fully vaccinated within 8 weeks of when they were notified that the request was not approved.

County employees who fail to comply with this policy are subject to release or discharge from County employment. County contractors who fail to comply with this vaccination or exception

[1] If a person will not work for an extended period due to a leave of absence (such as for FMLA leave or pregnancy disability leave), they may contact their department head or designee to request a deferral of the vaccination requirements until they return to work. But they must be fully vaccinated or have submitted a request for exemption by the time they return to work.

requirement may be barred from County worksites and not allowed to perform services for the County. In addition, the County may, as appropriate, suspend or terminate the applicable contract.

C. Limited Exemptions to Vaccination Requirement

1. Limited Exemptions for County Employees

Limited exemptions. County employees may request a reasonable accommodation to the vaccination requirement if they:

1. Have a contraindication recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccine's manufacturer to *every* approved COVID-19 vaccine. A contraindication means a condition that makes vaccination inadvisable;

2. Have a disability and are requesting an exception as a reasonable accommodation; or,

3. Object to COVID-19 vaccination based on their sincerely-held religious belief, practice, or observance.

How to request exemption. To seek a reasonable accommodation from the vaccination requirements in this Memorandum, County employees should:

1. Contact their department head or designee(s) to obtain a copy of the appropriate form. The available forms are:
    a. Medical Exemption and/or Disability Accommodation Request Form
    b. Religious Accommodation Request Form

2. Complete and submit the applicable form(s) to the County Equal Opportunity Division (EOD) at eodra@eod.sccgov.org.

If an accommodation is granted, the EOD will notify the employee and their department of the approval and the associated expiration date. If a request for accommodation is denied, the EOD will notify the employee and their department.

2. Limited Exemptions for County Contractors, Interns, and Volunteers

If a County contractor, intern, or volunteer is covered by this Memorandum and does not meet the vaccination requirements, the individual's sponsoring department may request an ad hoc exemption from Chief Operating Officer Miguel Márquez, who will consider the requested exemption on a case-by-case basis. To the extent interns are entitled to be considered as part of the County's Reasonable Accommodation process, the Chief Operating Officer will forward the requested exception to EOD. The Chief Operating Officer's consideration will include but not

be limited to the sponsoring department's need and whether the contractor, intern, or volunteer meets the standard for an exception under Section C-1.

CONCLUSION

Your timely attention to ensure compliance with these requirements is essential to the County's efforts to control the spread of COVID-19 and to comply with public health recommendations. Employees, contractors, interns, and volunteers may direct any questions to their department head or designee(s). If a department has any questions or concerns about these requirements, it may contact Chief Operating Officer Miguel Márquez.

EXHIBIT 38

Courier Times

NEWS

Bucks County orders jail staff to get COVID vaccine or be terminated

Jo Ciavaglia Bucks County Courier Times
Published 10:00 p.m. ET Aug. 24, 2021

Bucks County Corrections Department employees will be required to show proof they are vaccinated against COVID-19 under a new directive following a recent outbreak of the highly contagious virus at the jail.

The county has set an Oct. 1 deadline for employees to be fully vaccinated or obtain a medical or religious exemption, Bucks County spokesman James O'Malley confirmed.

Employees are required to have at least one dose of the vaccine or submit a request for exemption by Aug. 27, O'Malley said. Those who do not will be released from county employment.

So far, at least one other Pennsylvania county has adopted a similar policy for corrections staff.

Earlier this month, Allegheny County announced it will require all new corrections hires be vaccinated against COVID-19. Existing employees who are unvaccinated will be tested weekly for the coronavirus.

Pennsylvania state prison staff also are among the public employees who will be required to follow the Wolf administration's "vaccine or test rule."

COVID in jail: Bucks County mulling mandatory COVID vaccines for corrections staff as cases among inmates skyrocket

Wolf orders: Without a vaccine, some Pennsylvania workers will face regular testing for COVID-19

The Bucks County commissioners decided to mandate the vaccine earlier this month, and corrections staff were advised of the requirement on Aug. 17, O'Malley said.

Earlier this year, the county made COVID-19 vaccines mandatory for employees of Neshaminy Manor, its county-run nursing home.

O'Malley did not have data on the number of corrections staff who have been vaccinated. The department has 254 employees and 66 vacancies in security, support and treatment staff, he said.

As of July, Bucks County reported that at least 200 corrections employees were fully vaccinated, but the county did not require staff to disclose vaccine status.

Neighboring Montgomery County had no plans to mandate vaccines for its corrections staff as of earlier this month. Employees are not required to share their vaccine status, so it's unknown how many have received the shot.

As of last month, at least 256 Montgomery County corrections employees reported they were fully vaccinated, according to the county. Montgomery County requires weekly COVID testing for unvaccinated corrections staff.

The vaccine mandate in Bucks County follows the highest outbreak of COVID in eight months at the Doylestown jail, when 37 female and 10 male inmates tested positive for COVID-19 as of Aug. 10.

As of Tuesday, there are four active COVID cases among inmates and two active cases among staff, O'Malley said.

Virtual court: COVID outbreak at Bucks jail leads to return to virtual court for inmates

At least 400 individuals incarcerated in Bucks County jail and 125 corrections employees have tested positive for COVID-19 since April 2020, according to the latest county data.

A recent surge in new COVID cases in Pennsylvania has brought renewed attention to vaccine mandates for corrections staff, who may pose a risk for bringing the virus into jails where inmate vaccination rates are typically low.

In the Pennsylvania state prison system, where 88% of incarcerated people have been vaccinated — a rate far higher than in county jails — 25 inmates tested positive last week, according to the Pennsylvania Prison Society, a Philadelphia organization that advocates for humane treatment of incarcerated individuals.

The infection rate is higher among state prison staff, with less than 1 in 4 reporting they are vaccinated, according to the group.

Brit Montoro, a community activist with Lower Bucks 4 Change, was pleased to hear about the vaccine mandate for corrections staff, but added the county should also perform routine COVID testing.

“Bucks County Correctional has not implemented a policy of routine COVID-19 testing of the guards despite prisons being environments of the highest risk of transmission and has ignored concerned citizens of Bucks County related to this issue,” Montoro said.

Mask up: Face masks making a return in some Bucks County buildings. What you need to know

EXHIBIT 39

News

King County Executive
Dow Constantine

King County, State of Washington and City of Seattle announce vaccination requirement for most employees, private health care and long-term care workers

August 9, 2021

Summary

King County, in coordination with the State of Washington and the City of Seattle, announced that 13,500 executive branch employees will be required to be vaccinated by mid-October.

Story

King County Executive Dow Constantine announced King County will now require all employees to be fully vaccinated, effective Oct. 18, 2021. To meet this requirement, employees must have received their second shot of a Pfizer or Moderna vaccine, or first shot of a Johnson & Johnson vaccine, by Oct.4, 2021, and provide verified proof of vaccination. The requirement will apply to employees in the Executive branch, including the Assessor, Elections, and Sheriff's Office.

"A healthy King County depends on every eligible resident getting vaccinated. With the Delta variant surging, it is high time for everyone to do their part to protect one another, our children, and our economy," said Executive Constantine. "Joining with the state and the City of Seattle, we're helping close the vaccination gaps in our community and our workforce, to get everyone across the finish line and move our community forward into recovery."

Below is the release issued by the Governor's Office:

Gov. Jay Inslee today announced a requirement for most state workers, and on-site contractors and volunteers to be vaccinated against COVID-19 as a condition of employment. State employees and workers in private health care and long-term care settings will have until October 18 to be fully vaccinated.

The requirement applies to state workers, regardless of teleworking status. This applies to executive cabinet agencies, but the governor encouraged all others such as higher education, local governments, the legislative branch, other statewide elected officials and organizations in the private sector to do the same.

"It is the mission of public servants and those providing health care to serve our fellow Washingtonians. These workers live in every community in our state, working together and with the public every day to deliver services," Inslee said. "We have a duty to protect them from the virus, they have the right to be protected, and the communities they serve and live in deserve protection as well."

The governor made the announcement at a press conference on Monday at Kaiser Permanente in Seattle. He was joined by Seattle Mayor Jenny Durkan, King County Executive Dow Constantine, Kaiser Permanente Washington President Susan Mullaney, Washington State Secretary of Health Dr. Umair Shah, and Seattle-King County Public Health Officer Dr. Jeffrey Duchin.

"State employees, health care and long-term care workers are extremely pivotal in the fight against COVID-19, and we hope these steps will further our goal of getting as many people vaccinated," Secretary of Health Dr. Umair A. Shah, MD, MPH, said. "We should all be concerned with the increases of COVID-19 cases in our state and we know that vaccines are our best tool to end this pandemic."

The announcement comes as Washington is experiencing a severe increase in COVID cases and hospitalizations in every county, due to the Delta variant, with the overwhelming majority of cases and hospitalizations being among unvaccinated Washingtonians.

Prior to the governor's announcement, Kaiser Permanente WA mandated that it would be requiring all its employees to be vaccinated. "The growing threat of the Delta variant has put our unvaccinated communities in a serious and precarious situation. We have at our disposal the key to ending this deadly surge and even the pandemic — vaccines," said Susan Mullaney, president of Kaiser Permanente Washington. "As the largest integrated health care provider in the state of Washington, Kaiser Permanente has taken the important step of requiring that all employees and physicians be fully vaccinated. We look forward to working with the governor, the state, labor partners and our fellow health care systems to protect our state."

King County leads the state in vaccinations, with approximately 81.5% of eligible residents 12 years of age and older having initiated their vaccination series, 12% higher than the statewide average as of August 2.

"No patient should have to worry about getting COVID-19 from their health care provider, period," said Jeff Duchin, King County Public Health officer. "Requiring COVID-19 vaccination for health care personnel protects not only patients and health care workers, but also their families and our community — including those who cannot be vaccinated or do not respond to the vaccine due to being immunocompromised. I thank Governor Inslee for taking this important action as the threat of COVID-19 is increasing locally and nationally."

This new requirement includes well-defined exemptions to the vaccine. Individuals with legitimate medical reasons or sincerely held religious reasons will be exempt. The exemptions do not include personal or philosophical objections.

To keep staff, families and communities safe, there will be no test-out option for employees. Past opt-out testing policies in congregate facilities for unvaccinated staff have not been efficient at preventing outbreaks that impact employees, clients and families, resulting in the loss of life of dedicated staff. Providing a test-out option would be both a financial burden for staff and taxpayers and ineffective at protecting the lives of Washingtonians.

Employees who refuse to be vaccinated will be subject to dismissal from employment for failing to meet legal job qualifications. The state will work with labor organizations on meeting collective bargaining obligations and adhering to civil service rules.

The City of Seattle and King County also announced a COVID-19 vaccination requirement for their employees.

"From the initial days of the COVID-19 pandemic to today, Governor Inslee, Executive Constantine and I believe in the importance of speaking as one government. So many small businesses have stepped up to require vaccines and as some of Washington's largest employers, we are too. The spread of the Delta variant has required that we continue to make decisions that are safe for our employees, their families and our community. There is no doubt that vaccines work, and that they are our best defense against the highly contagious Delta variant," said Mayor Jenny Durkan.

"Seattle has led the way by listening to our public health officials- it's why we have the lowest cases, hospitalizations and deaths of every major city. It is crucial that in our workplaces where we work, eat, have meetings, and laugh together, we make sure we are doing what we can to keep ourselves and our colleagues, our children and families, customers, and members of the public safe from serious illness, hospitalization, or death from this virus."

"A healthy King County depends on every eligible resident getting vaccinated. With the Delta variant surging, it is high time for everyone to do their part to protect one another, our children and our economy," said Dow Constantine, King County executive. "Joining with the state and the City of Seattle, we're helping close the vaccination gaps in our community and our workforce, to get everyone across the finish line and move our community forward into recovery."

"Getting vaccinated against COVID is a public good. We have come so close to defeating this deadly disease," Inslee said. "We have the tool — the vaccine — to get this era behind us. It is safe, it is effective, and you will never regret getting it."

Quotes

> A healthy King County depends on every eligible resident getting vaccinated. With the Delta variant surging, it is high time for everyone to do their part to protect one another, our children, and our economy. Joining with the state and the City of Seattle, we're helping close the vaccination gaps in our community and our workforce, to get everyone across the finish line and move our community forward into recovery.
>
> *Dow Constantine, King County Executive*

> It is the mission of public servants and those providing health care to serve our fellow Washingtonians. These workers live in every community in our state, working together and with the public every day to deliver services. We have a duty to protect them from the virus, they have the right to be protected, and the communities they serve and live in deserve protection as well. Getting vaccinated against COVID is a public good. We have come so close to defeating this deadly disease. We have the tool — the vaccine — to get this era behind us. It is safe, it is effective, and you will never regret getting it.
>
> Jay Inslee, Washington State Governor

> State employees, health care and long-term care workers are extremely pivotal in the fight against COVID-19, and we hope these steps will further our goal of getting as many people vaccinated. We should all be concerned with the increases of COVID-19 cases in our state and we know that vaccines are our best tool to end this pandemic.
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> *Dr Umair A. Shah, MD,MPH, Secretary of Health*

> The growing threat of the Delta variant has put our unvaccinated communities in a serious and precarious situation. We have at our disposal the key to ending this deadly surge and even the pandemic — vaccines. As the largest integrated health care provider in the state of Washington, Kaiser Permanente has taken the important step of requiring that all employees and physicians be fully vaccinated. We look forward to working with the governor, the state, labor partners and our fellow health care systems to protect our state.
>
> Susan Mullaney, President of Kaiser Permanente Washington

> No patient should have to worry about getting COVID-19 from their health care provider, period. Requiring COVID-19 vaccination for health care personnel protects not only patients and health care workers, but also their families and our community — including those who cannot be vaccinated or do not respond to the vaccine due to being immunocompromised. I thank Governor Inslee for taking this important action as the threat of COVID-19 is increasing locally and nationally.
>
> *Jeff Duchin, MD, King County Public Health Officer*

From the initial days of the COVID-19 pandemic to today, Governor Inslee, Executive Constantine and I believe in the importance of speaking as one government. So many small businesses have stepped up to require vaccines and as some of Washington's largest employers, we are too. The spread of the Delta variant has required that we continue to make decisions that are safe for our employees, their families and our community. There is no doubt that vaccines work, and that they are our best defense against the highly contagious Delta variant. Seattle has led the way by listening to our public health officials- it's why we have the lowest cases, hospitalizations and deaths of every major city. It is crucial that in our workplaces where we work, eat, have meetings, and laugh together, we make sure we are doing what we can to keep ourselves and our colleagues, our children and families, customers, and members of the public safe from serious illness, hospitalization, or death from this virus.

Jenny Durkan, City of Seattle Mayor

FOR MORE INFORMATION, CONTACT:

Chase Gallagher, Executive Office, 206-263-8537

EXHIBIT 40

Novant, Atrium, health departments requiring all employees to get COVID-19 vaccine

August 30, 2021 at 10:08 am EDT

By WSOCTV.com News Staff

CHARLOTTE — Atrium Health and Novant Health have announced that they will require all employees to get the COVID-19 vaccine by this fall.

Last December, Atrium employees became the first in our area to roll up their sleeves and get their vaccinations. The hospital system strongly encouraged but didn't require employees to get vaccinated.

Now, with vaccinations decreasing, and infections and hospitalization back on the rise, Atrium is reversing their own policy.

[ALSO READ: How do you know if you have the delta variant; what are the symptoms?]

Atrium said everyone must be fully vaccinated by Oct. 31. The health care provider has 70,000 employees across 37 hospitals and more than 1,350 care locations.

"We view it as essential that each of our teammates receive their vaccination to protect themselves, their families and the people in their care," an Atrium spokesperson told Eyewitness News.

Channel 9 was in one of Novant's care units several months ago while COVID-19 hospitalizations were down, but with the numbers going back up, it's also requiring employees to get vaccinated.

Novant initially said everyone will need to be fully vaccinated with both doses of either Moderna or Pfizer by Oct. 15. Team members electing to receive the Johnson & Johnson (Janssen) vaccine must still receive the vaccine by Sept. 15.

"Roughly 67% of our team members have received at least one dose of vaccine," a spokesperson with Novant Health said in a statement late Monday afternoon. "Like systems across the country, we are seeing lower acceptance rates among our black and brown team members, as well as those who identify as Gen Z or Millennials. We are seeing a higher acceptance rate among those with higher-level clinical roles. Our physicians, for example, have accepted the vaccine at a higher rate (95%) than the overall team member vaccination rate."

[ALSO READ: COVID-19 cases, hospitalizations back on the rise in Meck County]

On Tuesday, NCDHHS announced it will require that all employees, volunteers, students, trainees, as well as contracted and temporary workers working at state-operated facilities, be fully vaccinated or receive an approved medical or religious exemption by Sept. 30.

On Monday, Mecklenburg County Public Health announced that employees will be required to receive the vaccine starting Aug. 2 and must show proof of vaccination by Sept. 7.

"As public health staff, we have led the COVID-19 response efforts for the county and know too well the very high level of sickness, death, and impact the pandemic has had in our community," said Public Health Director Gibbie Harris. "Despite significant prevention efforts, COVID-19 continues to spread in our community, including new highly contagious variants."

Harris told Channel 9 that employees have not been required to report if they are vaccinated and that there will be exemptions allowed -- as there are with other required vaccines, including flu. Those exemptions include medical and religious, consistent with state and federal requirements. Harris said if a staff person refuses to be vaccinated, there will be disciplinary action and they will be required to wear a mask 100% of the time while conducting county business and while in county buildings.

"As a provider of healthcare services, the Health Department requires a number of vaccines to protect the people that we serve. COVID-19 has been added to that list of required vaccines," Harris said. "Our efforts to vaccinate our community to prevent the spread of COVID continues."

WTVD reported that several other health care providers in the state, including UNC Health and Duke Health, have set deadlines for their employees to be vaccinated for COVID-19. Both providers said everyone must be fully vaccinated by Sept. 12.

On Thursday, the North Carolina Healthcare Association made it clear it's part of a statewide push. It said it approves the mandate for health care workers in the following statement:

"North Carolina's hospitals and health systems exist to improve and protect the health of our communities, which is why they place patient, visitor and team member health and safety at the heart of the care they provide. In keeping with that goal, the North Carolina Healthcare Association strongly supports hospital and health system policies that require all hospital employees and clinical team members to be vaccinated against COVID-19. NCHA recognizes that each hospital and health system is unique and encourages each to determine the appropriate time to implement a requirement. All hospitals should continue to require other infection control measures per Centers for Disease Control and Prevention guidance, such as wearing masks and other personal protective gear.

Our state's health systems and hospitals have seen first-hand how debilitating and deadly this disease can be. When the COVID-19 vaccines were first released, the NCHA and its members strongly encouraged all North Carolinians, including hospital and health system employees, to get vaccinated against COVID-19. In the months since, clinical data has shown the COVID-19 vaccines to be extraordinarily safe and effective, and our best tool to prevent the spread of the disease.

The evidence is clear – vaccination against COVID-19 has prevented people from becoming seriously ill, requiring hospitalization, or dying from the virus, as well as spreading it to others. To date, more than 4.7 million North Carolinians and more than 161 million Americans have been vaccinated with minimal side effects. Most concerning, however, is the North Carolina Department of Health and Human Services reporting that nearly 99% of COVID-19 cases, hospitalizations and deaths during May and June were among people not fully vaccinated. In addition, the Centers for Disease Control and Prevention has reported a sharp rise in new coronavirus cases as the delta variant becomes increasingly pervasive.

Protecting patients, visitors and healthcare personnel from COVID-19 continues to be of paramount importance. Hospital and health system employee vaccination against COVID-19 is vital to safely care for patients by protecting them from infection, and to mitigate the spread of the virus within healthcare facilities and among clinicians, patients and their families and friends."

Statement from Novant Health on mandatory COVID-19 vaccinations for employees:

"Since the COVID-19 vaccine first arrived at Novant Health, we have been working diligently to overcome vaccine hesitancy among our team members. These efforts include holding weekly forums to address individual concerns and common misconceptions, making the vaccine convenient and accessible, and providing continuous updates on the vaccine's safety and efficacy.

We appreciate and acknowledge the tens of thousands of team members who eagerly received the vaccine. Unfortunately, the reality is that vaccination rates remain stagnant across the country, including at Novant Health.

We agree with the North Carolina Healthcare Association, the Infectious Diseases Society of America, and many other health care systems in the region that a mandatory vaccine program is in the best interest of public health. Simply put, it is essential to ensure the safety of our patients, team members and communities. Therefore, we are requiring that all Novant Health team members be fully vaccinated by Sept. 15, 2021.

We understand that some team members were awaiting full FDA approval, which Pfizer's COVID-19 vaccine received on Aug. 23rd. Additionally, the review process for exemption requests is still underway as we are giving each request thoughtful and careful consideration. As a result, Novant Health is extending the timeframe to complete the vaccination process. Team members now have until Sept. 15 to receive the first dose of Pfizer or Moderna, and they will have until Oct. 15 to receive the second dose. Team members electing to receive the Johnson & Johnson (Janssen) vaccine must still receive the vaccine by Sept. 15.

While our hope is for every team member to accept the vaccine on their own, a mandatory vaccination program will ensure that Novant Health's patients and visitors, as well as our team members, have better protection against COVID-19 regardless of where they are in our health system. This disease is preventable thanks to a safe and effective vaccine, and we are committed to doing everything we can to bring an end to this pandemic."

Statement from Atrium Health on the vaccine policy change:

"Since the beginning of the pandemic, Atrium Health has earned the trust of our patients and the communities we are privileged to serve for our COVID-Safe practices, designed to maximize patient safety and limit their potential exposure to the virus. With the new Delta variant being far more potent than the original virus, we view it as essential that each of our teammates receive their vaccination to protect themselves, their families and the people in their care.

These new variants are contributing to a 200% increase in hospitalizations – and, among our patients, 99% of those hospitalized in recent weeks have been those who are unvaccinated. This further illustrates the effectiveness of the vaccine.

We have started communicating to al of our teammates (including remote workers, physicians, medical residents, faculty, fellows, trainees, contractors, students/visiting students, members of the medical staff, temporary workers and volunteer staff) that they must be fully vaccinated or have an approved medical or religious exemption. By making the vaccine mandatory for our teammates, Atrium Health, including Wake Forest Baptist Health and Atrium Health Navicent, and along with multiple other health systems across the region, are taking reasonable steps to make sure that our teammates – many of whom remain on the frontlines, interacting directly with people who have COVID – are protected and available to care for members of the community as we deal with the next phases of the pandemic.

We view this vaccine no differently than our requirement for our teammates to get an annual flu shot, as well as be vaccinated for measles, chicken pox and other infectious diseases. The COVID-19 vaccine is essential to protect the health of our teammates and the communities we serve. We believe it is vital that we maintain the

safest possible care environment for our patients and this is a critical component of our ability to remain COVID-Safe in the face of new variants impacting our region.

As to your question on masking, even though many people in the communities we serve have chosen to forego masks in their day-to-day walk of life, we're continuing to emphasize the importance of wearing them inside our facilities and require them in all common areas in order to better protect our teammates, patients and visitors."

(Watch Below: Novant, Atrium doctors say masks for kids heading back to school make sense)

EXHIBIT 41

Jul 20, 2021 01:30 PM MST

Banner Health expands its COVID-19 employee vaccination program

To protect Banner patients and one another, employees will be required to be vaccinated by November 1

PHOENIX (July 20, 2021) – To protect patients, team members and the community, today Banner Health notified its employees that being vaccinated for COVID-19 will be a condition of employment. With limited exceptions, all team members have until November 1 to be fully vaccinated.

"We care for some of the most vulnerable people in our communities and we owe it to them to take every measure possible to ensure the safest care environment," said Peter Fine, president and CEO for Banner Health, in a company-wide email on July 20. "… we are taking this step to reduce risk for our patients, their families, visitors and each other. Safety is an absolute top priority and the COVID vaccine mandate reflects that commitment. The vaccine data has fully supported the safety and efficacy to prevent disease and reduce its severity. There is overwhelming evidence for us to act on behalf of the communities that rely on us to care for and protect them."

Banner Health is implementing this requirement for several reasons, including the rise of the Delta variant, the pending lift of the Emergency Use Authorization by the Food and Drug Administration, the need to protect its patients and workforce, and to prepare for the flu season. In addition, national data shows that 97 percent of hospitalizations and 99 percent of COVID-19 deaths are in the unvaccinated.

More details about the program, including an exemption request process, will be shared with team members in the coming weeks.

In July, Banner launched an incentive program for employees who are fully vaccinated against COVID-19. Drawings will take place in July and August, with 10 winners total. Team members who are fully vaccinated at the time of the drawings will qualify. The winners will receive $10,000 each. Banner has also provided its employees with pay for time away to get vaccinated, mileage reimbursement and points toward its wellness program that offers discounts on health insurance.

Banner Health employs roughly 52,000 team members and is the largest private employer in the state of Arizona.

Headquartered in Arizona, Banner Health is one of the largest, secular nonprofit health care systems in the country. The system owns and operates 30 acute-care hospitals, Banner Health Network, Banner – University Medicine, academic and employed physician groups, long-term care centers, outpatient surgery centers and an array of other services; including Banner Urgent Care, family clinics, home care and hospice services, pharmacies and a nursing registry. Banner Health is in six states: Arizona, California, Colorado, Nebraska, Nevada and Wyoming. For more information, visit www.BannerHealth.com.

Banner Health | COVID-19 Awareness

For further information contact us at: media@bannerhealth.com

EXHIBIT 42

HOUSTON Methodist LEADING MEDICINE

POLICY System_HR95 MANDATORY COVID-19 VACCINE PROCEDURE - PHASED IMPLEMENTATION

Effective Date: 08/09/2021	**Origination Date:** 04/01/2021
Reference Number: 24783	**Date Revised/Reviewed:** 08/09/2021
Version: 6	**Target Review Date:** 08/09/2024

Originating Area:
Human Resources

Applies To:
Houston Methodist Hospital, The Medical Center
Houston Methodist Baytown
Houston Methodist Clear Lake
Houston Methodist Continuing Care Hospital
Houston Methodist Sugar Land
Houston Methodist The Woodlands
Houston Methodist West
Houston Methodist Willowbrook
Houston Methodist Research Institute
Houston Methodist Corporate Division
Houston Methodist Global Health Care Services
Houston Methodist Institute for Academic Medicine
Houston Methodist Specialty Physician Group
Houston Methodist Primary Care Group
Houston Methodist Coordinated Care Organization

I. POLICY STATEMENT

To create a safe environment, free of infection/transmission of disease and to protect our patients, employees, and the community from Sars-Cov-2 (COVID-19) infection, Houston Methodist is requiring mandatory immunization of all covered Houston Methodist (HM) employees.

II. PROCEDURES

A. The implementation of this policy will be conducted in phases.

HM Phase 1 employees are defined as all HM management.

HM Phase 2 employees are defined as all HM employees not covered in Phase 1.

HM Phase 2 medical staff is defined as all physicians and allied health professionals who are credentialed to be on one or more HM medical staff/allied health professional staff.

HM Phase 3 contractors, students and rotating learners are defined as all agency contractors, contracted services employees, students and rotating learners.

In the event this policy is extended beyond the phases identified above, it will be updated accordingly as additional phases are defined and implemented.

B. COVID-19 vaccine will be available free of charge to all HM employees. The vaccination program will be coordinated through each HM entity's Employee Health department. Employees also have the option of vaccination elsewhere from a third-party provider of their choice.

C. Proof of vaccination by a third party must include record of vaccine, the date of vaccine administration, lot number (should the lot be recalled), the location where the vaccine was administered.

D. In addition to the vaccination requirement, all HM employees are expected to comply with all other safety requirements defined for COVID-19 as indicated by HM management based on CDC and other applicable regulatory agencies that govern public health and/or patient safety.

E. Phase 1 Employees:

1. Subject to the exemptions defined in this policy, all HM Phase 1 employees who have not begun the vaccination process will be required:

   a) To get any approved one-dose vaccine (e.g., J&J) or provide proof of vaccination by a third-party provider to Employee Health **on or before April 15, 2021**,

   b) Get the first shot of any approved two-dose vaccine (e.g., Pfizer, Moderna) and schedule an appointment for a second dose, or proof of vaccination and date of second vaccine appointment from a third-party provider **on or before April 15, 2021**, or

   c) Apply for and submit all required documentation for an exemption based on a medical condition (including pregnancy deferment) or sincerely held religious belief **on or before April 7, 2021**, in accordance with the procedure described in this policy.

   If proof of vaccination is not provided, or if an exemption is not filed by the stated deadline, you will be assumed to have not completed the vaccine requirement on time.

2. HM Phase 1 employees who received only the first of the two-dose vaccine as of April 1, 2021, and whose second doses are scheduled after April 15, 2021, are required to provide the date of their second dose appointment to Employee Health by April 15, 2021.

   If their second dose is scheduled on or before April 15, 2021, they are required to provide proof of vaccination from a third-party provider, or present proof of vaccination by a third-party provider to Employee Health **on or before April 15, 2021**.

   If proof is not provided, you will be assumed to have not timely completed the vaccine requirement.

3. For all HM Phase 1 employees receiving a two-dose vaccine including those who received only a first dose when this policy was announced, proof of the second vaccination must be submitted to employee health within **two (2) days** after the second dose has been received.

   If exceptional circumstances exist, and an employee is unable to receive the second dose at the appointed time, please contact Employee Health within **two (2) days** of the scheduled appointment.

   If proof of vaccination or rescheduling due to exceptional circumstances is not provided by the stated deadlines, you will be assumed to have not completed the vaccine regimen on time.

4. Any HM Phase 1 employee (i) who is not vaccinated with a first or second dose of the two-dose COVID-19 vaccine by **April 15, 2021**, or (ii) does not have an approved exemption as provided in this policy by **April 15, 2021** will be placed on a two-week, unpaid suspension.

   If the vaccine regimen (including a second dose) is not completed before the expiration of the suspension period on **April 29, 2021**, HM will immediately initiate the employment termination process as described in this policy.

5. Any HM Phase 1 employee who does not get a second dose at the appointed time will, absent exceptional circumstances, be placed on an immediate two-week, unpaid suspension.

   If the second dose is not administered before the expiration of the suspension period, HM will immediately initiate the employment termination process as described in this policy.

F. Phase 2 Employees:

1. Subject to the exemptions defined in this policy, all HM Phase 2 employees who have not begun the vaccination process will be required:

   a) To get any approved one-dose vaccine (e.g., J&J) or provide proof of vaccination by a third-party provider to Employee Health **on or before June 7, 2021**,

   b) To receive both doses of any approved two-dose vaccine (e.g., Pfizer, Moderna) through HM, or provide proof of vaccination from a third-party provider **on or before June 7, 2021**. Since scheduling second vaccinations varies on the manufacturer guidelines and availability of appointments with providers, employees are highly encouraged to receive their first vaccination of a 2-dose vaccine no later than May 7, 2021 to ensure compliance with complete vaccination by June 7, 2021.

c) Apply for and submit all required documentation for an exemption based on a medical condition (including *pregnancy* deferment) or sincerely held religious belief **on or before May 3, 2021**, in accordance with the procedure described in this policy.

Employees whose exemptions are denied after May 3, 2021 must follow the following protocol:

(1) Get any approved one-dose vaccine (e.g., J&J) or provide proof of vaccination by a third-party provider to Employee Health on or before June 7, 2021, or

(2) Schedule the first appointment for a two-dose vaccine to be completed within one week of the exemption denial date. If received through a third-party provider, proof of the first vaccination **and** the date of the second dose appointment must be submitted to Employee Health within **(2) days** of the scheduled appointment or by June 1, whichever comes later.

If the second dose is received from a third-party, proof of completion of the second dose through must be submitted to Employee Health within (2) days of the scheduled appointment or by June 7, whichever comes later.

If proof of vaccination or scheduled vaccination dates are not provided by the stated deadlines above, you will be assumed to have not completed the vaccine requirement on time.

2. Any HM Phase 2 employee who does not meet the vaccine program requirements as outlined in section F.1 will be placed on a two-week, unpaid suspension starting June 8, 2021 (or later as applicable for employees identified in section F.1.c above).

If the vaccine program requirements are not completed before the expiration of the suspension period on **June 21, 2021 or as otherwise stated for those receiving vaccinations after exemption denials**, HM will immediately initiate the employment termination process as described in this policy.

G. HM Phase 2 Medical Staff. As approved by the Medical Executive Committees of the medical staffs of each HM hospital, the following provisions apply to all HM Phase 2 medical staff:

1. Subject to the exemptions defined in this policy, all HM Phase 2 medical staff will be required to provide an attestation to the applicable HM medical staff services office by June 7, 2021 attesting that they have had either both doses of a two-dose vaccine (e.g., Pfizer or Moderna) or one dose of a single dose vaccine (e.g., J&J).

2. Alternatively, a HM Phase 2 medical staff member may apply for and submit all required documentation for an exemption based on a medical condition (including deferment) or sincerely held religious belief in accordance with the procedure described in this policy.

3. Exemption from vaccination may be granted for medical contraindications (including pregnancy if properly supported by medical documentation) and sincerely held religious beliefs. Exemption requests should be submitted to the applicable medical staff services office.

4. If a requested exemption or deferment is denied, and the HM Phase 2 medical staff member does not provide the required attestation by June 7, 2021, that individual will be automatically suspended in accordance with the applicable HM medical staff or allied health practitioner bylaws.

H. HM Phase 3 contractors, students and rotating learners.

1. Effective July 1, 2021, it is the policy of Houston Methodist that all agency contractors, vendors, students and rotating learners who come on Houston Methodist premises must be vaccinated for COVID-19 in accordance with the requirements and deadlines of this section of the implementation procedure.

   Contractors and learners with remote assignments are not required to be vaccinated. Any contractors or learners who come on site to Houston Methodist must be vaccinated. Individuals who are not vaccinated may participate virtually.

2. Agency contractors, students and learners already performing work, training, or studies on Houston Methodist premises prior to July 1, 2021 must be fully vaccinated with both doses of an approved 2 dose vaccine or 1 dose of a 1-dose vaccine (e.g. J&J) by **July 1, 2021**.

3. New contractors, students and rotating learners starting on or after July 1, 2021 must be vaccinated as follows:

   a. If the duration of the contract or learning opportunity is 4 weeks or longer, they can begin the vaccination process on or before their start date but must be fully vaccinated within 4 weeks.

   b. If the duration of the contract or learning opportunity is less than 4 weeks, the individual must be fully vaccinated before their start date.

4. For contractors, students and rotating learners who refuse vaccination:

   a. If the contract or learning assignment expires/ends on or before July 1, 2021, the contract/assignment should not be renewed.

   b. If the contract or learning assignment expires/ends after July 1, 2021, Houston Methodist will provide notice of intent to terminate the assignment in accordance with the contract/learning agreement on or before July 1, 2021.

   c. An exception may be considered based on contractual terms or other business needs. If an exception can be accommodated, the unvaccinated contractor, student, or learner must follow the same enhanced safety protocols as Houston Methodist employees and physicians or be subject to removal from the premises and refused authorization to return. However, simply agreeing to follow enhanced safety protocols is not grounds for granting an exception.

5. Religious and medical exemptions requested by contractors, students and rotating learners.

   a. Because Houston Methodist is not the contractor's employer, nor the degree-granting institution of students and rotating learners, Houston Methodist is not the appropriate party to evaluate requests for religious or medical exemptions.

   b. In the event a contracting agency believes they must provide a medical or religious exemption to their employee, they must partner with the HR Director or Manager that supports the physical location where the contractor/student/learner performs their responsibilities. The HR Director or Manager will partner with the leadership teams over the departments where they contractor works and infection control to evaluate whether an exemption can be accommodated without posing a direct safety threat to Houston Methodist employees or patients.

   c. In the event an educational institution believes they must provide a medical or religious exemption to their employee, they must partner with the Institute of Academic Medicine who will review the student or learner's program and consult with Infection Control to determine if the exemption can be accommodated without posting a direct safety threat to Houston Methodist employees or patients.

   d. If an exemption can be accommodated, the unvaccinated contractor, student, or learner must follow the same enhanced safety protocols as Houston Methodist employees and physicians or be subject to removal from the premises and refused authorization to return. However, simply agreeing to follow enhanced safety protocols is not grounds for granting an exemption.

6. Documentation of Compliance.
   a. All contract agencies and educational institutions for students and learners must ensure these individuals are vaccinated according to the criteria above.
   b. All contract agencies and educational institutions for students and learners must obtain proof of vaccination status and agree to provide it to Houston Methodist upon request.
   c. Houston Methodist will not collect proof of vaccination from contractors, students or learners.
   d. Houston Methodist will create an audit process to monitor agency compliance. Non-cooperation with the audit process may result in immediate termination of the contract or learning opportunity for the individuals assigned to Houston Methodist.

I. Exemption Process and Protocols for HM Employees:

1. Exemption from vaccination may be granted for medical contraindications (including pregnancy if properly supported by medical documentation) and sincerely held religious beliefs. Employees are required to submit a ***Request for Medical Exemption from COVID-19 Vaccination*** **or** ***Request for Religious Exemption from COVID-19*** **to Employee Health via the Enterprise Portal/MARS Employee Self-Service portal,** and any additional required certification that verifies the reason for the requested exemption.

2. Employees will be notified within seven (7) days of submission of their application if it is approved or denied, and, if approved, of any restrictions or requirements they will be required to follow so long as they remain unvaccinated. If additional clarification is needed, employees will be contacted within the same time period and are expected to provide the requested clarification within five (5) days to Employee Health absent exceptional circumstances. No employment action will be taken until the exemption process is complete.

3. Employees who applied for and were denied an exemption for a medical condition or a sincerely held religious belief as part of the HOPE bonus may apply again for an exemption through this process.

4. Approved exemptions will only be valid for the year in which they were requested and/or the period for which the exemption is approved or the reason for the exemption persists. For example, if an exemption request is submitted and approved due to pregnancy, the employee will be required to obtain an extension of the exemption after the employee is no longer pregnant. Currently, exemptions for any or all future years will require completion and submission of a ***Request for Medical/Religious Exemption from COVID-19 Vaccination*** form each year an exemption is requested.

5. Phase 1 Employees:

   a) ***Request for Medical/Religious Exemption from COVID-19 Vaccine*** must be submitted to Employee Health the employee's entity via email no later than **April 7, 2021**.

   b) Employee Health will also collect and document the ***Request for Religious Exemption*** from COVID-19 Vaccination. Exemption requests must be submitted by **April 7, 2021** and will be reviewed in accordance with HM HR policies.

   c) *No employment action will be taken until the exemption process is complete.*

6. Phase 2 Employees: See Section F.

J. Protective Measures for Nonvaccinated Individuals with Medical or Religious Exemptions, Deferments and New Hires who are not yet fully vaccinated

To ensure the safety of patients, employees, visitors, learners, students, contractors and others from the risk of contracting COVID-19 at Houston Methodist, the following measures must be followed by all individuals who have received medical or religious exemptions or deferments to the COVID-19 vaccine requirement, or who are newly hired and not yet fully vaccinated:

1. Nonvaccinated individuals must wear a face mask at all times, except when breaking for lunch or drinking.

2. Nonvaccinated individuals who come in contact with patients and visitors, such as when providing direct patient care to ANY patient, or working in reception, cafeteria, and other public areas that serve patients and visitors, must also wear a face shield when working in these patient-facing areas or in any environment that does not allow for 6 feet of social distancing.

3. Nonvaccinated employees must be tested for COVID-19 at least once every 7 days. Houston Methodist will provide COVID-19 tests for employees. Contractors, students, and learners must be tested for COVID-19 before coming to any Houston Methodist campus for the first time, and must manage a 14 day testing process for their employees and students/learners. Proof of monitored testing will be included in the audit of contract/agreement compliance described in section H above.

4. Houston Methodist has implemented the following mandatory COVID-19 Surveillance Monitoring requirement for employees who are not vaccinated or who have deferments:
    a. Complete a COVID-19 PCR Test as part of the surveillance program within 7 days of hire. The nasopharyngeal and the nasal swab are both acceptable PCR tests.
    b. Re-test once every 7 days until the surveillance monitoring program ends
    c. Employees scheduled to work with a gap of more than 7 days between scheduled workdays will be considered compliant if they are tested on their next scheduled workday after their last test.
    d. Employees who take PTO for a week or more will be considered compliant if they are tested on their first scheduled day back from PTO.
    e. Employees are encouraged to be tested at their designated on-site testing location. Employees who do not have an on-site testing location are encouraged to test at the nearest hospital with an on-site testing capability. On-site testing will speed the update of employee compliance records in Employee Health.
    f. Employees may also be tested at a third-party testing facility such as Walgreens or CVS, but the employee is responsible for ensuring test completion and test results are communicated to employee health within published deadlines to avoid discipline for noncompliance
    g. Employees will receive automated email communications to remind them to schedule their next COVID-19 test, as well as confirmations of completed tests and test results.
    h. Employees should schedule their COVID-19 test via the Enterprise Portal to Employee Health within MARS.

5. Special considerations for individuals returning from Leaves of Absence and ending exemptions or deferments
    a. Employees returning to work from Leaves of Absence and those with expiring deferments have 14 days to get their first dose of vaccine (or second vaccine of a 2-part series if they already received a first vaccine prior to their LOA or deferment). Failure to comply with this requirement within 14 days of their return to work or expiration of deferment will result in termination.
    b. Employees described in **Section II.J.5.a.** above have 35 days from their first dose of a 2-part vaccination (e.g. Pfizer or Moderna) to get their second dose. Failure to comply with this requirement by the deadline will result in termination.

6. Additional Infection Control guidelines regarding rules for social distancing, lunches, lunch meetings, and other interactions with unvaccinated individuals are communicated from senior leadership and are expected to be followed by all individuals covered by this policy including employees, physicians, contractors, students and rotating learners.

K. Employees hired after July 1, 2021 who are not fully vaccinated:

1. Must receive the first dose of a 2-part COVID-19 vaccine or the single-dose vaccine before close of business on the second day of orientation.
2. Must receive the second dose of a 2-part COVID-19 vaccine within 35 days of their start date.
3. Must follow the protective measures and COVID-19 Surveillance Monitoring process described in **Section II.J.** above.
4. May request the exemption process through employee health. If approved for an exemption, these employees will be asked to sign acknowledgement of policy requirements as conditions of employment during the onboarding process.
5. New hires who fail to meet these requirements will be terminated.

L. Consequences for Employee for Failure to Comply

1. Failure of any employee to receive a COVID-19 vaccination or comply with the stated deadlines for completing the Request for Exemption process by the stated deadlines of their assigned vaccine implementation phase will result in the employee being placed on unpaid suspension (PTO may not be used during this time) for up to 14 days so that the employee can come into compliance. Employees who, after July 1, 2021 return from LOA, have an expiring deferment, or are new hires, will not receive the 2-week unpaid suspension described for employees in the phased implementation and will be terminated as outlined earlier in the policy.

2. HM Phase 1 and 2 employees who come into compliance before the end of the applicable 14-day suspension period will be scheduled to return to work as soon as administratively possible based on department scheduling protocols. All employees who have not received both doses of the vaccine or have not met the exemption requirements as of the completion of the applicable 14-day suspension period will be terminated from employment by HM.

3. Failure to comply with protective measure requirements (such as surgical masks and face shields and surveillance testing) for those employees approved for a medical or religious exemption, deferment from vaccination, or hired after July 1, 2021 will result in the following consequences:

   Progressive discipline steps for each incident of noncompliance including:

   a. Communication Record of verbal warning for the first incident
   b. Disciplinary Counseling Record for the second incident
   c. Final Disciplinary Counseling Record for the third incident
   d. Termination for any additional occurrence

To support affected employees with getting used to this new safety protocol, a grace period was in effect between July 1 and July 14 where a first violation during this period was to be addressed through education and reminders of the requirement. Second violations during this time period will result in progressive discipline starting with step (a) above.

Employees who are instructed to follow the protective measures and refuse will be removed from the workplace and are considered insubordinate under HR01. Consequences for insubordination include but are not limited to unpaid suspension and/or termination.

III. MANAGEMENT RESPONSIBLITIES

A. Ensure 100% of covered employees are aware of this policy, the mandatory vaccine requirement, the exemption process, PPE and surveillance monitoring protocols, key deadlines for their specific circumstances, and any applicable educational materials regarding the vaccine, as appropriate.

B. Review periodic reports of each covered employee's status regarding compliance in obtaining COVID-19 vaccination or approved exemption.

C. Ensure non-vaccinated employees are paid for their time spent participating in the mandatory COVID-19 surveillance testing process.

D. Maintain the confidentiality of any medical information or information concerning vaccine status of employees. Such information should be treated as need to know only.

E. Management should refrain from asking employees follow up questions about their vaccine status that may tend to reveal a disability. If an employee indicates that they qualify for an exemption, the employee should be referred to the exemption process without being required to answer any further questions.

F. Ensure all employees, vaccinated or not, are aware of any department specific requirements related to using protective equipment when performing certain job activities within the department or elsewhere within the facility to minimize health risks to patients, self and others.

G. Ensure all employees with an exemption follow any additional required restrictions, safety protocols, or safety requirements related to using protective equipment when performing certain job activities within the department or elsewhere within the facility to minimize health risks to patients, self and others.

H. Ensure all policy and procedural steps are followed as outlined in this policy including communicating and administering the "failure to comply" consequences in a timely and consistent manner.

IV. EMPLOYEE RESPONSIBILITIES

A. Ensure vaccination compliance by the stated deadline for your implementation phase.

B. For those employees with approved exemptions or deferments, comply with all job restrictions, safety protocols, and safety requirements as directed due to non-vaccinated status. Wear appropriate PPE specified for non-vaccinated employees, which include

masks and face shields as directed by infection control, and other PPE for the period of time designated by management and/or infection control. Comply with the COVID-19 Surveillance Monitoring program for nonvaccinated employees.

C. Follow all COVID related reporting and safety protocols, whether you are vaccinated or not.

D. Monitor one's own compliance by ensuring documentation is uploaded by stated deadlines within Enterprise Portal, accessible via MARS, where applicable. Monitor one's emails for reminders and alerts regarding one's exemption or deferment status.

Employees who upload documentation from 3rd party vaccination or COVID testing sites are encouraged to exceed the deadline requirements by 48 hours to avoid delays in the compliance monitoring system caused by manual data entry of their documentation into the employee health enterprise system. Employees who submit required information close to the deadline will likely receive automated notifications indicating non-compliance due to time delays in manual system data entry.

E. Monitor email communications to all employees that are sent from the HR-Hub to ensure understanding of up-to-the-minute changes regarding infection control requirements and surveillance monitoring, where applicable.

V. EMPLOYEE HEALTH RESPONSIBILITIES

A. Provide COVID-19 vaccinations to all employees during the designated timeframe with appropriate consent.

B. Maintain all records of COVID-19 immunizations and exemptions, ensuring timely input of compliance in appropriate management information systems.

C. Review the ***Request for Medical/Religious Exemption from COVID-19 Vaccination document/s*** in a timely manner and coordinate any clarifications as quickly as possible.

D. Review all submitted documents and complete the ***Request for Religious Exemption from COVID*** process in accordance with HM HR policies.

E. Ensure new hires after 7/1/2021 who receive approved exemptions or deferments complete the policy acknowledgement letter.

F. Work with appropriate departments/resources to provide additional health education consultation regarding benefits of vaccination and appropriate provision of protective equipment for non-vaccinated individuals.

G. Ensure that personnel outside of Employee Health who have been designated to administer HM COVID-19 vaccines follow the same protocols including completion of appropriate consent forms by each individual they vaccinate. These designated personnel are responsible for providing directly to a member of Employee Health the consent forms either via fax, email, or hand delivery (rather than through inter-office mail).

VI. HUMAN RESOURCE RESPONSIBILTIES

A. Participate in review of ***Request for Religious Exemption or Deferment from COVID-19 Vaccination*** in a timely manner and coordinate any clarifications as quickly as possible.

B. Monitor compliance reports from Employee Health and ensure suspension and termination (or site removal for non-employees) for non-compliance are followed in accordance with policy.

VII. SIGNATURE OF APPROVING EXECUTIVE: Carole Hackett

TITLE: SVP, CHRO Human Resources

SIGNATURE ON FILE

_____ _____

Signature of Approving Executive Date Signed

Revision History

Revision	Date	Changed by	Revision Summary
0	04/01/2021	Michelle Parker	Original
1	04/09/2021	Michelle Parker	Added Phase II details for all non-management employees.
2	04/25/2021	Michelle Parker	Added Phase II details for medical staff.
3	6/17/2021	Michelle Parker	Added Phase III details for contractors and students/rotating learners. Added Section J Protective Measures as communicated by infection control Modified Section K Consequences so that discipline for failing to wear a mask or face shield follows our traditional progressive discipline process, except for insubordinate behavior which retains the prior disciplinary consequences of earlier policy versions. Added employee responsibilities for clarification.
4	07/28/2021	Michelle Parker	Added Sections II.J.5 for employees returning from LOA, with expiring deferments or ending exemptions; Added Section K for new hires that are not fully vaccinated before their start date. Expanded section II.L.1 to clarify that employees returning from LOA or with deferments expiring after 7/1 will not have the 2 week unpaid suspension period offered during phased implementation and will be terminated if they do not meet compliance deadlines. Expanded Section IV.D. Employee Responsibilities. Added Section V.E.
5	8/9/2021	Michelle Parker	Updated the non-vaccinated employee surveillance process from testing every 14 days to testing every 7 days.

EXHIBIT 43

KAISER PERMANENTE® | About

August 2, 2021

Protecting health and safety through vaccination

Kaiser Permanente requires COVID-19 vaccination for all employees and physicians amid resurging pandemic.

PRESS RELEASE

Contact: Marc Brown
marc.t.brown@kp.org
510-407-2592

OAKLAND, Calif., — Kaiser Permanente, the nation's largest integrated, nonprofit health care organization, announced it will make COVID-19 vaccines mandatory for all its employees and physicians. This is another step in the organization's ongoing effort to protect the health and safety of its workforce, members, patients, and communities.

"As the country's largest integrated care delivery system, we feel it is our responsibility to do everything we can to help bring an end to the pandemic, especially in light of the dramatic increase in COVID-19 cases from the highly infectious delta variant" said Greg A. Adams (https://about.kaiserpermanente.org/who-we-are/leadership-team/national-leaders/greg-a-adams), chair and chief executive officer, Kaiser Foundation Hospitals and Health Plan, Inc. "Large groups of unvaccinated people are fueling the current increase in cases and 97% to 99% of COVID-19 hospital admissions are unvaccinated patients. Making vaccination mandatory is the most effective way we can protect our people, our patients, and the communities we serve. We encourage all health systems and business and industry leaders across the country to play a role in ending the pandemic by doing the same."

As of July 31, 77.8% of Kaiser Permanente employees and more than 95% of Permanente Medical Group physicians have been fully vaccinated, and Kaiser Permanente has set a target date of September 30, 2021, to achieve a fully vaccinated workforce. Unvaccinated employees and physicians will be required to become fully vaccinated for COVID-19 or apply for medical or religious exemption. Employees will be provided additional education on the safety and efficacy of the COVID-19 vaccine and will receive paid administrative time to get vaccinated at Kaiser Permanente's on-site vaccination clinics or at other locations. The organization is working with its labor unions on implementation of the employee vaccination mandate and will also coordinate with local, state, and federal laws.

The Kaiser Permanente organization includes more than 216,000 employees and more than 23,000 Permanente Medical Group physicians.

"For 16 months, we have been doing everything we can to save lives, care for COVID-19 patients, and prevent our communities from contracting this deadly virus," said Ramin Davidoff (https://about.kaiserpermanente.org/who-we-are/permanente-medicine/permanente-medical-groups/ramin-davidoff-md), MD, co-CEO of The Permanente Federation. "The COVID-19 vaccines offer us the path to move beyond the pandemic in the same way vaccination has brought an end to the epidemics of smallpox, polio, measles, and other deadly diseases."

"We must take action to stop this pandemic and get vaccinated. The COVID-19 vaccines are scientifically proven to be safe and effective, dramatically reducing

the risk of death and serious health outcomes if they become infected. With Kaiser Permanente's mandatory vaccination policy, we ensure that we are doing all we can to protect ourselves, each other, and those we serve from this deadly virus," added Richard S. Isaacs (https://about.kaiserpermanente.org/who-we-are/permanente-medicine/permanente-medical-groups/richard-s-isaacs-md-facs), MD, FACS, co-CEO of The Permanente Federation.

As of July 30, Kaiser Permanente has cared for more than 907,418 patients with COVID-19 and has safely administered over 6.8 million vaccine doses with over 68% of Kaiser Permanente members receiving at least one dose.

About Kaiser Permanente

Kaiser Permanente is committed to helping shape the future of health care. We are recognized as one of America's leading health care providers and not-for-profit health plans. Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. We currently serve approximately 12.5 million members in 8 states and the District of Columbia. Care for members and patients is focused on their total health and guided by their personal Permanente Medical Group physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

EXHIBIT 44

AUGUST 16, 2021 | Albany, NY

Governor Cuomo Announces COVID-19 Vaccination Mandate for Healthcare Workers

COVID-19 VACCINE HEALTH PUBLIC SAFETY

Department of Health Issues Section 16 Orders to Hospitals and Long-Term Care Facilities Requiring Policy to Ensure All Employees Are Vaccinated

First Dose Required by September 27

Department of Health Authorizes Third Dose for Immunocompromised New Yorkers

Governor Andrew M. Cuomo announced today that all healthcare workers in New York State, including staff at hospitals and long-term care facilities (LTCF), including nursing homes, adult care, and other congregate care settings, will be required to be vaccinated against COVID-19 by Monday, September 27. The State Department of Health will issue Section 16 Orders requiring all hospital, LTCF, and nursing homes to develop and implement a policy mandating employee vaccinations, with limited exceptions for those with religious or medical reasons. To date, 75% of the state's ~450,000 hospital workers, 74% of the state's ~30,000 adult care facility workers, and 68% of the state's ~145,500 nursing home workers have completed their vaccine series. Lt. Governor Kathy Hochul's administration was briefed prior to the announcement.

"When COVID ambushed New York last year, New Yorkers acted, while the Federal Government denied the problem," **Governor Cuomo said.** "Now, the Delta variant is spreading across the nation and across New York -- new daily positives are up over 1000% over the last six weeks, and over 80 percent of recent positives in New York State are linked to the Delta variant.

We must now act again to stop the spread. Our healthcare heroes led the battle against the virus, and now we need them to lead the battle between the variant and the vaccine. We have always followed the science, and we're doing so again today, with these recommendations by Dr. Zucker and federal and state health experts. But we need to do more. I have strongly urged private businesses to implement vaccinated-only admission policies, and school districts to mandate vaccinations for teachers. Neither will occur without the state legally mandating the actions -- private businesses will not enforce a vaccine mandate unless it's the law, and local school districts will be hesitant to make these challenging decisions without legal direction."

Governor Cuomo also announced that the Department of Health has authorized a third COVID-19 vaccine dose for New Yorkers with compromised immune systems, following the Centers for Disease Control and Prevention's recommendation last week. Eligible New Yorkers can receive their third dose 28 days after the completion of their two-dose vaccine series, effective immediately.

The CDC is currently recommending that moderately to severely immunocompromised people receive an additional dose, including people who have:

- Been receiving active cancer treatment for tumors or cancers of the blood;
- Received an organ transplant and are taking medications to suppress the immune system;
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system;
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome);
- Advanced or untreated HIV infection;
- Active treatment with high-dose corticosteroids, cancer chemotherapy that causes severe immunosuppression, or other medications that may suppress your immune response.

New Yorkers should contact their healthcare provider about whether getting an additional dose is appropriate for them at this time.

New York State Health Commissioner Dr. Howard Zucker said, "While we have made tremendous progress in getting New Yorkers vaccinated, this pandemic is far from over and more must be done. The data and science tell us that getting more people vaccinated as quickly as possible is the best way to keep people safe, prevent further mutations, and enable us to resume our daily routines. This mandate will both help close the vaccination gap and reduce the spread of the Delta variant. I want to thank all New York State's healthcare workers for stepping up once again and showing our state that getting vaccinated is safe, easy, and most importantly, effective."

These steps follow Governor Cuomo's August 2 announcement that MTA and Port Authority employees working in New York facilities will be required to be vaccinated for COVID-19 by Labor Day, and his July 28 announcement that state employees and patient-facing employees in state-run hospitals will be required to get vaccinated for COVID-19 by Labor Day. State employees who choose to remain unvaccinated will be required to undergo weekly COVID testing.

Contact the Governor's Press Office

Contact us by phone:

Albany: (518) 474-8418
New York City: (212) 681-4640

Contact us by email:

Press.Office@exec.ny.gov

EXHIBIT 45

Trinity Health Announces COVID-19 Vaccine Requirement for All Colleagues

The Catholic health system will require its 117,000 employees across 22 states to receive the vaccine.

LIVONIA, MICH., July 8, 2021 - Trinity Health today announced effective immediately, the national health system will require all colleagues, clinical staff, contractors, and those conducting business in its health care facilities be vaccinated against COVID-19. The requirement applies to Trinity Health's more than 117,000 employees in 22 states nationwide in an effort to stop the spread of the virus and keep all patients, colleagues and the broader communities safe.

Since December 2020, when the U.S. Food and Drug Administration approved the first vaccine for Emergency Use Authorization, Trinity Health has strongly encouraged vaccination for all colleagues and within the communities its various Health Ministries serve. To date, the health system estimates nearly 75% of Trinity Health employees have already received at least one dose of the vaccine, and it now looks to close the gap with this new requirement.

"Safety is one of our Core Values. We feel it is important that we take every step available to us to stop the spread and protect those around us-especially the most vulnerable in our communities who cannot be vaccinated including young children and the more than 10 million people who are immunocompromised," said Trinity Health President and CEO Mike Slubowski. "Over the last year, Trinity Health has counted our own colleagues and patients in the too-high coronavirus death toll. Now that we have a proven way to prevent COVID-19 deaths, we are not hesitating to do our part."

The Centers for Disease Control and Prevention (CDC) estimate more than 331 million doses of the COVID-19 vaccine have been administered in the U.S. The vaccines have proven to be safe and effective against symptomatic infections, hospitalizations and death with more than 99% of COVID-19 deaths today occurring in unvaccinated people.

"The science has shown us that the COVID-19 vaccine is the single most effective tool in slowing, and even stopping, the spread of the virus," said Dan Roth, M.D., Trinity Health executive vice president and chief clinical officer. "As a Catholic Health Ministry - even if we work remotely or do not regularly encounter patients - we view ourselves as caregivers, and it's important that we do everything we can to end the pandemic and save lives."

Employees at Trinity Health and its Health Ministries must meet a series of rolling deadlines, with most locations requiring they submit proof of vaccination by Sept. 21, 2021. It has not yet been determined if a COVID-19 vaccine booster will be required annually, but if so, employees will also need to submit proof of the booster as needed. Exemptions are available for religious or health reasons and must be formally requested, documented and approved. Employees who do not meet criteria for exemption and fail to show proof of vaccination will face termination of employment.

About Trinity Health

Trinity Health is one of the largest Catholic health care systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Trinity Health includes 91 hospitals, as well as 113 continuing care locations. Based in Livonia, Michigan, and with annual operating revenues of $19.4 billion, the organization returns $1.3 billion to its communities annually in the form of charity care and other community benefit programs. Trinity Health employs 117,000 colleagues, including 6,800 employed physicians and clinicians. For more information, visit www.trinity-health.org. You can also follow Trinity Health on LinkedIn, Facebook or Twitter.

EXHIBIT 46

VA | U.S. Department of Veterans Affairs

News Release

Office of Public Affairs
Media Relations

Washington, DC 20420
(202) 461-7600
www.va.gov

FOR IMMEDIATE RELEASE
July 26, 2021

VA mandates COVID-19 vaccines among its medical employees including VHA facilities staff

WASHINGTON — July 26 Department of Veterans Affairs Secretary Denis McDonough announced he will make COVID-19 vaccines mandatory for Title 38 VA health care personnel — including physicians, dentists, podiatrists, optometrists, registered nurses, physician assistants, expanded-function dental auxiliaries and chiropractors — who work in Veterans Health Administration facilities, visit VHA facilities or provide direct care to those VA serves.

VA is taking this necessary step to keep the Veterans it serves safe.

Each employee will have eight weeks to be fully vaccinated.

"We're mandating vaccines for Title 38 employees because it's the best way to keep Veterans safe, especially as the Delta variant spreads across the country," McDonough said. "Whenever a Veteran or VA employee sets foot in a VA facility, they deserve to know that we have done everything in our power to protect them from COVID-19. With this mandate, we can once again make — and keep — that fundamental promise."

The department's decision is supported by numerous medical organizations including the American Hospital Association, America's Essential Hospitals and a Multisociety group of the leading Infectious Disease Societies. The American Medical Association, American Nurses Association, American College of Physicians, American Academy of Pediatrics, Association of American Medical Colleges, and National Association for Home Care and Hospice also endorsed mandating COVID-19 vaccination for health care workers.

In recent weeks, VA has lost four employees to COVID-19 — all of whom were unvaccinated. At least three of those employees died because of the increasingly prevalent Delta variant. There has also been an outbreak among unvaccinated employees and trainees at a VA Law Enforcement Training Center, the third such outbreak during the pandemic.

All VA employees are eligible to be vaccinated at no personal expense at any of our facilities. Employees will also receive four hours of paid administrative leave after demonstrating they have been vaccinated. Information in these FAQs or clinician and Veteran videos has details about the vaccine, its safety and effectiveness.

The safety and wellbeing of our Veterans and personnel is paramount.

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EXHIBIT 47

Hospitals, health systems mandating vaccines for workers

Kelly Gooch and Hannah Mitchell - Updated Friday, August 27th, 2021 Print | Email

The number of hospitals and health systems requiring COVID-19 vaccination for employees is growing.

Here are the healthcare organizations that have announced mandates:

Editor's Note: This webpage was updated Aug. 27 and will continue to be updated. The list is in chronological order based on when the mandate was announced or reported on.

Integris Health in Oklahoma City, is requiring staff to be fully vaccinated by Nov. 1, *The Oklahoman* reported Aug. 27. Employees seeking a medical or religious exemption must request one by Oct. 15.

New York Gov. Andrew Cuomo said Aug. 16 that all healthcare workers in the state need to get their first COVID-19 vaccine dose by Sept. 27. Currently, 75 percent of the state's hospital workers are already vaccinated. The health department said Aug. 26 that religious exemptions would not be an availble alternative to vaccine.

MetroHealth System in Cleveland, said Aug. 26 it is requiring employees, contractors and volunteers to get vaccinated by Oct. 30. More than 80 percent of its 7,800 employees are already vaccinated.

DuPage Medical Group in Downer's Grove, Ill., said all team members must be vaccinated, according to an Aug. 26 news release shared with *Becker's.*

Illinois Gov. J.B. Pritzker said Aug. 26 that all healthcare workers must get vaccinated or undergo weekly testing, *Effingham Radio* reported. The health department may require increased testing in certain situations, or if positivity rates increase. Employees must receive their first dose of a two-dose vaccine or a single-dose vaccine by Sept. 5. Their second doses must be received within 30 days of the first dose.

Sentara Healthcare in Norfolk, Va., said Aug. 25 that all employees must be fully vaccinated by Oct. 28. The mandate extends to all affiliated physicians, volunteers, students and others who work inside or for the health system.

Bartlett Regional Hospital in Juneau, Alaska, is mandating its employees to get vaccinated, *KTOO* reported Aug. 25 The hospital's board of directors voted unanimously for an employee vaccine mandate on Aug. 24. The details of the mandate have not been written yet, but the hospital will allow employees to apply for religious or medical exemptions.

Geisinger in Danville, Pa., said Aug. 25 it's requiring that all workers be vaccinated by Oct. 15. Geisinger's requirement applies to current employees as well as new employees, faculty, medical staff, residents, fellows, temporary workers, trainees, volunteers, students and temporary staff. New employees must be vaccinated as a condition of employment beginning Oct. 15. For employees who comply with the vaccine requirement or receive an exemption, Geisinger will pay a one-time $500 bonus in late October.

Northwestern Medicine in Chicago updated its COVID-19 policy. The 11-hospital system previously held back on a vaccination requirement but has now decided to require vaccination or testing for employees. Northwestern employees must complete vaccination or receive a medical or religious exemption by Oct. 31. Employees who do not comply with the vaccination requirement or receive an exemption must undergo weekly testing.

Ochsner Health in New Orleans, is mandating all employees be vaccinated by Oct. 29, according to a news release shared with *Becker's* Aug. 24. Additionally, contractors, students, volunteers, agency nurses and vendors

must also be inoculated. Currently, 69 percent of its staff is vaccinated.

Roper St. Francis Healthcare in Charleston, S.C., said Aug. 24 it's mandating the vaccine for all employees, *Live 5 News* reported. Employees must be fully vaccinated by Nov. 1, and there will be medical and religious exemptions.

Waterbury (Conn.) Health is requiring its staff, volunteers, contractors and students to get vaccinated, *WFSB 3* reported Aug. 24. About 86 percent of its staff is already vaccinated.

Doylestown (Pa.) Health is mandating its staff get vaccinated by Oct. 4, *Patch* reported Aug. 24. Employees will be able to apply for medical or religious exemptions.

Amita Health will be requiring employees to be fully vaccinated by Nov. 12, the Chicago-based health system said Aug. 24. Amita is offering reasonable accommodations for those who are unable to get vaccinated for health or religious reasons.

Edward-Elmhurst Health (Warrenville, Ill.) mandated vaccines for employees, providers, volunteers, contractors, students and instructors, according to an Aug. 24 news release shared with *Becker's.* Vaccinations must be completed by Oct. 25. Exemptions will be granted for medical or religious reasons.

CoxHealth in Springfield, Mo., said Aug. 23 that it would require all of its employees to get their first vaccine dose by Oct. 15. The decision was based on the FDA's full approval of the Pfizer vaccine, the health system's CEO Steve Edwards said. Nearly 70 percent of its employees are already vaccinated, as well as more than 90 percent of physicians.

West Virginia University Health System in Morgantown, announced Aug. 23 that employees must be fully vaccinated by Oct. 31. The mandate applies to employees of WVU Health System facilities, including those in West Virginia, Ohio, Pennsylvania, Maryland and Virginia, the health system said.

Mon Health in Morgantown, W. Va., said Aug. 23 that its facilities will require vaccinations for employees, with exceptions only for medical and religious reasons.

Envision Healthcare in Nashville, Tenn., said Aug. 20 that all 30,000 employees must be fully vaccinated by Nov. 1, with certain exceptions available.

Oregon is requiring its healthcare workers to be fully vaccinated, *Oregon Public Broadcast* reported. Gov. Kate Brown said Aug. 19 that staff must be fully vaccinated by Oct. 18 or six weeks after the vaccines receive full FDA approval, whichever is later.

Massachusetts Gov. Charlie Baker signed an executive order Aug. 19 that all state employees will need to be fully vaccinated by Oct. 17, WBUR reported. Those who are not vaccinated will face consequences such as losing their jobs.

Connecticut Gov. Ned Lamont signed an executive order requiring state hospital employees to be vaccinated by Sept. 27, according to an Aug. 19 *Hartford Courant* report. Employees must be fully vaccinated or have received their first dose and have an appointment for the second dose. Those who do not get vaccinated will be required to undergo weekly COVID-19 testing. Religious and medical exemptions will be available.

Presbyterian Healthcare Services in Albuquerque, N.M., is requiring vaccines for its 13,000-member workforce, the *Albuquerque Journal* reported Aug. 18. The health system's requirement comes as the state has ordered that workers in certain medical close-contact congregate settings, including hospitals and nursing homes, be vaccinated, with limited exceptions. Unless they qualify for an exemption, unvaccinated workers must receive their first dose by Aug. 27, and their second dose, as needed, within 40 days of receiving the first one.

Emerson Hospital in Concord, Mass., said Aug. 18 that all of its staff must be vaccinated by Nov. 1 as a condition of employment. Currently, 85 percent of employees and 93 percent of physicians are fully vaccinated. Medical and religious exemptions will be granted on a limited basis.

Rhode Island Gov. Dan McKee said all healthcare workers must be vaccinated by Oct. 1, according to an Aug. 18 news release shared with *Becker's.* Those who are not vaccinated must wear a mask and undergo testing twice a week. After the deadline, any unvaccinated healthcare worker without an exemption will not be allowed to report to work. Failure to comply with the rule can affect a provider's license or result in administrative action against the facility.

The University of Alabama at Birmingham Health System is requiring employees and people working in its hospitals and clinics to be vaccinated, the health system said Aug. 17. Employees who have a disability, medical condition or sincerely held religious belief may request an exemption, but they may be subject to additional safety requirements.

Akron (Ohio) Children's Hospital is requiring its employees to be vaccinated or undergo regular testing, NBC affiliate *WFMJ 21* reported Aug. 17. The mandate's effective date has not been determined, but it will most likely be in a few weeks.

New Mexico said Aug. 17 that all hospital employees will have to be vaccinated, with limited exceptions. The mandate will affect employees who have direct or indirect exposure to patients. To be eligible for an exemption, an employee must get a note from a physician or nurse practitioner validating their need for a medical or disability exemption or document why the vaccine conflicts with religious beliefs.

Unvaccinated employees who do not qualify for an exemption must receive their first dose of the vaccine within 10 days of Aug. 17, and their second dose within 40 days of receiving the first dose.

Tower Health will require vaccination for employees when the FDA fully approves the vaccine, the West Reading, Pa.-based health system said in an Aug. 17 news release. Vaccination will be a condition of employment for current employees, new hires and contract staff. For workers covered under collective bargaining, the requirement will be subject to discussions between management and union representatives, the health system said.

CareFirst BlueCross BlueShield is requiring employees, board directors and guests to get vaccinated, the healthcare company said Aug. 16. Employees have until Nov. 1 to be fully vaccinated, unless they have a medical or religious exemption.

NorthShore University HealthSystem in Evanston, Ill., is requiring all of its staff to get inoculated by Oct. 31, according to a memo shared with *Becker's* Aug. 16.

The District of Columbia is requiring that healthcare workers receive at least the first dose of Pfizer or Moderna or one dose of Johnson & Johnson COVID-19 vaccine, officials said Aug. 16. Workers must be vaccinated by Sept. 30.

Family West Health (Fruita, Colo.) and Community Hospital (Grand Junction, Colo.) executives have signed a joint statement mandating their staff be vaccinated. Community Hospital reported at a news conference Aug. 13 that 65 percent of its staff is already vaccinated. At Family West, 70-80 percent of its staff is vaccinated. The specific terms and effective dates will vary by hospital.

Philadelphia healthcare workers will be required to be vaccinated or be tested for COVID-19 twice per week, *ABC 6* reported Aug. 13. By Oct. 15, all healthcare workers will be required to provide proof of vaccination unless they have a religious or a medical exemption.

UCLA Health will require COVID-19 vaccines for faculty, staff, academic appointees and students by Sept. 1, adhering to a statewide policy from the University of California, the system told *Becker's* Aug. 13. Limited

medical exemptions and accommodations will be available based on disability or religious beliefs.

Inspira Health in Vineland, N.J. will require all employees to be fully vaccinated against COVID-19 by Oct. 15, it told *Becker's* Aug 13. Inspira will comply with Gov. Phil Murphy's executive order to begin COVID-19 testing of unvaccinated staff by Sept. 7.

CHI Memorial in Chattanooga, Tenn., is requiring employees to be fully vaccinated by Nov. 1, according to an Aug. 12 news release shared with *Becker's*. The requirement also includes physicians, advanced practice providers, volunteers and others caring for patients at the hospital.

SCL Health (Broomfield, Colo.) and Boulder (Colo.) Community Health said Aug. 12 all employees will have to be vaccinated by Nov. 1, according to a *Colorado Sun* report. Employees may apply for medical or religious exemptions.

JPS Health Network in Fort Worth, Texas said Aug. 12 it will require all of its workers to be fully vaccinated against COVID-19, pending full FDA approval of the vaccines, Fox 4 reported.

Maine will require all of its healthcare employees to be vaccinated against COVID-19, Gov. Janet Mills said Aug. 12. Employees must be fully inoculated by Oct. 1. Maine will not offer a testing alternative for those who do not get vaccinated. There is a medical exemption available for people who physicians deem immunization is "medically inadvisable."

Children's Hospital Colorado in Aurora, said Aug. 12 that it is requiring team members to receive a complete vaccination series by Oct. 1. The requirement will be a condition of employment and applies to all employees, medical staff, trainees, volunteers, vendors, medical students and contract staff.

CommonSpirit Health is requiring full COVID-19 vaccination for its 150,000 employees, the Chicago-based health system said Aug. 12. The compliance deadline for the vaccination requirement is Nov. 1, although the implementation date will vary by region in accordance with local and state regulations.

Dignity Health in San Francisco, which has more than 60,000 employees in 21 states, is mandating the COVID-19 vaccine. Its staff will have to be vaccinated by Nov. 1, the health system said Aug. 12. All physicians, volunteers and employees caring for patients will need to be vaccinated.

St. Luke's Health in Houston, is making the COVID-19 vaccine a condition of employment, the health system said in an Aug. 12 news release shared with *Becker's*. It is mandating employees, volunteers and all others who care for patients within its facilities be fully vaccinated against COVID-19 by Nov. 1. Medical and religious exemptions will be available for those who qualify.

Mount Sinai Health System announced Aug. 12 that the New York City-based organization is requiring faculty and staff to get at least one vaccine dose vaccine by Sept. 13. Those who do not meet that deadline or receive a medical or religious exemption will be subject to disciplinary action, up to and including termination, said Mount Sinai. Beginning in September, exempt faculty and staff must undergo weekly testing.

Bryan Health (Lincoln, Neb.), CHI Health (Omaha, Neb.), Nebraska Medicine (Omaha), Children's Hospital & Medical Center (Omaha, Neb.), Boys Town (Neb.) National Research Hospital, Madonna Rehabilitation Hospitals (Lincoln, Neb.) and Midwest Surgical Hospital (Omaha, Neb.) signed a joint statement Aug. 12 that their employees will be required to be vaccinated against COVID-19, the *Lincoln Journal Star* reported. Hospital employees can apply for a medical or religious exemption. The statement did not give an employee vaccination deadline or detail consequences of noncompliance.

Columbia Memorial Health in Hudson, N.Y. is requiring front-line staff, volunteers, students and operations staff to get inoculated against COVID-19, the hospital said Aug. 11. Those mandated to get vaccinated must do so "as soon as practical," *Hudson Valley 360* reported.

Valleywise Health in Phoenix, will require its staff to be vaccinated by Nov. 1, the health system said Aug. 11. It's 4,000 employees, including remote workers, students, volunteers and on-site vendors, will need to be inoculated.

Keck Medicine of USC in Los Angeles, said Aug. 11 that it is requiring healthcare workers to be fully vaccinated, beginning Sept. 20. The requirement includes employees, as well as contract and temporary workers, volunteers, vendors and contractors, and Keck School of Medicine of USC staff and trainees who work in our facilities.

Baptist Memorial Hospital in Memphis, Tenn., is requiring all vendors coming in and out of its facilities to be vaccinated against COVID-19, *Local Memphis* reported Aug. 11. Vendors need to be vaccinated or have a medical exemption. The hospital said the vast majority of its vendors are complying with the mandate. The hospital, which employs 19,000 people, said it will not be requiring its own employees to be vaccinated. It recently reported that about 42 percent of its workers are unvaccinated.

Broadlawns Medical Center in Des Moines, Iowa, said Aug. 10 it will require its 1,500 employees to be fully vaccinated by Nov. 1, according to the *Des Moines Register*. Employees may seek a religious or medical exemption. The public hospital run by Polk County said 76 percent of its staff is already vaccinated.

Texas Children's Hospital in Houston, is mandating that all employees and contractors receive their first COVID-19 vaccine dose by Sept. 21. The second dose must be received by Oct. 19. Exemptions are permitted for employees with certain religious beliefs or medical conditions.

Pennsylvania will require its 25,000 employees who work in state-run health facilities to get inoculated, according to an Aug. 10 news release. Employees must get vaccinated by Sept. 7 or undergo weekly testing. Those who get vaccinated will get an extra day off work in October.

Highmark Health and Allegheny Health Network in Pittsburgh, are requiring employees to get vaccinated against COVID-19, they said Aug. 10. Employees must get vaccinated by Sept. 30. Employees who are not vaccinated by Aug. 16 will be required to wear a face mask and face shield while working in a hospital or clinical setting. About 73 percent of its 21,000 employees are vaccinated.

Jefferson Health in Philadelphia, which has 32,000 employees, said Aug. 10 that its staff will be required to be fully vaccinated by Oct. 29, *Biz Journal*s reported. The mandate will apply to all employees, medical staff, as well as faculty and staff in its academic environments. Those who fail to get vaccinated by the deadline will be terminated.

MercyOne is requiring colleagues and medical staff to be vaccinated, the Des Moines, Iowa-based health system said Aug. 10. The organization is offering exemptions for strongly held religious beliefs or medical reasons.

Ellis Hospital in Schenectady, N.Y., is requiring that employees be fully vaccinated by Oct. 1, *News 10* reported Aug. 9.

Virginia Commonwealth University Health System in Richmond announced Aug. 9 that it is requiring that employees be vaccinated. Health system employees must get their first vaccine dose by Sept. 15.

Regional One Health in Memphis, Tenn. said Aug. 9 that its staff will be required to get inoculated against COVID-19 by Oct. 31

Monadnock Community Hospital in Petersborough, N.H. will be requiring its employees to get the COVID-19 vaccine. All of its employed physicians are already vaccinated, but overall the hospital's vaccination levels are approximately 80 percent, according to an Aug. 9 *Monadnock Ledger-Transcript* report.

Kadlec Regional Medical Center in Richland, Wash. is requiring its employees to show proof of being vaccinated against COVID-19 by Sept. 30, the *Tri-City Herald* reported Aug. 9. Those who do not get vaccinated will be required to sign a declination and follow additional protocols.

The Franciscan Missionaries of Our Lady Health System in Baton Rouge, La. will be requiring its employees to get vaccinated against COVID-19 or face termination, according to an Aug. 9 *Acadia Parish Today* report. All employees, students, volunteers and contractors must get vaccinated by Dec. 1 or risk consequences. Physicians, physician assistants and nurses must be vaccinated by Oct. 31 or they will be suspended without pay. If they're not fully vaccinated by Nov. 30 they will be fired.

Baton Rouge (La.) General will mandate that its employees get fully inoculated against COVID-19 by Spet. 30, according to an Aug. 9 *Acadia Parish Today* report. Those who do not get vaccinated will have to complete a quarterly education program designed in collaboration with Rochester, Minn.-based Mayo Clinic. About half of its staff is already vaccinated.

Methodist Le Bonheur Healthcare, a Memphis, Tenn.-based health system with 13,000 employees, said Aug. 9 that it is requiring that all employees be fully vaccinated by Oct. 31. The requirement applies to employees across hospital and outpatient locations in West Tennessee and North Mississippi. Limited exceptions will be approved for religious and medical reasons.

Ann & Robert H. Lurie Children's Hospital of Chicago said Aug. 9 that it will require that employees, students, contractors, badged vendors and volunteers be vaccinated by Oct. 18. The hospital will require proof of vaccination as a condition of employment and will provide exemptions for medical or religious reasons.

Saratoga (Fla.) Hospital said Aug. 9 that all employees will be required to be fully vaccinated against COVID-19 by Sept. 7. Those who do not get vaccinated will need to get tested weekly for the virus.

Perry County Memorial Hospital said Aug. 9 that all employees will be required to get fully vaccinated against COVID-19 by Oct. 4. To date, 75 percent of its staff is already vaccinated. The mandate will apply to all employees, regardless of whether they provide direct patient care. Volunteers, contractors and vendors will also need to be vaccinated.

Virginia Mason Franciscan Health in Seattle said Aug. 6 that all employees need to be vaccinated against COVID-19. The details of the mandate are still being finalized, according to an Aug. 6 Kitsap Sun report.

Swedish Health Services in Seattle is requiring its staff to get inoculated against COVID-19. Employees requesting a medical or religious exemption would be excused from the rule. As of July 21, 85 percent of its staff is already vaccinated, the Seattle Times reported Aug. 6.

Emory Healthcare in Atlanta will require vaccinations for its healthcare providers and employees, according to a statement shared with *Becker's* Aug. 6. Employees must receive their vaccinations by Oct. 1.

Nemours Children's Health System, which cares for patients in five states, said Aug. 6 that it is requiring vaccination for employees. The requirement is a condition of employment. The health system said employees must receive at least one dose by Sept. 1.

Summa Health in Cleveland is requiring all of its employees to get their final COVID-19 vaccine dose two weeks before Oct. 31. Those who refuse could be disciplined or fired, the health system said Aug. 5. Employees who receive medical or religious exemptions will be asked to wear a mask. To date, 70 percent of its employees are vaccinated.

Cape Fear Valley Health in Fayetteville said Aug. 5 that all employees, students, vendors and volunteers need to be vaccinated by Oct. 1. Employees will not be required to use their vacation time to get their vaccines. They can also apply for medical or religious exemptions.

Dayton (Ohio) Children's is requiring all of its employees to be vaccinated by Oct. 1, or risk termination. More than 60 percent of its staff is already vaccinated, the health system said Aug. 5.

Premier Health in Dayton, Ohio said Aug. 5 it's requiring all employees to be fully vaccinated by Dec. 1.

Kettering Health in Dayton, Ohio is requiring employees, medical staff, students, volunteers and vendors conducting business in their facilities to be vaccinated against COVID-19 by Oct. 4, the health system said Aug. 5

The California Department of Public Health issued an order Aug. 5 requiring workers in healthcare to be vaccinated. The order applies to workers in hospitals, skilled nursing facilities, intermediate care facilities, ambulatory surgery centers and in most other healthcare settings. Workers who do not qualify for a medical or religious exemption need to receive their second shot by Sept. 30. Unvaccinated exempt workers must meet testing and safety requirements.

Providence is requiring caregivers, where permitted by state law, to get vaccinated and show proof of vaccination, the Renton, Wash.-based health system said Aug. 5. The health system said those unable to be vaccinated must sign a declination and follow additional protocols. The compliance deadline is Sept. 30.

TriHealth in Cincinnati has decided to require vaccination for all team members, physicians and volunteers, according to a statement shared with *Becker's* Aug. 5. The health system is providing an exemption process for medical or religious reasons.

UnityPoint Health will require its more than 33,000 team members to be fully vaccinated, the West Des Moines, Iowa-based health system said Aug. 5. Employed team members must be fully vaccinated by Nov. 1 unless they obtain an exemption or temporary deferral.

Cincinnati Children's Hospital is requiring its staff to be vaccinated against COVID-19 by Oct. 1. The hospital said Aug. 5 many of its patients are too young to be eligible for the vaccine. Proof of vaccination will be required as a condition of employment unless a medical or religious exemption has been granted.

Christ Hospital Health Network in Cincinnati said Aug. 5 that its employees will be required to be vaccinated by Oct. 1.

UC Health in Cincinnati said Aug. 5 that employees must be vaccinated by Oct. 1.

St. Elizabeth Healthcare in Edgewood, Ky., said Aug. 5 that COVID-19 vaccines will be required for its staff by early this fall.

UK Healthcare in Lexington, Ky., said Aug. 4 that COVID-19 vaccines will be mandated for healthcare providers, staff, trainees, students and all others who work in its facilities. The health system is requiring employees to get their first dose by Sept. 15. There will be a declination process for employees who receive a religious or medical exemption as defined by the Americans with Disabilities Act.

CHI Saint Joseph Health in Lexington, Ky., said Aug. 4 that it will be requiring its staff to be vaccinated against COVID-19, according to a *Kentucky.com* report. Details and dates for the mandate will be provided to staff soon.

UW Health in Madison, Wis., is requiring its staff to be vaccinated against COVID-19, the health system said Aug. 4. Although 90 percent of its staff is already vaccinated, the remaining 10 percent must receive their first vaccination by Oct. 1 and their final dose by Nov. 1. Staff who have a documented medical condition that prevents them from being vaccinated or a religious conviction can file for an exemption.

Essentia Health in Duluth, Minn., is requiring its entire staff to be fully vaccinated this fall, according to an Aug. 4 *Star Tribune* report. To date, 87 percent of physicians, 84 percent of advanced practice providers and 70

percent of all other employees have been vaccinated, the health system said. Staff and contractors will have to receive their first dose by Oct. 1 and their second dose by Nov. 1.

Marshfield (Wis.) Clinic Health System said all employees will have to be vaccinated by Nov. 15, according to an Aug. 4 *ABC 9* report.

Oregon Health & Science University, by Sept. 1, plans to require its employees, students, volunteers and long-term vendors to provide documentation showing they are fully vaccinated or formally decline vaccination, the Portland-based organization said Aug. 4. OHSU said those who formally decline will have to complete vaccine-related education and follow necessary safety measures.

Dana-Farber Cancer Institute in Boston updated its vaccine requirement for employees. *The Boston Globe* previously reported June 24 that Dana-Farber will wait until after the FDA fully approves a vaccine. However, it told *Becker's* Aug. 4 that it will now require employees to have received their last dose two weeks before Oct. 1. The mandate is no longer dependent on the FDA's full authorization. All new hires must be vaccinated as a condition of employment.

MemorialCare in Fountain Valley, Calif. will require its staff to be vaccinated at all facilities, the health system told *Becker's* Aug. 4. The health system has set a target date of Sept. 30 to be vaccinated or to have received a deferral, medical or religious exemption.

Sutter Health in Sacramento, Calif., is mandating that its workforce be fully vaccinated against COVID-19 by Sept. 30. The mandate will require employees, volunteers and vendors who enter a Sutter facility or provide patient care off-site to provide documentation of vaccination, unless they have received a medical or religious exemption, the health system said Aug. 4.

Washington Regional Medical System in Fayetteville, Ark., has mandated vaccination for medical staff, as well as its 3,300 employees as of Oct. 1, J. Larry Shackelford, president and CEO, shared with *Becker's* Aug. 4. The organization is also requiring prospective new hires to provide proof of having received at least one dose two weeks before beginning work, according to a message sent to staff July 21. Employees may request an exemption based on disability or sincerely held religious belief.

Advocate Aurora Health in Downers Grove, Ill., and Milwaukee is requiring its remote and in-person staff, volunteers, and on-site vendors to be fully vaccinated, the health system said in an Aug. 4 news release shared with *Becker's*. With limited exemptions for religious or medical reasons, the entire staff must provide proof of full vaccination by Oct. 15.

Nationwide Children's Hospital in Columbus, Ohio, is requiring all employees, care providers, volunteers and vendors to be fully vaccinated, the hospital told *Becker's* Aug. 4. Workers must be fully vaccinated, effective Oct. 1.

Allina Health in Minneapolis said Aug. 3 the vaccine will be a condition for employment at the health system, according to a news release shared with *Becker's*. All employees, volunteers, students and contractors will be required to have had at least one vaccine dose by Oct.1, with limited exemptions for medical and religious reasons. To date, more than 73 percent of employees are already vaccinated.

The Ohio State University Wexner Medical Center in Columbus said Aug. 3 that it is requiring workers to receive either the first vaccine dose or an approved vaccine exemption before Oct. 15. The requirement applies to all faculty, staff and students.

PeaceHealth, a system based in Vancouver, Wash., said Aug. 3 that all caregivers will be required to be vaccinated or submit a qualifying medical exemption. The requirement starts Aug. 31. The health system said those who are unvaccinated must undergo regular COVID-19 testing, as well as additional masking, potential reassignment to non-patient care settings and other safety protocols.

OhioHealth will require the vaccine for its 35,000 associates, providers and volunteers, the Columbus-based health system said Aug. 3. The requirement applies to employed and independent physicians, those in patient-facing and non-patient-facing roles, students and vendors. The compliance deadline is Dec. 1.

Valley Children's Healthcare in Madera, Calif. is requiring its staff, physicians, vendors and those conducting business in its facilities to be vaccinated against COVID-19, effective Sept. 21. If an employee is granted a medical or religious exemption, they will have to undergo weekly COVID-19 testing. A large percentage of the hospital's patient population is too young to receive the vaccine, which increases their vulnerability to contracting the virus, the hospital told *Becker's* Aug. 3.

Dartmouth-Hitchcock Health in Lebanon, N.H., announced Aug. 3 that it will require employees to get vaccinated as a condition of employment, effective Sept. 30. The health system said employees must submit documentation that they have been fully vaccinated or obtain an approved medical or religious exemption.

MultiCare Health System in Tacoma, Wash., is requiring all hospital and clinic employees to get vaccinated against COVID-19 this fall. Details are still being worked out, and more information will be released in the coming weeks, *The Spokesman-Review* reported Aug. 3.

Froedtert Health in Wauwatosa, Wis., said Aug. 3 that it will require all staff, vendors, students and volunteers to get the COVID-19 vaccine by Nov. 1.

MaineHealth in Portland said Aug. 3 that it will require all employees to be vaccinated against COVID-19 by Oct. 1. The health system said it would consider medical and religious exemptions to the requirement.

Baptist Health in Louisville, Ky. is requiring employees to be vaccinated by Oct. 31, the health system told its staff Aug. 2. Employees must get their first vaccine by Sept. 15. Contractors, independent healthcare providers, vendors or anyone providing service on-site must also be vaccinated. Employees with a start date of Sept. 13 or later will be required to have their first vaccine dose within one week of being hired, the health system told *Becker's.*

Rochester (N.Y.) Regional Health, the University of Rochester Medical Center and Monroe Community Hospital in Rochester are mandating employees be vaccinated by Sept. 8 or undergo frequent COVID-19 testing, according to an Aug. 2 news release shared with *Becker's.*

Norton Healthcare in Louisville, Ky., will require employees, with allowance for religious and medical exemption, to be fully vaccinated, Russell Cox, president and CEO, said Aug. 2. Employees must receive their first dose by Sept. 15.

M Health Fairview in Minneapolis announced Aug. 2 that flu and COVID-19 vaccinations are a requirement for employees and providers, according to a staff memo shared with *Becker's*. The deadline is Oct. 31, and receiving the shots is a condition of continued employment. M Health Fairview is providing a medical and religious accommodation process.

Kaiser Permanente, an Oakland, Calif.-based organization with more than 216,000 employees and more than 23,000 Permanente Medical Group physicians, said Aug. 2 that it will make vaccines mandatory for workers, with the exception of workers in Oregon. Kaiser spokesperson Michael Foley told *Kaiser Health News* unvaccinated employees in Oregon will undergo weekly testing; unvaccinated employees in other states must become fully vaccinated or apply for medical or religious exemption. Kaiser's compliance deadline is Sept. 30.

Hawaii Pacific Health in Honolulu said it will require employees to be vaccinated, the *Honolulu Star-Advertiser* reported Aug. 2. The health system's compliance deadline is Oct. 1. According to the newspaper, employees who obtain medical or religious exemptions must get tested regularly.

Queen's Health System in Honolulu said it will require employees to be vaccinated, the *Honolulu Star-Advertiser* reported Aug. 2. The health system's compliance deadline is Oct. 1.

Memorial Hermann Health System in Houston announced its mandatory COVID-19 vaccine policy Aug. 2. Uner the policy, managers and above must be compliant by Sept. 11, the health system said. The deadline for all other employees, in addition to the system's affiliated providers and volunteers, is Oct. 9. Memorial Hermann will provide exemptions for medical or religious reasons.

Northwell Health in New Hyde Park, N.Y. is mandating vaccines for its employees after vaccine rates stagnated at 77 percent, the health system told *Becker's* Aug. 2. Health system employees will have to be fully vaccinated by Aug. 16 or will be required to be tested for COVID-19 on a weekly basis. Unvaccinated employees could also face adverse actions, which could progress to include termination.

All New Jersey hospitals will require their staff to get vaccinated under a new mandate by New Jersey Gov. Phil Murphy. Healthcare staff will have until Sept. 7 to get vaccinated or will have to get a COVID-19 test up to twice a week. However, if vaccination rates don't increase significantly, the governor will consider requiring vaccinations for healthcare staff as a condition of employment, he said Aug. 2.

Arkansas Heart Hospital in Little Rock said July 30 its directors, executives, managers, advanced practice nurses, physicians and physician assistants will be required to be fully vaccinated for COVID-19 by Sept. 30. On Aug. 1, new employees will be required to receive their first dose within 30 days of employment.

Phoenix Children's is mandating vaccines for all staff, effective Oct. 1. The hospital told *Becker's* July 30 that most of its staff is already fully vaccinated, but it will support the remaining employees as they work toward getting inoculated.

Michigan Medicine in Ann Arbor is mandating its staff be vaccinated against COVID-19, it said July 30. All staff, remote or in-person, must submit proof of vaccination by Aug. 30. Employees who are approved for a religious or medical exemption will be required to complete weekly testing and wear a mask indoors. Ultimately, noncompliant staff will be subject to disciplinary action. As of July 30, 76 percent of hospital employees have reported receiving their COVID-19 vaccines.

Texas Health Resources in Arlington said July 30 that it will require vaccination as a condition of employment. Employees will need to have received either both shots of the Pfizer or Moderna vaccine or one Johnson and Johnson shot, effective Sept. 10. The policy also applies to physicians and advanced practice providers on the medical staffs, students, vendors and contractors.

NCH Healthcare System in Naples, Fla., is requiring all employees to be fully vaccinated by Sept. 16. The mandate will be a condition of employment, the health system said July 30.

Vidant Health in Greenville, N.C., said July 30 that employees are required to be vaccinated. Managers, physicians and credentialed providers must be vaccinated by Oct. 1. Team members, new hires and contract workers will have until Dec. 1 to be vaccinated. Employees who are granted medical or religious exemptions may be subject to requirements such as weekly COVID-19 testing or reassignments away from working in units with immunocompromised patients.

Conway (Ark.) Regional Health System said July 29 that it will require new hires and leaders, including executive leadership, directors and managers, to get vaccinated. The requirement is effective Aug. 8. Leaders receiving two vaccine doses will be required to receive the second dose by the end of August, the health system said. New hires receiving two vaccine doses will be required to get the second dose within 30 days of employment.

Millinocket (Maine) Regional Hospital will require employees to receive the Pfizer or Moderna shots when they receive final FDA approval, the *Press Herald* reported July 29. Staff will be able to request exemptions.

Methodist Health System in Dallas said July 29 that it will require its workforce to be vaccinated by Oct. 1. The health system said once it achieves its workforce vaccination goal, full-time employees will receive a $500 bonus, and part-time employees will receive $250.

Self Regional Healthcare in Greenwood, S.C., is requiring team members to get vaccinated, *Fox Carolina* reported July 29. The organization said it aims to have unvaccinated employees inoculated by Sept. 30, according to the report.

ChristianaCare said July 29 that it will require employees, medical-dental staff, residents, students, contracted employees, temporary labor, volunteers and vendors to be vaccinated. Caregivers at the Newark, Del.-based health system must receive their first vaccine dose of a two-dose vaccine or their single Johnson & Johnson shot by Sept. 21.

Children's Hospital of Philadelphia will require workforce members at any location to get inoculated, the hospital said July 29. A deadline has not been announced.

Mary Washington Healthcare in Fredericksburg, Va., will require its workforce to get vaccinated by Oct. 31, the health system said July 29. The requirement will apply to employees, medical staff and volunteers.

CaroMont Health in Gastonia, N.C., is requiring employees to get a COVID-19 vaccine, but it hasn't committed to a specific timeline, according to a July 28 Gastonia Gazette report.

UCHealth, an Aurora, Colo.-based health system with 26,000 employees, said July 28 that it will require employees, providers, volunteers and partners to be vaccinated by Oct. 1. UCHealth's employees may receive the vaccine of their choice or obtain an exemption for medical or religious reasons. Those who obtain an exemption must wear a mask at all times in UCHealth facilities and be tested weekly, the health system said.

Pullman (Wash.) Regional Hospital will require employees to be fully vaccinated or complete the exemption process, by Oct. 27, the hospital said July 28. Employees can request a medical exemption, religious belief exemption or personal belief exemption. The personal belief exemption will expire on June 1, 2022, or within two months of full FDA approval of a vaccine.

Baylor Scott & White Health, a 51-hospital health system based in Dallas, is requiring employees, providers, volunteers, vendors, students and contract staff to receive both doses of the Moderna or Pfizer COVID-19 vaccine, or the single-dose Johnson & Johnson shot, unless granted an exemption, the health system said in a statement shared with *Becker's* July 28. The deadline for the requirement is Oct. 1.

State-run New York hospitals will need patient-facing healthcare workers to get vaccinated by Labor Day, Gov. Andrew Cuomo said July 28. Employees who are not patient-facing and do not get vaccinated will be required to get tested weekly. The requirement will be instated at 10 hospitals and healthcare facilities.

Spectrum Health in Grand Rapids, Mich., said July 28 that it will require the COVID-19 vaccine for team members, medical staff, students, volunteers and contractors. The 14-hospital health system plans to require vaccination within eight weeks of the FDA approving the first vaccine, or sooner depending on pandemic circumstances. Spectrum will consider exemptions.

Hospital for Special Surgery in New York City said July 27 its employees will be required to be vaccinated against COVID-19 by Sept. 15, the system told Becker's. Employees may apply for a medical or religious exemption. About 76 percent of its 5,000 employees have already been vaccinated.

Ascension, a 149-hospital health system based in St. Louis, will require COVID-19 vaccination for its 160,000 employees. Ascension's requirement will apply to workers who provide direct patient care, as well as those who work in health system sites of care or remotely, the health system said July 27. This includes workers employed by subsidiaries and partners; physicians and advanced practice providers (employed and independent); and volunteers and vendors entering health system locations. Ascension said employees have until Nov. 12 to complete the vaccine series and meet the vaccination requirement.

Care New England is moving forward with mandatory vaccination for all staff, the Providence, R.I.-based health system said July 27. Vaccination has been required for students, volunteers and new hires since July 1,

and the next step is to require managers to begin the vaccination series before Labor Day, said Care New England.

Baystate Health said July 26 that employed team members, including those working remotely, clinical staff, contractors, volunteers, students, and those conducting business within the Springfield, Mass.-based health system, will be required to be fully vaccinated by Oct. 1. Employees will be able to request an exemption for religious or medical reasons, and pregnant employees may request a deferral.

California healthcare organizations will be required to have all of their employees fully vaccinated or they will be required to get tested weekly, Gov. Gavin Newsom said July 26. Unvaccinated healthcare employees will also be required to wear appropriate personal protective equipment. The policy will take effect Aug. 9 and employees will have until Aug. 23 to fully comply.

Truman Medical Centers/University Health in Kansas City, Mo., said July 26 that vaccination will be a requirement for staff members, according to *KMBC*. The deadline to be vaccinated is Sept. 20.

Mayo Clinic in Rochester, Minn., said all health system staff must be fully vaccinated by Sept. 17. Those who do not meet the deadline will be able to keep their jobs. However, they will be required to complete a formal refusal process, which includes watching education modules, wearing face masks and maintaining social distancing while on campus.

The Department of Veterans Affairs is mandating COVID-19 vaccinations for 115,000 of its front-line healthcare workers, the first federal agency to do so. Starting July 28, those workers have eight weeks to get fully vaccinated or face penalties, including possible removal.

Rush University Medical Center in Chicago is requiring its workers, contractors and volunteers to get the shot. They must be fully vaccinated by Oct. 1.

HonorHealth in Scottsdale, Ariz., said July 23 that it will require vaccination as a condition of employment. Employees must submit proof of vaccination by Nov. 1.

Sanford Health in Sioux Falls, S.D., said July 22 that all employees across its 46 hospitals and hundreds of other medical facilities will be required to be vaccinated by Nov. 1. More than 90 percent of clinicians and 70 percent of nurses are already vaccinated, the health system said. Those who do not get vaccinated will not be working, but a final decision on a furlough has not been decided.

Duke University Health System, a three-hospital health system based in Durham, N.C., is requiring vaccination for employees. The deadline for employees is Sept. 21, news station *ABC11* reported July 22.

Cone Health in Greensboro, N.C., said July 22 that it will require vaccination for workers, effective July 30. The mandate will apply to employees, medical and dental staff, professional students and volunteers. The deadline for compliance is Oct. 1.

UNC Health said July 22 that it will require teammates at UNC Medical Center, UNC Rex Healthcare, Chatham Hospital, Johnston Health, UNC Health Southeastern, UNC Rockingham Health Care, UNC Physicians Network Practices and UNC Health Shared Services locations to get vaccinated. The deadline for employees at the Chapel Hill, N.C.-based health system is Sept. 21.

Wake Forest Baptist Health said July 22 that the Winston-Salem, N.C.-based organization is requiring teammates to be fully vaccinated or obtain an approved medical or religious exemption. The mandate applies to remote workers, physicians, medical residents, faculty, fellows, trainees, contractors, students/visiting students, members of the medical staff, temporary workers and volunteer staff.

Novant Health is requiring team members to be fully vaccinated, the Winston-Salem, N.C.-based health system said July 22. Workers must be vaccinated by Sept. 15.

Atrium Health is making vaccination mandatory for all teammates, the Charlotte, N.C.-based health system said July 22. Teammates, including remote workers, physicians, medical residents, faculty, fellows, trainees, contractors, students/visiting students, members of the medical staff, temporary workers and volunteer staff, must be fully vaccinated or obtain an approved medical or religious exemption by Oct. 31.

Arkansas Children's in Little Rock is requiring that its leaders (managers, directors, vice presidents, senior vice presidents and executive vice presidents) receive a first vaccine dose as a condition of employment, according to a message sent July 22 from Marcy Doderer, president and CEO. Leaders must receive their first dose by Aug. 20 and be fully vaccinated by Sept. 30. Beginning Aug. 16, all new Arkansas Children's new hires will also be required to receive a first shot by their start date and a second one within 30 days of employment, said Ms. Doderer.

OSF HealthCare, a multistate health system based in Peoria, Ill., said July 21 that it will require all employees to be vaccinated against COVID-19 by the end of September. The requirement does not apply to Michigan Nursing Association bargaining unit members. OSF HealthCare has 150 locations in Michigan and Illinois.

Banner Health will require COVID-19 vaccination as a condition of employment for its roughly 52,000 team members, the Phoenix-based health system said July 20. The deadline for employees to be fully vaccinated is Nov. 1, with limited exceptions.

Southcoast Health, a three-hospital health system offering services in southeastern Massachusetts and Rhode Island, said vaccines will be mandated for all employees, staff and providers once at least one of the vaccines receives full FDA approval, *The Standard-Times* reported July 20. Employees will be able to request exemptions if they have documented medical and religious reasons, or if they are pregnant or intend to become pregnant.

Valley Health, a Winchester, Va.-based health system with 6,300 employees and affiliated physicians, said July 19 that it will add COVID-19 vaccination to its list of required vaccinations for all employees, medical staff members and contractors. Health system officials said the standard is effective immediately for new employees, who must provide evidence of vaccination or complete the vaccination series two weeks before beginning work. Employees who are managers or above and medical staff members must provide evidence of prior completion of the vaccination series or receive their first dose by Aug. 16. Remaining staff have until Nov. 1 to either obtain an exemption or be fully vaccinated.

Tidelands Health in Georgetown, S.C., said July 16 that it will mandate vaccination for employees, employed providers, volunteers, learners and contractors. Employees have until Sept. 7 to comply, and the health system is providing an attestation and declination process for those who cannot get vaccinated for medical or religious reasons. Tidelands Health said employees who have previously tested positive for COVID-19 may also choose to decline the shot.

Hackensack Meridian Health, a 17-hospital system based in Edison, N.J., will require its staff to be fully vaccinated against COVID-19, NorthJersey.com reported July 15. A memo to employees cited by NorthJersey.com gave Nov. 15 as the deadline for the mandate. Workers, including physicians and nurses, must receive at least one dose of the Pfizer, Moderna or Johnson & Johnson shots by Oct. 1 and a second dose of Pfizer or Moderna by Nov. 15. The deadline to request an exemption is Aug. 16.

Beacon Health System in South Bend, Ind., said July 15 that it will require employees and others who work regularly at a Beacon facility to be fully vaccinated by Oct. 1. Employees may request an exemption.

Vanderbilt University Medical Center in Nashville, Tenn., will require its entire staff to get the vaccine, according to an employee newsletter distributed July 15. All hospital leaders must get the first dose or achieve a medical exemption by Aug. 15 They must fully be vaccinated by Sept. 15. The deadline for all employees is under consideration.

The University of Mississippi Medical Center in Jackson said July 15 that it will implement a new vaccination policy requiring those who work or learn in a medical center-controlled space to be fully vaccinated against

COVID-19, with limited exceptions, or wear an N95 mask while at any medical center facility. Medical center officials said those who are fully vaccinated will only be required to wear a mask of their choosing or as determined according to the clinical situation in patient care areas. The policy will be phased in over three months, with all who work in a medical center-controlled space required to be fully vaccinated or wearing an N95 mask at all times on or by Nov. 1.

Hartford (Conn.) HealthCare said July 14 that it will require COVID-19 vaccination for its employees. Health system officials said employees may apply for an exemption, but those without an approved exemption must show proof of vaccination by the end of September.

St. Jude Children's Research Hospital said July 14 that the Memphis, Tenn.-based hospital and its foundation partner, ALSAC, are requiring that St. Jude and Memphis-area ALSAC employees be vaccinated against COVID-19 by Sept. 9. In a memo, St. Jude President and CEO James Downing, MD, told employees they must have their final dose scheduled and administered by the deadline, or, if vaccinated outside of St. Jude, have the documentation to the hospital by the deadline date.

University of Chicago Medicine will require its workers to be vaccinated against COVID-19, according to a July 13 memo to students, faculty and staff. The mandate will apply to employees of University of Chicago Medical Center and to medical center volunteers and contractors at both the Hyde Park campus and other medical center sites, health system leaders wrote. They added that the mandate may be subject to discussion with unions representing workers.

Piedmont Healthcare in Atlanta said June 12 it is requiring leaders, physicians, providers and new employees to be fully vaccinated against COVID-19, with plans to eventually extend the mandate to all its more than 23,000 workers. As of Sept. 1, the mandate will apply to that initial group and to the rest of Piedmont's employees in "the near future," following Sept. 1.

Virtua Health in Marlton, N.J., will require its more than 14,000 workforce members to be fully vaccinated against COVID-19. Virtua employees must be fully vaccinated by Sept. 15. Virtua said July 12 that all employees, regardless of vaccination status, will continue to maintain COVID-19 safety protocols per CDC guidelines, and it will consider employee requests for exemptions based on religious beliefs or disability/medical condition.

Inova Health System in Falls Church, Va. informed its 18,000 employees that they will have to be vaccinated by Sept. 1.

Trinity Health in Livonia, Mich., will require its 117,000 employees across 22 states to get the COVID-19 vaccine after the number of employees who received at least one shot stagnated at 75 percent.

St. Luke's Health System in Boise, Idaho, will require its employees to be vaccinated against COVID-19, according to a memo sent to employees July 8 from Chris Roth, president and CEO of the health system. St. Luke's will require all employees, providers, volunteers and contractors to receive their first vaccine dose by Sept. 1.

Mercy in St. Louis will require its 40,000 employees across 44 hospitals and healthcare facilities to receive the COVID-19 vaccine, health system officials said on July 7. All employees will be required to be vaccinated by Sept. 30.

University Hospital in Newark, N.J. will require all of its employees to be vaccinated, according to a June 30 report.

Yale New Haven (Conn.) Health officials said in a June 30 press conference that all health system employees will be mandated to get the vaccine, however, the deadline is still being determined.

Connecticut Children's Medical Center in Hartford will require all employees to be fully vaccinated against COVID-19. The hospitals' CEO and president, Jim Shmerling, PhD, said hospital employees will have until Sept. 30 to get vaccinated, according to a June 29 letter to employees.

Henry Ford Health System in Detroit, which employs more than 33,000 people, said June 29 it will require its workforce to be vaccinated, effective Sept. 10. The requirement applies to team members, students, volunteers and contractors.

SSM Health in St. Louis said June 28 it will require its nearly 40,000 employees, providers and volunteers to be fully vaccinated by late September. Team members can request a medical or religious exemption.

Medical University of South Carolina Health employees were provided a final deadline of June 30 to be vaccinated, or to obtain a medical or religious exemption, as part of the Charleston-based health system's mandate. The health system fired five out of about 17,000 employees for noncompliance.

Mass General Brigham will require employees to be vaccinated, the Boston-based health system said June 24. The requirement will apply to Mass General Brigham's 80,000 employees once one of the three vaccines being distributed in the U.S. is fully approved by the FDA. The health system said employees will be able to request exemption if they are pregnant or intend to become pregnant. Employees may also request an exemption for medical and religious reasons. A deadline for the mandate will be determined after FDA approval.

Beth Israel Lahey Health in Cambridge, Mass., said June 24 it plans to require all physicians and staff to be vaccinated against COVID-19 and the flu as a condition of employment. Flu vaccination will be required later this year, and COVID-19 vaccination for employees will be required after one of the vaccines is fully approved by the FDA.

Wellforce in Burlington, Mass., which includes Boston-based Tufts Medical Center, will require vaccination for employees, the system said June 24. The requirement takes effect after full FDA approval of one of the vaccines, which is expected later this year.

The Connecticut Hospital Association said June 24 it has adopted a consensus, statewide policy reflecting a commitment by the state's hospitals and health systems to implement mandatory vaccination for employees and clinical staff. The association will develop best practices for implementation.

Meritus Health in Hagerstown, Md., said June 16 it will require vaccination for employees. The requirement applies to employees, medical staff members, volunteers, contractors and partners. As of Aug. 1, new employees must be vaccinated before starting work, the health system said. And as of Sept. 1, all employees, medical staff, volunteers, contractors and partners must be vaccinated or will need to be tested every 14 days. Meritus Health is providing medical and religious exemptions.

BJC HealthCare in St. Louis will require employees to be fully vaccinated beginning in the fall, according to a June 15 statement from the health system. Employees and those who work in BJC facilities must comply with the mandate by Sept. 15 or receive a medical or religious exception.

San Francisco will require personnel in high-risk settings such as skilled nursing facilities, acute care hospitals, homeless shelters and jails to be vaccinated, the city said June 14. The requirement takes effect once one of the vaccines being distributed in the U.S. receives full FDA approval.

NewYork-Presbyterian in New York City said all employees, physicians, students, clinical rotators, volunteers and vendors must have received their first dose no later than Sept. 1. For two-dose vaccines, workers must complete the vaccination process on the prescribed timeline. Newly hired employees also must follow a vaccination or exemption process.

Community Health Network in Indianapolis is requiring employees to be fully vaccinated by Sept. 15 unless they receive exemptions for religious or medical reasons, according to a June 10 news release. The requirement

applies to vendors, contractors and volunteers who work at Community's hospitals and care sites.

The District of Columbia Hospital Association, said June 9 that hospitals in Washington, D.C., signed a consensus statement to mandate vaccination for their workers. Each of the 14 hospitals will set their own vaccination deadline.

University of Maryland Medical System in Baltimore announced June 9 that it will require vaccination for current and new employees. The 13-hospital health system said teammembers and partners who remain unvaccinated will be required to get tested weekly, and health system leaders at the manager level and above will have until Aug. 1 to be vaccinated or comply with weekly testing. Beginning Sept. 1, all teammembers will be required to get inoculated or participate in weekly testing.

Children's National Hospital in Washington, D.C., announced June 9 that it is making the vaccine mandatory for all employees. Unvaccinated employees have until Sept. 30 to be fully vaccinated.

The Maryland Hospital Association said June 7 that hospitals and health systems in the state signed a consensus statement to mandate vaccination for their workers. Each organization will set their own vaccination deadline.

Indiana University Health in Indianapolis is requiring employees to be fully vaccinated, *The Indianapolis Star* reported June 1. Employees must be vaccinated by Sept. 1 or obtain an exemption.

University of Louisville (Ky.) Health is requiring team members and providers, including residents, fellows and rotating students, to be fully vaccinated by Sept. 1, according to a May 26 news release.

RWJBarnabas Health in West Orange, N.J., is requiring supervisors and employees ranked above them to be vaccinated no later than June 30 and said May 20 that it plans to extend the mandate to all employees.

University of Pennsylvania Health System in Philadelphia said May 19 that it is making the vaccine mandatory for all employees and clinical staff by no later than Sept. 1. New hires must provide proof of at least one dose two weeks before beginning work.

Houston Methodist rolled out its mandatory vaccination policy March 31, with April 15 as the deadline for managers to receive at least one dose or get an exemption. All employees had a deadline of midnight June 7 to get the COVID-19 vaccine as part of the health system's mandate. The count as of June 8: Nearly 100 percent compliance with 24,947 workers being fully vaccinated.

EXHIBIT 48

Current Status: *Active* **PolicyStat ID:** *9779821*

Origination: *7/30/2021*
Last Revised: *7/29/2021*
Next Review: *1/25/2022*
Owner: *Joseph Castro: Chancellor*
Area: *Chancellor*
Codes: *COVID-19, HR 2021-3*

COVID-19 Vaccination Interim Policy

I. Policy Statement

The California State University (CSU) is committed to safeguarding the health and well-being of our students, faculty, staff, administrators, and the communities we serve, as well as maintaining higher education access and attainment for our students. As we work towards the safe resumption of increased on-campus learning, working and other activities, we embrace a comprehensive strategy designed to reduce the likelihood of transmission of the COVID-19 virus. This approach contributes to the overarching goal of achieving population-level immunity throughout the CSU.

As the Centers for Disease Control and Prevention noted in a recent update, "[g]etting vaccinated prevents severe illness, hospitalizations, and death." In light of the evidence established to date regarding the effectiveness and safety of available COVID-19 vaccines,[1] and in the face of recent increasing infection rates due to many factors, including the Delta variant of the virus, the CSU hereby requires that, effective immediately, all individuals who access Campus/Programs[2] as defined below must comply with this policy. Students and Employees must have received an Approved COVID-19 vaccine subject to the terms and Exemptions described below.

II. Definitions

A. Approved Vaccine:

A COVID-19 vaccine is an Approved Vaccine if the U.S. Food & Drug Administration (FDA) has issued a License or an Emergency Use Authorization (EUA) for the vaccine; or the World Health Organization has determined that the vaccine has "met the necessary criteria for safety and efficacy."

B. Campus/Programs:

Any CSU campus, property or facility owned or operated by the University in connection with its teaching; research, scholarship, and other creative activities; public service; or other programs and services.

Any in-person program or activity (on- or off-campus) operated or controlled by the University. Examples of off-campus programs include CSU-hosted international programs and University-sponsored athletic programs.

C. Certification:

Submission of information establishing that a Student or Employee has received an Approved Vaccine or

qualifies for an Exemption from the vaccine requirement. Each campus will collect from every Student or Employee the following, as applicable: (1) declaration of current COVID-19 vaccination status (with an Approved Vaccine, the last required dose of which was administered at least 14 calendar days prior to the date of Certification); (2) declaration of Medical Exemption; (3) declaration of Religious Exemption; or (4) declaration that the individual does not plan to access Campus/Programs, and that if their plans change, they will submit a revised Certification in advance of any such access. Each Certification shall include an attestation by the Student or Employee that the information provided is accurate and truthful.

D. Contractor:

A person or entity, including an Auxiliary Organization, that performs work for the CSU as specified under the terms of a contract or agreement.

E. Employees:

Faculty, staff, volunteers, student workers and administrators of the CSU.

F. Exemptions:

A Student or Employee may be excused from the vaccine requirement in this policy as described below:

Medical Exemption: due to a medical (including mental health) condition for which an Approved Vaccine presents a significant risk of a serious adverse reaction. Any medical Exemption must be verified by a certified or licensed healthcare professional.

Religious Exemption: due to either (i) a person's sincerely held religious belief, observance, or practice, which includes any traditionally recognized religion, or (ii) beliefs, observances, or practices which an individual sincerely holds and that occupy a place of importance in that individual's life, comparable to that of traditionally recognized religions.

G. Other Safety Measures:

Any action, as determined by the CSU, other than getting an Approved Vaccine, that decreases the likelihood of COVID-19 transmission or illness and allows the core mission and activities of the campus to continue. Other Safety Measures may include but are not limited to asymptomatic (surveillance) and symptomatic testing; physical/social distancing; wearing face coverings or personal protective equipment; frequent hand hygiene and respiratory etiquette; improving ventilation of indoor spaces; and isolation or quarantine when warranted.

H. Student:

Any admitted, matriculated, or continually enrolled student participating in any CSU in-person activities.

III. Policy

A. Every Campus (including the Chancellor's Office) shall require that each Student and Employee provide a Certification in accordance with Campus procedures and deadlines as soon as possible, and no later than September 30, 2021.

B. Students and Employees may claim an Exemption to the Approved Vaccine requirement in accordance with Campus procedures.

C. In order to access Campus/Programs, any person, including a visitor, who has not obtained an Approved Vaccine (even if they have an Exemption) may be subject to Other Safety Measures, as determined by the campus President.

D. Any Student or Employee who does not provide a Certification may be denied access to Campus/ Programs.

E. Campus Presidents are responsible for implementing this policy, and may, on rare occasions, consider extenuating or individual circumstances. Any such consideration shall be in consultation with the Chancellor's Office and consistent with all applicable CSU policies including those prohibiting discrimination, harassment, and retaliation based on protected status or activity.

F. This policy supplements and does not replace CSU policies governing Other Safety Measures.

G. Contractors shall ensure that their agents and employees undertake applicable Other Safety Measures. In consideration of the nature of the Contractor's services (including proximity to members of the University community), duration, and extent of on-campus presence, Presidents may, at their discretion, also require that a Contractor's agents and employees receive an Approved Vaccine.

IV. General Provisions

A. Confidentiality of Information.

Campus procedures for implementing this policy (including in connection with data collection) shall be governed by applicable CSU policies regarding confidentiality, privacy, and security of health records, as well as state and federal law. Information shall be used only for the specific purpose intended and only accessible to CSU personnel who have a business need-to-know.

B. Accessibility.

Campus procedures for implementing this policy shall be governed by applicable CSU policies regarding accessibility, as well as applicable state and federal law.

C. Documentation to Support Certification.

Vaccination Status. Any person submitting a declaration of current COVID-19 vaccination status (with an Approved Vaccine) shall verify that, at the campus's request, they will promptly provide proof of vaccination.

Medical Exemption. Any person submitting a declaration of Medical Exemption shall verify that, at the campus's request, they will promptly provide documentation from a certified or licensed healthcare professional to support their declaration.

Religious Exemption. Any person submitting a declaration of Religious Exemption shall verify that, at the campus's request, they will promptly provide a statement that describes the applicable religious or other comparable belief that is the basis for their Exemption.

D. Broad Dissemination of Policy Information.

Campuses shall disseminate information about this policy, including Exemptions, using methods designed to reach diverse audiences (including individuals who may not have internet access). Such information shall provide appropriate point(s) of contact for this policy, including email and telephone numbers.

E. Access and Availability of Vaccinations and Testing.

COVID-19 testing required by the CSU shall be provided to Students and Employees at no charge.

Information about the availability of Approved Vaccines and COVID-19 testing, including those offered free-of-charge, shall be widely disseminated, using methods designed to reach diverse audiences, including individuals who may not have Internet access. Such information shall include how to schedule appointments for vaccination and testing (including location), as well as the type(s) of available COVID-19 tests.

F. Superseding Public Health Directives.

In the event that a federal, state, or local governing public health agency imposes a requirement that restrictively conflicts with this policy or a campus's implementation of this policy, the applicable public health mandate shall govern and be implemented. Campuses shall consult with the Office of General Counsel in the event of inconsistent directives issued by agencies with overlapping jurisdiction.

G. Procedures.

Campus Presidents shall establish procedures to facilitate implementation of this policy.

V. Discipline

Violations of this policy, including dishonesty, may subject Employees to discipline pursuant to California Education Code section 89535.

Violations of this policy, including dishonesty, may subject Students to discipline under CSU Executive Order 1098, Student Conduct Procedures.

VI. Authority

This policy is issued pursuant to Section II of the Standing Orders of the Board of Trustees of the California State University.

VII. Endnotes

[1]https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html

[2]Capitalized terms are defined in the "Definitions" section of this policy.

All revision dates: 7/29/2021

Attachments

Frequently Asked Questions 07-29-2021.pdf

Approval Signatures

Step Description	Approver	Date
Final Approval	Joseph Castro: Chancellor [SH]	7/29/2021
Work Group Approval	Tammy Kenber: Assoc VC, HR	7/28/2021

EXHIBIT 49

COVID-19 Vaccine

IN THIS SECTION

With the ultimate goal of returning our campuses to normal operations, beginning with the fall 2021 semester, **all Indiana University (including IUPUI) students, faculty and staff will be required to have a COVID-19 vaccine** and be fully vaccinated or have an approved exemption before returning to campus. This requirement is part of IU's ongoing successful response to and management of the COVID-19 pandemic on its campuses and will allow the university to lift most restrictions on masking and physical distancing.

A person is considered fully vaccinated two weeks after having all doses of a vaccine (2 doses for Pfizer, Moderna; 1 dose for Johnson & Johnson).

If you have questions about receiving a COVID-19 vaccine, exemptions or know you won't be fully vaccinated before returning to campus, just let us know. Please feel free to reach out to vaxreq@iu.edu or 812-855-4848.

Have your COVID-19 vaccine or need an exemption?

Complete our self-report form to let us know you're fully vaccinated or request an exemption.

Let us know.

How to report your COVID-19 vaccine

All current students, faculty and staff will use IU's COVID-19 vaccine report form to attest that they are vaccinated and report all doses of your vaccine. Incoming students should plan to complete the self-report form once have created their IU email account.

If you're arriving from an international location

Students, scholars, faculty and staff arriving from an international location may not have access to a COVID-19 vaccine in their current location and may not be able to be fully vaccinated before arriving on campus this August.

Individuals in this situation should let us know that they cannot meet the August 15 deadlineand should plan to receive a COVID-19 vaccine upon their arrival in the U.S. They can continue to participate in orientation, classes and other activities as they work toward becoming fully vaccinated.

COVID-19 vaccines authorized by the FDA and recommended by the World Health Organization will meet IU's requirement. If you've already received a vaccine that is not one authorized/recommended by either of these organizations, you'll need to receive one that is. There are no known safety issues at this time with receiving an FDA-authorized vaccine after receiving one that has not yet been authorized/recommended.

Please review our frequently asked questions for additional information about arriving from an international location, not being fully vaccinated before arriving on campus and vaccine verification.

Exemption request process

Approved exemptions include:

1. **Religious exemptions**.
2. **Ethical exemption**.
3. **Medical exemptions with documentation** from your provider of an allergy to the COVID-19 vaccines or their components.
4. **Medical deferrals** for the following circumstances with a note from your provider:
    1. Active pregnancy or active breastfeeding only if the provider is requesting an exemption. The exemption lasts only until you're no longer actively pregnant or actively breastfeeding. Pregnancy and breastfeeding are not contraindications for vaccination.
    2. Immunocompromised individuals only with provider request for an exemption and only for those who have recent (within the past 3-6 months) hematopoietic or solid organ transplant, or on active treatment with Rituximab within the past 3-6 months.
    3. Have received COVID-specific monoclonal antibodies in the past 90 days.
5. An **online program exemption** for students who are in a 100% online program with no on-campus component. This must be an online program; not simply taking all online classes.

You can request an exemption using the online request form. IU's Medical Response Team, among other designated IU leaders, will promptly review exemption requests, responding within five business days.

COVID-19 vaccines are:

Safe. The currently FDA-authorized and WHO-recommended COVID-19 vaccines were developed using the normal scientific process for vaccine development. There were no short cuts or relaxing of standards. The vaccines were tested by all three phases of scientifically rigorous clinical trials , which showed no major safety concerns. In addition, the CDC has collected data from more than 2 million people outside of the trials that have shown no major safety issues with the Pfizer and Moderna vaccines.

Effective. Research shows that all currently authorized and recommended COVID-19 vaccines are very effective at preventing COVID-19, especially severe disease.

Free. There is no cost for the COVID-19 vaccine no matter where you receive it.

IU's COVID-19 vaccine requirement

Learn about the requirement, reporting your vaccine and more.

Read the FAQ

Vaccine eligibility

Everyone age 12 and over is eligible to receive the COVID-19 vaccine in the U.S. Pfizer is currently the only one authorized for those age 12-17.

Scheduling your vaccine appointment

The COVID-19 vaccine is available at locations in all counties in Indiana, including dedicated vaccine clinics, pharmacies and other retail locations. There are vaccine locations near or on many IU campuses.

To schedule an appointment in Indiana, visit ourshot.in.gov, select the county you want to schedule in and then select your preferred vaccine site.

Outside of Indiana, use vaccinefinder.org to search for vaccine clinic sites across the country.

What to expect when getting your vaccine

Getting your COVID-19 vaccine will be much like getting any other vaccine. You should wear short sleeves or a shirt with sleeves that can easily be rolled up to your upper arm.

You'll receive the injection in your upper arm. Before you leave the vaccine site, you'll be given the appointment date and time for your second dose, depending on which vaccine you get. It is ideal to return to the same location for your second dose.

In the 24-48 hours after receiving your vaccine, your arm may feel sore. Other potential side effects will likely be mild and may include fever, fatigue, muscle or joint pain, or headache.

People who get the Pfizer or Moderna vaccine most often feel a greater immune response after their second dose.

If you feel any of the above side effects, this simply means your body is building protection against COVID-19. It's a good thing!

If you develop symptoms more than 48 hours after receiving the vaccine or they last for more than 24 hours, they could be unrelated to the vaccine. Stay home and contact your doctor.

EXHIBIT 50

Safe Steps to Safe Schools

Home COVID Appointments Safe Steps Daily Pass Report Cards

Resources FAQ Back to School Info

Frequently Asked Questions

Los Angeles Unified will update our COVID-19 site as more information becomes available. The following are frequently asked questions for families and employees about COVID-19 testing, vaccinations and the Daily Pass web app.

>> Lea las preguntas frecuentes en español
>> Return to Campus FAQ

LOS ANGELES UNIFIED'S TESTING PROGRAM

Expand All

Why is Los Angeles Unified conducting its own COVID-19 testing?

How often will the students and staff who work on campus be tested for COVID?

Why are employees and students being asked to take a test within 14 days of their return to a school site?

What if a student does not want to participate in the testing program?

Will all students be tested?

Will Early Childhood Education and Adult School students and staff be part of the testing program?

What will happen if my child is absent on the day testing is scheduled?

Do infants participating in the District's infant care program need to get tested?

Is Los Angeles Unified working with the Los Angeles County Department of Public Health?

Will my test results be shared with any other entities and/or agencies?

Why do vaccinated staff and students have to participate in periodic testing?

Can my supervisor ask to see my test results?

Will students and staff in independent charter schools be part of the program?

Can I talk to someone who speaks Spanish if I have any questions?

Can a relative or friend of a student get tested for COVID-19?

What should I do if I don't get a Daily Pass? When can I return to work or school?

COVID SAFETY PROTOCOLS

Expand All

Will temperatures be checked before entering a school or office?

What happens if my child has to quarantine? Will my child continue with their learning?

What happens if an employee or student tests positive for the virus?

If I test positive for COVID-19, can I take another test to confirm?

What isolation instructions will be given if an employee or student tests positive?

Does an employee or student who tested positive need to take another test before returning to work or school?

Will schools and school buses be cleaned more often?

What is the distinction between isolation and quarantine?

What should I do if I or anyone in my household has COVID-19 like symptoms?

What should an employee do if a member of their household tests positive?

What is the quarantine policy for students or staff considered a "close contact" to someone who tested positive for the virus?

What should I do if my child or I are in close contact with someone suspected of being positive for COVID-19?

Do vaccinated students without symptoms have to quarantine with their class?

What is a “close contact” to a case and what does it mean to be a close contact?

What determines if a class will close, or a school will close because of an outbreak?

Do household members of close contacts have to take the same precautions?

Will I know about an outbreak in my student's school?

I was tested for COVID-19 at a non-Los Angeles Unified site, and tested positive. What should I do?

Who is in the Community Engagement team?

WHAT TO EXPECT WHEN SCHEDULING AND TAKING AN LA UNIFIED COVID TEST

Expand All

What is the testing process for employees and students who have made an appointment at a stationary site?

Will I be able to choose the kind of COVID-19 test I receive?

Who is conducting the testing?

How much does testing cost?

What safety precautions are being taken during the testing process?

Is consent required for the COVID-19 test?

Can an employee or student be tested by their own healthcare provider?

As an LA Unified employee, can I return to work after taking a test?

How long does it take to receive test results?

What should I do if my test result is inconclusive, invalid or if I don’t receive a result within 2 days?

Where can I find my child’s student ID since I need to enter their Student ID to schedule an appointment?

Do I need to submit a hard copy of the consent and authorization forms?

If I'm symptomatic can I get a COVID-19 test at the school to enter the campus?

Can I call the help desk and ask them to schedule an appointment for me over the phone?

If I miss my appointment, can I reschedule my test?

What if I am having trouble booking an appointment?

ACCESSING THE VACCINE

Expand All

Will Los Angeles Unified administer vaccines?

How do I make an appointment to get vaccinated?

What vaccine will Los Angeles Unified provide?

Are COVID-19 vaccines free?

Who is eligible to receive a COVID-19 vaccine?

What do I need to bring to my vaccine appointment?

VACCINE SAFETY AND SCIENCE

Expand All

Why should I vaccinate my child if cases are low and children aren't severely impacted by COVID-19?

Are the vaccines safe for youth?

What side effects are seen in adolescents?

Why is the vaccine only for adolescents 12 and over? When do you expect vaccines to be available for younger children?

Can a COVID-19 vaccine make me sick with COVID-19?

After getting a COVID-19 vaccine, will I test positive for COVID-19 on a viral test?

Where can I get trusted information about COVID-19 vaccines in general?

Where can I get trusted information about COVID-19 vaccines for youth?

Do I need two vaccinations?

DAILY PASS

Expand All

What is the Daily Pass?
What is needed in order to enter a school or a District office?
What are the Daily Health Check screening questions?
Can anyone use the Daily Pass to schedule a COVID-19 test?
Who can schedule a COVID-19 vaccination appointment on the Daily Pass?
Who can get a Daily Pass QR code?
How far in advance can the Daily Health Check be completed?
What happens if the Daily Health Check questions are answered incorrectly?
Does the Daily Health Check need to be completed for every site visited?
Is the use of the Daily Pass going to be mandated for all sites?
What if someone does not have a device or does not want to use the Daily Pass on their personal phone?
How will the Daily Pass QR code be used?
Who will have access to the information in the Daily Pass?
What if an employee or student develops symptoms during the day?
What are the next steps if access to a Daily Pass is not obtained?

VACCINATION REQUIREMENT

Collapse All

Will the District require employees to be vaccinated?

Yes. As part of Los Angeles Unified School District's efforts to provide the safest possible environment in which to learn and work, all District employees, Partners, Contractors and other adults who provide services on District property will be mandated to be fully-vaccinated against COVID-19 no later than October 15, 2021 as a condition of continued employment/service.

What does "Fully-Vaccinated" mean?

"Fully-vaccinated" refers to an individual who has received the first and second doses of the vaccine (or, in the case of Johnson & Johnson, the single required dose) and has completed the two-week period that follows to ensure maximum immunity.

Will the District allow employees time for getting vaccinated, for vaccine reaction, and protect the notification/privacy of appointments and vaccination status?

Employees will:

- Be allowed to be vaccinated during their workday (up to three hours) including travel time.
- Be allowed time for vaccine reaction, to be determined on a case-by-case basis.
- Be allowed to submit verifiable vaccination documentation from a health care provider.
- Be allowed to take up to three hours during their work day to take a dependent to be vaccinated.
- Notify their supervisor one day ahead (and secure a substitute if applicable) if they are scheduling an appointment during their workday.

What if an employee refuses to be vaccinated due to a disability/medical condition or sincerely held religious belief?

Although the District is requiring vaccines for employees, the District will still engage in an interactive process to determine if a reasonable accommodation exists to permit an employee to continue working who cannot take the vaccine due to disability or sincerely held religious belief.

Do I have to be vaccinated if I am pregnant or breastfeeding?

Although, currently, there is no contraindication to the administration of the COVID-19 vaccine during pregnancy or if a person is breastfeeding, it is recommended that you consult with your doctor to determine whether or not you qualify for a medical exemption.

When will employees receive educational information about the vaccines and vaccination process?

Vaccination information is available at https://achieve.lausd.net/Page/17454. Additionally, an informational video about the COVID-19 Vaccination is available on MyPLN (keyword: Covid Vaccine), where the District's Medical Director shares information about the COVID-19 vaccine.

How will the District address concerns from individuals who are vaccine-hesitant?

Educational materials and resources are available in the District's website at http://achieve.lausd.net/covidvaccine. In addition, the Los Angeles Unified Medical Director will provide clear information about the vaccine through a MyPLN course (keyword: COVID Vaccine).

What is the District's implementation timeline for this policy?

All District employees, Partners, Contractors and other adults who provide services on District property will be mandated to be fully-vaccinated against COVID-19 no later than October 15, 2021.

Will the District continue COVID-19 testing after the vaccination policy goes into effect? Will testing frequency change for vaccinated employees?

Yes. Los Angeles Unified will continue to provide free weekly COVID testing on school campuses for all students and employees – both vaccinated and unvaccinated. If infection rates in our community decrease, testing frequency may be reduced, and exemptions for vaccinated individuals may be considered in accordance with medical guidance.

What is the reasonable accommodation process that will be followed?

The process is outlined in LAUSD Policy Bulletin BUL-4569.1.

Do I have to be vaccinated if I have already had COVID-19?

Yes, you are still required to get vaccinated to be fully protected against getting COVID-19. According to the Los Angeles County Department of Public Health, it is recommended you get the vaccination as soon as your isolation is over, and your symptoms are gone.

Must employees utilize the Daily Pass to verify their vaccination status?

Yes. Employees who did not receive both doses of their vaccine through the District must upload any external vaccine verification through the Daily Pass. Attachment A provides a job aid on how to upload the external

vaccine verification.

What are the consequences of an employee failing to comply with the vaccine requirement?

The District may take disciplinary action, including but not limited to placement on unpaid leave and/or separation from service.

Will there be a waiver for those on Leaves of Absences and not at work, such as an employee who is out on parental bonding time?

All mandated leaves remain in effect and any waivers for those on Leaves of Absences will be addressed on a case-by-case basis.

Will students be required to be vaccinated for COVID-19 to attend school in-person?

The District's vaccination initiative is designed to provide access to all students once eligible. At this time, the vaccine is not mandatory for Los Angeles Unified students; however, we strongly encourage all families to consider their options with regard to the vaccine.

Are Los Angeles Unified employees required to take time off to receive the vaccination or do so outside of work hours?

Employees may receive the vaccine and accompany their child to receive the vaccine during paid working hours.

Choose Your Language

Helpdesk

For families: (213) 443-1300
For employees: (213) 241-2700
The helpdesk is open 6 am to 6 pm Monday through Friday for any questions about Los Angeles Unified and the COVID-19 pandemic.

Student & family wellness:
(213) 241-3840
The helpdesk is open 8 am to 5 pm Monday through Friday. Please call for support with mental health, immunizations, health insurance, food & housing, enrollment, and more.

EXHIBIT 51

NYC mandates vaccinations for public school teachers, staff

By JENNIFER PELTZ August 23, 2021

NEW YORK (AP) — All New York City public school teachers and other staffers will have to get vaccinated against the coronavirus, officials said Monday, ramping up pandemic protections as the nation's largest school system prepares for classes to start next month.

The city previously said teachers, like other city employees, would have to get the shots or get tested weekly for the virus. The new policy marks the first no-option vaccination mandate for a broad group of city workers in the nation's most populous city, though Mayor Bill de Blasio announced Friday that coaches and students in football, basketball and other "high-risk" sports would have to get inoculated before play begins.

Unions bristled at the new requirement, saying the city needed to negotiate, not dictate. Two big city workers' groups were planning to file a labor complaint or take legal action.

About 148,000 school employees — and contractors who work in schools — will have to get at least a first dose by Sept. 27, according to an announcement from the Democratic mayor and the city health and education departments.

“We’re going to do whatever it takes to make sure that everyone is safe,” de Blasio said at a virtual news briefing. Schools Chancellor Meisha Ross Porter called the policy “another layer of protection for our kids,” including her own 11th-grader.

The city hasn’t immediately said whether there will be exemptions or what the penalty will be for refusing, though de Blasio told MSNBC later Monday that “there will clearly be consequences.” The previous vaccinate-or-test requirement had provisions for unpaid suspensions for workers who didn’t comply.

De Blasio said the city would start bargaining this week with school system unions over specifics, and officials hope for agreements. But the mayor said the city intends to implement the requirement Sept. 27, with or without a deal.

A union known as DC 37 — which represents school aides, lunchroom workers and other staffers along with thousands of other city employees — said it would file an unfair labor practices complaint with the state Public Employment Relations Board. And the Municipal Labor Committee, an umbrella group of unions that together represent about 350,000 city workers, voted Monday to pursue legal action that could mean a lawsuit over the city’s varying vaccination policies for city employees, chairperson Harry Nespoli said.

“All we want to do is sit down and try to negotiate the best policy that will protect the city and its workers,” said Nespoli, who’s vaccinated but worried about maintaining the option of undergoing testing instead of inoculation.

“We’re concerned about the people in New York, too. We don’t want to see people get sick,” he said, but “there has to be an alternative if that person doesn’t want to take that jab.”

The city didn’t immediately comment on the labor groups’ planned actions.

Other school unions also said they needed answers and input.

“I understand completely why you have the requirement: There’s a pandemic. We just have to make sure that we negotiate” accommodations if a doctor certifies that someone shouldn’t get vaccinated, said Gregory Floyd, the president of Teamsters Local 237. It represents about 4,400 school safety agents.

The United Federation of Teachers raised the potential of arbitration “if necessary.”

Custodians’ union President Robert Troeller said he believed about 60% of the 850 members of Local 891 of the International Union of Operating Engineers had gotten at least a first shot, but some others “are dead-set against this.”

At least 63% of all school employees already have been vaccinated, not including those who may have gotten their shots outside the city.

Citywide, over 70% of adults have gotten at least a first dose.

The new requirement came as federal regulators gave full approval to Pfizer’s COVID-19 vaccine, one of three vaccines available in the U.S. All already have authorization for emergency use, but officials hope the full approval will increase public confidence in the vaccines.

School starts Sept. 13 for the city’s roughly 1 million public school students.

U.S. Education Secretary Miguel Cardona hailed the city’s “leadership” on teacher vaccinations, tweeting that it’s important to maximize the amount of inoculated people in schools.

New York, like some other cities and states, has been fighting the virus' highly contagious delta variant by ratcheting up pressure to get more people inoculated.

New York City last week began requiring proof of vaccination t o enter restaurant dining rooms, gyms and many other public places, a first-in-the-nation policy that a few other cities have copied. Meanwhile, New York state announced last week that hospital and nursing home workers would have to get inoculated.

Vaccine mandates for teachers are fairly rare so far in the U.S., though Washington state, for one, says teachers must be inoculated or face dismissal.

Vaccinate-or-test requirements for school employees are somewhat more common, existing in places including Los Angeles and Chicago, which are the two biggest U.S. school districts after New York. The state of New Jersey joined the list Monday with a new policy affecting teachers and state employees.

New York state's court system announced a vaccinate-or-test rule Monday for judges and staffers. Such policies already exist for other state employees and transit system workers.

A new poll from The Associated Press-NORC Center for Public Affairs Research found that about 6 in 10 Americans say students and teachers should have to wear face masks while in school, and that teachers and eligible students should also be required to get vaccinated. But Democrats and Republicans differ sharply on these issues, the poll found.

EXHIBIT 52

Aug 24, 2021

Ohio State announces vaccination requirement

Decision follows full FDA approval of Pfizer vaccine

Ohio State University President Kristina M. Johnson sent the following message to students, faculty and staff today (Aug. 24).

Dear Students, Faculty and Staff:

The rising prevalence of the more transmissible Delta variant is fueling the resurgence of COVID-19 cases and hospitalizations – including in young and otherwise healthy unvaccinated people. Central, southern and southeastern Ohio have now recorded the highest number of hospitalized COVID-19 patients since January. Further, the number of hospitalized patients in these areas of the state rose an alarming 448% between mid-July and mid-August.

Throughout the pandemic, the university has taken measures to help keep our Ohio State community safe and healthy. With Monday's news that the U.S. Food and Drug Administration has granted full approval to the Pfizer-BioNTech vaccine, Ohio State will now require every student, faculty and staff member to be vaccinated against COVID-19. The university is taking this step because vaccines are the safest and most effective form of protection against COVID-19. We are focused on enhancing the health and safety of our community. This step will increase our ability to support our students in continuing their educational experiences as well as help protect our current and the state's future workforce.

Scientists have learned a significant amount about the Delta variant, and this research underscores why being vaccinated is critical to combating COVID-19. Studies show that the Delta variant can be orders of magnitude (in one study, 1,000 times) more severe and it affects younger people in higher percentages than the original coronavirus strain. Additionally, vaccinated individuals can

transmit the Delta variant – at least for the first few days that they are infected – even if they are not sick themselves. These factors combined mean it is also much more transmissible than the initial strains of COVID-19.

The good news is that vaccinated individuals, though they can get COVID-19, are less contagious than unvaccinated individuals and they are significantly less likely to be hospitalized or die from the virus. Masks also continue to be an effective tool at combating the spread of COVID-19. That is why we are implementing our vaccine requirement with urgency as well as continuing our protocol to require everyone to wear masks indoors regardless of vaccination status.

The deadline for all Ohio State students, faculty and staff to have at least the first dose is Friday, October 15, 2021. For people receiving a two-dose sequence, the second dose deadline is November 15, 2021. This vaccination requirement mirrors the Wexner Medical Center's **announcement < https://wexnermedical.osu.edu/mediaroom/pressreleaselisting/wmc-announces-change-to-vaccine-policy>** . More than 73% of our community has had at least one shot already, and this step will further protect us all. We also stand the best chance of continuing to enjoy the traditions that we love throughout the academic year with higher vaccination rates in our campus community.

If you have already been vaccinated, thank you. Details about the reporting process will be announced in the coming weeks.

Getting your vaccine is **free and easy < https://safeandhealthy.osu.edu/get-vaccinated>** :

- You can walk in for an appointment today or schedule one on Ohio State's Columbus campus or at Wexner Medical Center locations around central Ohio. There are also sites throughout the state of Ohio, including in the communities in which the university's campuses are located, so it is easy to **find < https://gettheshot.coronavirus.ohio.gov/>** a location near you.

The Pfizer-BioNTech vaccine is currently the only FDA fully approved vaccine, though Moderna, Johnson & Johnson or World Health Organization-approved vaccines will also be accepted to meet this requirement. Please note that boosters may be required in the future. A limited set of exemptions will be

approved on a case-by-case basis (**read more about the exemptions < https://safeandhealthy.osu.edu/covid-19-vaccine-requirement#Vaccine_exemptions>**). Additional information, including non-compliance measures, is available on the **Safe and Healthy Buckeyes website < https://safeandhealthy.osu.edu/covid-19-vaccine-requirement>** .

There is strong support for this requirement in our community, including student, faculty, staff and university leadership. From the beginning of the pandemic, we have made data-driven, science-based decisions and followed the guidance of medical and public health professionals, including the U.S. Centers for Disease Control and Prevention and state and local public health partners. The health and safety of our community is and always will be a top priority. Thank you for doing your part to protect our campus community.

Sincerely yours,

Kristina M. Johnson, PhD

President

EXHIBIT 53

The Board of Education Approves a Vaccine Mandate for all School District Employees

Posted on August 26, 2021
Categories: News, Press Releases

At a special meeting today, the Board of Education approved a resolution to mandate COVID-19 vaccination for all School District of Philadelphia employees. The Board authorized this mandate to protect the health and safety of all School District students and staff.

“It is the Board’s duty to protect our children, many of whom cannot get vaccinated, and being vaccinated is the best protection against the virus,” said Board President Joyce S. Wilkerson. “We believe that preventing COVID-19 infections through vaccines will lead to fewer missed school days, more in-person learning days, and ultimately, to improved student achievement.”

The vaccine mandate was approved as Philadelphia faces a growing number of COVID-19 infections and hospitalizations, driven by the Delta variant which is more transmissible than earlier forms of the virus. The School District has been striving to prevent COVID-19 cases through layered strategies, including masking, social distancing, hand hygiene, on-site COVID-19 testing and quarantining or isolating when necessary. This approach aligns with both the CDC and Philadelphia Department of Public Health (PDPH) guidelines.

The Board’s resolution directs the Superintendent to develop and implement a mandatory vaccination plan that would require employees, contracted workers and service employees who work in District facilities and on District property to be fully vaccinated and to submit proof of vaccination status. The plan would also include a process to request exemptions and accommodations for certain documented medical circumstances or sincerely held religious beliefs. Details of the plan will be developed and shared soon with District staff and school communities.

EXHIBIT 54

University of California –Policy

Policy: SARS-CoV-2 (COVID-19) Vaccination Program

Responsible Officers:	Provost & Executive Vice President for Academic Affairs (Campuses, ANR, Labs) Executive Vice President – University of California Health (UC Health) Executive Vice President and Chief Operating Officer (Campuses, ANR, Labs)
Responsible Offices:	Academic Affairs University of California Health (UCH) University of California Operations (UCO)
Issuance Date:	December 14, 2020 Last Updated July 15, 2021
Effective Date:	July 15, 2021
Last Review Date:	July 15, 2021
Scope:	All University of California locations and faculty, academic personnel, staff, trainees, students, and others accessing University facilities and programs.

	UC Health	Campuses, ANR, Labs
Contact:	Anne Foster, MD	Amina Assefa
Title:	Chief Clinical Officer	Director, Emergency Management
Email:	Anne.Foster@ucop.edu	Amina.Assefa@ucop.edu
Phone:	(510) 987-0306	(510) 987-9594

TABLE OF CONTENTS

I. POLICY SUMMARY

The purpose of this policy is to facilitate protection of the health and safety of the University community, including its patients as well as its Students, Trainees, Personnel and all others who work, live, and/or learn in any of the University's locations or otherwise participate in person in University Programs.

The University strongly recommends that all members of the University community obtain the COVID-19 vaccine as soon as they are eligible. In addition, this policy provides for a COVID-19 Vaccination Program under which any Covered Individual is required, subject to limited deferrals, exceptions, and associated non-pharmaceutical interventions, to be fully vaccinated against COVID-19 before physically accessing the University's Locations and Programs. This policy further provides that Locations must begin collecting proof of vaccination and processing requests for Exceptions and Deferrals for all Covered Individuals no later than July 15, 2021, to facilitate fall planning efforts.

II. DEFINITIONS

Covered Individuals: A Covered Individual includes anyone designated as Personnel, Students, or Trainees under this Policy who physically access a University Facility or Program in connection with their employment, appointment, or education/training. A person accessing a Healthcare Location as a patient, or an art, athletics, entertainment, or other publicly accessible venue at a Location as a member of the public, is not a Covered Individual.

Covered Non-Affiliates: A Covered Non-Affiliate is a person who accesses a University Facility or Program as a Non-Affiliate (other than as an "official volunteer") under the Regulations Governing Conduct of Non-Affiliates in the Buildings and on the Grounds of the University of California.

Contraindications and Precautions: A contraindication or precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC), or by the vaccine's manufacturer, as based on a condition in the potential vaccine recipient that may increase the risk for a serious adverse reaction to the vaccine, may cause diagnostic confusion if the vaccine is administered, or may compromise the ability of the vaccine to produce immunity. Contraindications and Precautions are limited and do not include conditions that are unrelated to vaccines or injectable therapies, such as food, pet, venom, or environmental allergies, or allergies to oral medications.

COVID-19 Vaccination Program or Program: A set of rules governing Physical Presence at University Locations or in University Programs intended to reduce the incidence of SARS-CoV-2 infection and resultant COVID-19 disease, disability, and death in connection with University Facilities or Programs.

Deferral: An approved deferral of vaccination based on pregnancy. Pregnancy Deferral will extend throughout the term of the pregnancy and until the Covered Individual returns to work or instruction, as applicable.

Disability: A physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. “Disability” includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

Exception: An approved exception to COVID-19 vaccination based on a Medical Exemption, Disability, or Religious Objection. For purposes of this policy, a person who is pregnant is not eligible on that basis alone for an Exception, but is eligible for a Deferral for the duration of pregnancy.

Fully Vaccinated: A person is considered “fully” vaccinated when two weeks have passed since they completed a COVID-19 Vaccine series (for example, 1 dose of the Janssen/J&J vaccine, or 2 doses within no more than 12 weeks of the Moderna or Pfizer vaccine); as well as any boosters consistent with manufacturer instructions and applicable agency approval, authorization, or listing.

Healthcare Location: A collection of buildings and Personnel that service an academic health system including hospitals, ambulatory surgery centers, outpatient centers, clinics, or other locations where preventive, diagnostic, therapeutic, or other interventional physical or behavioral healthcare services are provided to UC Health patients, employees, or research participants and any associated educational, research, or administrative facilities and offices. A Healthcare Location refers only to that part of a campus that meets this definition and does not include student health and counseling centers.

Implementation Date: The deadline for initial implementation of the Program, which is two (2) weeks before the first day of instruction at any University campus or school for the Fall 2021. For locations that do not operate on an academic calendar (e.g., UCOP, ANR, medical centers, national laboratories), the deadline is September 1, 2021. For new employees whose first date of employment is later, the deadline is 8 weeks after the first date of employment. For students starting or returning to campus after Fall 2021, the deadline is the first date of instruction for the term when they first enroll.

Location (or Facility): Any United States campus, medical center, or facility operated by the University in connection with its research, teaching, or public service (including clinical care) missions or programs, including University housing. A Location does not include a property owned by the University but leased to a third party unless (and only to the extent) a University Program occurs at that site.

Location Vaccine Authority (LVA): The office or person responsible for implementing the COVID-19 Vaccination Program for a Location, typically the Chief Medical Officer or Occupational Health office at a Medical Center or an Occupational Health or Student Health office at an academic campus. The LVA is a health care provider and its records are considered confidential health records for purposes of the University’s privacy policies.

Medical Exemption: An excuse from receiving COVID-19 vaccine due to a Medical Contraindication or Precaution.

Non-Pharmaceutical Intervention (NPI): An action, other than getting vaccinated or taking medicine, that members of the University community can take to help prevent or slow the spread of COVID-19 and other contagious illnesses. NPIs include, for example, staying home, especially when a person is sick or when a member of the person's family or household is sick; quarantining when an unvaccinated person has been exposed to someone else with the illness; avoiding large gatherings; physical/social distancing; wearing personal protective equipment or face coverings; frequent handwashing and cleaning; and asymptomatic (surveillance) and symptomatic testing.

Participation: Participation in the COVID-19 Vaccination Program (by providing proof of vaccination or obtaining an approved Exception or Deferral under this policy). Participation is a condition of Physical Presence at any University Location or Program as set forth in this policy. For Covered Individuals who must be vaccinated under this policy, Participation compliance will require repeat vaccinations or boosters on an annual or recurring basis consistent with FDA-approved labeling and CDC recommendations.

Personnel: University faculty, other academic appointees, and staff, including but not limited to visiting, volunteer, without salary, and emeritus/a professors, visiting or volunteer academic appointees, contract, recall, and emeritus/a employees. "Personnel" also includes, for purposes of this policy, official volunteers, as defined in the Regulations Governing Conduct of Non-Affiliates in the Buildings and on the Grounds of the University of California.

Physical Presence: Physical presence at a University Location or Program for any work, research, or education/training related purpose (as distinguished from accessing a Healthcare Location as a patient, or an art, athletics, entertainment, or other publicly accessible venue at a Location as a member of the public). Physical presence includes living in housing furnished by the University, using University amenities such as entertainment venues, museums, libraries, workout facilities, or dining halls or food courts in one's capacity as Personnel or a Student or Trainee, or participating in person in a University Program even if not occurring at a Location. Access is not defined by reference to any particular frequency (e.g., daily, weekly, monthly, *ad hoc*).

Reasonable Accommodation: An adjustment made to the requirements of the COVID-19 Vaccination Program for a Covered Individual who has received an approved Exception or Deferral to allow them to Physically Access a University Location or Program without impairing the health and safety objectives of this policy. Covered Individuals who are granted Exceptions or Deferrals will be required to observe Non-Pharmaceutical Interventions as a condition of Physical Presence.

Religious Objection: A Covered Individual's objection to receiving the COVID-19 vaccine based on that person's sincerely held religious belief, practice, or observance.

Responsible Office: The office at a Location responsible for processing requests for Exception or Deferral. The list of such offices can be found online at: COVID-19 Vaccination Program: Responsible Offices..

Students: The term "Student" has the same meaning as defined in the current version of PACAOS 14.40: an individual for whom the University maintains student records and

who: (i) is enrolled in or registered with an academic program of the University; (ii) has completed the immediately preceding term, is not presently enrolled, and is eligible for reenrollment; or (iii) is on an approved educational leave or other approved leave status, or is on filing-fee status. For purposes of this policy, the term "Student" also includes K-12 students, children enrolled in day care programs, and campers who are eligible for vaccination outside clinical trials; as well as visiting students and extension students.

Trainees: Trainees include participants in post-graduate training programs who are neither Students nor Personnel; as well as individuals enrolled in continuing education, lifelong learning, seminars, workshops, and other non degree-granting educational programs.

University or UC: The University of California.

University Program: A program or activity operated by the University to support the University's teaching or research mission and generally offered exclusively to University Personnel or Students. Examples of covered Programs that may not be conducted at a Location include the UC Education Abroad Program and University-sponsored athletics programs.

Vaccine: A COVID-19 Vaccine satisfies the requirements of this policy if: (i) the U.S. Food and Drug Administration (FDA) has issued a License or an Emergency Use Authorization (EUA) for the vaccine or; (ii) the World Health Organization has approved Emergency Use Listing (EUL).

Vaccine Information Statement ("VIS"): An information sheet produced by or including information derived from the Centers for Disease Control and Prevention, the California Department of Public Health, or UC Health or any of its components, explaining in plain language the benefits and risks of a COVId-19 vaccine to vaccine recipients. A VIS generally must be provided to an individual being vaccinated prior to each dose of the vaccine, in a language they understand. For purposes of this policy, a VIS may also include FDA fact sheets for vaccine recipients and caregivers.

III. POLICY TEXT

This policy supplements, and does not replace, policies or guidelines requiring University Personnel, Trainees, Students, patients, and visitors to observe Non-Pharmaceutical Interventions, as further described in Appendix A: COVID-19 Prevention Strategies.

A. COVID-19 Vaccination Program. As a condition of Physical Presence at a Location or in a University Program, all Covered Individuals must Participate in the COVID-19 Vaccination Program by providing proof of Full Vaccination or submitting a request for Exception or Deferral no later than the Implementation Date. This requirement will be subject to implementation guidelines and any local procedures for enforcement. Alternative remote instructional programming is not expected to be available in most cases and the availability of alternative remote work arrangements will depend on systemwide guidance and any local policies or procedures, as well as the nature of the work to be performed.

1. **Access to Vaccination.** All Locations that are campuses and medical centers must offer COVID-19 vaccination on-site or maintain a list of nearby and accessible off-site locations offering vaccination to Covered Individuals during working and non-working hours. This provision is not intended to restrict a Covered Individual's choice of provider, but to maximize their access to the Vaccine.
2. **Proof of Vaccination.** Covered Individuals must submit proof of their vaccination or of a University-approved Exception or Deferral to their Location Vaccine Authority, by providing: (i) in the case of one who has been Fully Vaccinated, a copy of their CDC vaccination card (or foreign equivalent in the case of Covered Individuals who received their vaccinations abroad); official documentation issued by a State vaccine registry; or an official medical record; or (ii) in the case of one who has received an Exception or Deferral, documentation that the Exception or Deferral has been granted. Proof of vaccination may be subject to audit.

   Request for Exception/Deferral. A Covered Individual seeking an Exception or Deferral must, no later than the Implementation Date, submit their request to the appropriate Responsible Office. While a request is pending, the Covered Individual must, as a condition of Physical Presence, observe Non-Pharmaceutical Interventions defined by the LVA consistent with applicable public health directives and the guidelines in Appendix A: COVID-19 Prevention Strategies. If an Exception or Deferral is granted, the issuing office must notify the Covered Individual and the LVA of the approval and the associated expiration date, if any. If a request for Exception or Deferral is denied, the Covered Individual will be notified and, thereafter, will be expected to promptly become Fully Vaccinated or denied Physical Presence at the relevant University Location(s) or Program(s).
3. **Education.** Any Covered Individual who has not provided proof of Full Vaccination by the Implementation Date will receive from the Location Vaccine Authority or designee information concerning:
   a. The potential health consequences of COVID-19 illness for themselves, family members and other contacts, coworkers, patients, and the community;
   b. Occupational exposure to SARS-CoV-2;
   c. The epidemiology and modes of transmission, diagnosis, and non-vaccine infection control strategies (such as the use of appropriate precautions, personal protective equipment or face coverings, and respiratory hygiene/cough etiquette), in accordance with their level of responsibility in preventing COVID-19 infections;
   d. The potential benefits of COVID-19 vaccination; and
   e. The safety profile and risks of any COVID-19 vaccine.

The information may be conveyed through any combination of written information statements, verbal communications, or online or in-person training programs, as required by the Location Vaccine Authority.

This educational requirement is not an alternative to required Participation in the COVID-19 Vaccination Program as a condition of Physical Presence at a University Location or Program as set forth above.

4. **Registration Holds.** Program implementation and enforcement with respect to Students will be handled consistent with the procedural provisions of the Student Immunization Policy. Students who fail to provide proof of vaccination or apply for an Exception or Deferral by the Implementation Date may, therefore, be subject to a registration hold.
5. **Non-Pharmaceutical Interventions.** All Covered Individuals must participate in Non-Pharmaceutical Interventions described in Appendix A: COVID-19 Prevention Strategies, as implemented by the relevant University Location or Program. In the event of a COVID-19 outbreak, Covered Individuals and Covered Non-Affiliates who are not Fully Vaccinated may be excluded from the Location or site of the outbreak.
6. **Optional Additional Measures.** Covered Individuals may wear masks or face coverings even if they are Fully Vaccinated.

B. Covered Non-Affiliates. Each University Location and Program will define any requirements for public or other Covered Non-Affiliate Physical Presence (for example, at health facilities, entertainment venues, museums, libraries, workout facilities, or dining halls or food courts), consistent with applicable public health guidance.

C. Superseding Public Health Directives. A federal, state, or local public health agency with jurisdiction may impose a COVID-19 vaccination requirement that lawfully supersedes this policy. In the event of a perceived conflict between public health requirements and this Policy, UC Legal should be consulted.

D. Tracking and Reporting

1. **Vaccination Data.** The following information must be recorded and tracked by the Location Vaccine Authority or designee in the Covered Individual's confidential health record, consistent with University privacy and security policies including BFB-IS-3 (Electronic Information Security Policy):
   (i) date(s) of administration and vaccine type and manufacturer; or
   (ii) documentation of a University-approved Exception or Deferral.
2. **Vaccines Administered by the University**
   a. *Registries.* For all vaccinations administered by the University in its capacity as healthcare provider, appropriate information will be submitted to the California Immunization Registry (CAIR) or such other registries as may be required by applicable public health agencies or University policy. While vaccine recipients ordinarily are permitted to opt out from registry reporting in California, the California Department of Public Health has mandated that all

participating vaccinators report each dose of COVID-19 vaccine administered. Accordingly, the typical opt-out option does not apply.

b. Adverse Events. Any adverse events associated with COVID-19 vaccine administered at a Location and reported to the University must be tracked and logged by the LVA or designee and reported to federal and state public health officials using the Vaccine Adverse Event Reporting System (VAERS).

E. Program Evaluation. Unless UCOP requires more regular reporting, Individual Healthcare Locations must, and other Locations may, evaluate Program Participation on an annual and ongoing basis, including evaluation of equity in Program implementation; as well as reasons identified for non-Participation or untimely Participation and the number and population-level characteristics of Covered Individuals who are not vaccinated.

IV. COMPLIANCE / RESPONSIBILITIES

A. CDC and FDA generally translate VIS into many languages commonly spoken in California and elsewhere in the United States and post these online. Whenever the University is administering a vaccine in its capacity as healthcare provider, the relevant VIS should be provided to a person receiving vaccine in a language that they understand. In the unlikely event relevant VIS translations are unavailable, they should be accompanied when distributed with a document with taglines such as those approved by the U.S. Department of Health & Human Services to facilitate language access by all affected Personnel, Trainees, and Students. Interpreters should also be made available in person, by video, or by phone during vaccine clinics.

B. Each campus is responsible for: (i) assuring any necessary updates are made to its local Infectious Diseases/Infection Prevention and Control Programs; (ii) establishing deadlines for COVID-19 Vaccination Program Participation on an annual or ongoing basis, in consultation with epidemiology and infection prevention experts and occupational health representatives as applicable and consistent with any supply limitations; and (iii) assuring implementation of the COVID-19 Vaccination Program at all sites.

1. Implementation includes informing Personnel, Trainees, and Students of the requirement and deadline for Program Participation, dates and Locations for on-site administration, and that vaccines will be provided at no cost to them if they wish to receive the vaccine from the University.

2. Each campus should implement strategies for vaccine access, including efforts to ensure vaccination availability during all work shifts and to address vaccine hesitancy, particularly among groups at most significant risk for contracting COVID-19 and suffering severe illness.

C. Chancellors, Laboratory Directors, and the Vice President ANR are responsible for implementing this policy. Deans, Department Chairs, unit heads, managers, supervisors, student affairs leaders, and others with responsibility for personnel

management will support Program implementation and enforcement. Consultation with Academic Senate leaders, especially on the campus, is encouraged with respect to implementation procedures for academic appointees.

V. PROCEDURES

A systemwide implementation working group will develop implementation guidelines for this policy, which will subsequently be attached to the policy. Each Location may establish local procedures consistent with those guidelines to facilitate implementation of the policy.

VI. RELATED INFORMATION

- Advisory Committee on Immunization Practices – *Ethical Principles for Allocating Initial Supplies of COVID-19 Vaccine – United States, 2020 (MMWR Nov. 23, 2020)* and *Meeting Information (November 23 and December 1, 2020)*
- American College Health Association Recommends COVID-19 Vaccination Requirements for All On-Campus College Students in Fall 2021
- American College of Obstetricians and Gynecologists, COVID-19 Vaccination Recommendations for Obstetric-Gynecologic Care (December 2020)
- UC Health Coordinating Committee – Bioethics Working Group Vaccine Allocation Recommendations
- Cal. Health & Safety Code Division 2, Chapter 2, Article 3.5
- California Department of Public Health, Licensees Authorized to Administer Vaccine in California
- Centers for Disease Control and Prevention, COVID-19 Contraindications and Precautions
- Centers for Disease Control and Prevention, COVID-19 Vaccine Training: General Overview of Immunization Best Practices for Healthcare Providers
- FDA COVID-19 Vaccine Information
- FDA AstraZeneca COVID-19 Vaccine (includes fact sheet and translations) [COMING SOON]
- FDA Janssen COVID-19 Vaccine (includes fact sheet and translations)
- FDA Pfizer-BioNTech COVID-19 Vaccine (includes fact sheet and translations)
- FDA Moderna COVID-19 Vaccine (includes fact sheet and translations)
- CDC COVID-19 Vaccination
- CDC COVID Vaccination Program Planning Guidance
- CDC Vaccine Recommendation Process

- American Medical Association, Opinion 8.7, Routine Universal Immunization of Physicians and KB O'Reilly, *Are Physicians Obligated to Get Vaccinated Against COVID-19?* (November 16, 2020)
- Infectious Disease Society of America – COVID-19 Vaccine Information
- Congregation for the Doctrine of the Faith, Note on the Morality of Using Some Anti-COVID-19 Vaccines (December 21, 2020)
- UC Responsible Offices

VII. FREQUENTLY ASKED QUESTIONS

1. *What is the relationship between this policy and the previously posted interim policy?* This policy replaces the previously posted interim policy in its entirety.
2. *The policy both encourages and requires members of the University Community to be vaccinated. Which is it?* The policy strongly *encourages* all members of the University Community to be vaccinated. Only Covered Individuals are *required* to Participate in the Program by becoming Fully Vaccinated or receiving a University-approved Exception or Deferral.
3. *Why is UC allowing exceptions for reasons other than medical exemption? If California can eliminate personal belief and religious exceptions for K-12 students, why can't UC do the same?* The University is required by law to offer reasonable accommodations to individuals who qualify for an Exception to the vaccination requirement based on their disability, as well as to employees who object to vaccination based on their sincerely-held religious belief, practice, or observance. A decision was made to apply the COVID-19 vaccine mandate consistently across all groups of individuals covered by this policy. Vaccination against the virus that causes COVID-19 is a critical step for protecting the health and safety of our communities and ending the pandemic.
4. *Is this a one-time mandate or will I be required to get boosters or annual shots?* This is a permanent policy. Infectious disease experts anticipate that annual or more frequent boosters will be necessary and receipt of boosters will be required, consistent with product labeling, in the same way that the initial vaccination is required by this policy and subject to the same Exceptions and Deferrals.
5. *Am I required to be vaccinated to attend school?* Covered Individuals must receive the COVID-19 vaccine as a condition to Physical Presence at Locations and in University Programs, unless they have been granted an Exception or Deferral.
6. *Will this requirement apply to union-represented employees?* Yes, in accordance with any applicable collective bargaining requirements.
7. *How do I apply for an Exception or Deferral?* Individuals covered by this policy who seek an exception (on medical, disability, or religious grounds) or deferral (during pregnancy) must complete the request form and submit it to their location's Responsible Office. Model forms have been published with this final policy for adaptation or as-is use by each location. Employees should use the forms adopted

by their location. Details will be communicated by each UC Location to Covered Individuals.

8. *I am pregnant. Will I be eligible for a medical exemption?* No, but you are eligible for a Deferral throughout your pregnancy or (if later) when you return to work or instruction, as applicable. You may also be eligible for a disability accommodation. According to the Centers for Disease Control and Prevention (CDC), pregnant people and recently pregnant people are at increased risk for severe illness from COVID-19 when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care, or a ventilator or special equipment to breathe, or illness that results in death. Additionally, pregnant people with COVID-19 are at increased risk of preterm birth and might be at increased risk of other adverse pregnancy outcomes compared with pregnant people without COVID-19. There is currently *no evidence* that any vaccines, including COVID-19 vaccines, cause female or male fertility problems. Accordingly, the University strongly recommends that all Students, Trainees, and Personnel be vaccinated unless they have Contraindications or Precautions. However if you are pregnant, you will be eligible for Deferral through the end of the pregnancy or (if later) when you return to work or instruction, as applicable.
9. *I was recently diagnosed with COVID-19, and/or I had an antibody test that shows that I have natural immunity. Does this support a Medical Exemption?* You may be eligible for a temporary Medical Exemption (and, therefore, a temporary Exception), for up to 90 days after your diagnosis and certain treatments. According to the US Food and Drug Administration, however, "a positive result from an antibody test does not mean you have a specific amount of immunity or protection from SARS-CoV-2 infection … Currently authorized SARS-CoV-2 antibody tests are not validated to evaluate specific immunity or protection from SARS-CoV-2 infection." For this reason, individuals who have been diagnosed with COVID-19 or had an antibody test are not permanently exempt from vaccination.
10. *I am participating or have participated in a vaccine clinical trial for a vaccine that has not been approved, and so I have not received a CDC card. Am I considered to be in compliance with the policy?* The University will accept any FDA- or WHO-authorized vaccine as fulfilling the mandate. If you participated in a trial of a vaccine that has received authorization from *either* body, and you can show that you did not receive the placebo (that is, your record has been "unblinded"), then you will be considered in compliance with the policy. Boosters may later be required as explained above.
11. *How will I know if my co-workers or fellow Students are going unvaccinated?* You probably won't know. Because vaccination-related information is private and confidential, the University will not disclose vaccine status of Covered Individuals except on a need-to-know basis; however third parties and some Locations may distribute badge attachments, stickers, pins, or other indicators that vaccinated individuals may use to show that they have received the vaccine.
12. *I teach both seminar and lecture classes, and as a result am typically exposed to many students. Will I be informed if someone in my class is not vaccinated? If not,*

will all students be required to wear masks? As will be the case in any public setting, you will not be informed of the vaccination status of individual students and should expect that some may not be vaccinated due to pending or granted Exceptions or Deferrals. Guidance on face coverings for individuals who have and have not been Fully Vaccinated is provided in Appendix A: COVID-19 Prevention Strategies.

13. *Will University of California Health specify which authorized or licensed vaccine is preferred?* No. Any COVID-19 vaccine authorized or approved by the U.S. Food and Drug Administration or by the World Health Organization will be accepted to satisfy the vaccination requirement.
14. *Will Locations provide paid time off for non-exempt employees for the time needed to get vaccinated?* Yes. Non-exempt employees and hourly academic appointees may take up to four hours of paid time to obtain each dose of the SARS-CoV-2 (COVID-19) vaccine. These employees and academic appointees must provide advance notice to their supervisor. If an employee or academic appointee needs more time for this purpose before September 30, 2021, the employee or academic appointee may request 2021 Emergency Paid Sick Leave (EPSL) (Reason 3(d)) for the additional time.
15. *What if I experience flu-like symptoms as a result of the vaccine that mean I cannot work as scheduled, or attend classes?* Employees should contact their supervisors or local human resources offices for instruction but as a general matter, accrued sick leave, vacation, and/or PTO may be used to take time off as needed to recover. Before September 30, 2021, employees may also request EPSL (Reason 3(e)) for that purpose. Students should contact their faculty/instructors regarding minor illnesses or disability services to address any significant issues.
16. *If I have applied for or been granted an Exception or Deferral, what Non-Pharmaceutical Interventions (NPIs) will I be required to observe?* See Appendix A: COVID-19 Prevention Strategies, which describes required NPIs. Additional safety measures may be deemed necessary, depending on the circumstances, by local public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. In that case, a person who has received an approved Exception or Deferral (or whose request is pending) will be informed of any additional requirements.
17. *Who will pay for the vaccine?* Initial supplies have been paid for by the federal government. Vaccines administered by the University to consenting Covered Individuals as part of the COVID-19 Vaccination Program (e.g., during vaccine clinics or at employee health or occupational health offices) are administered free of charge. In addition, all of the University's health plans cover CDC-recommended vaccines administered by an employee's primary care physician or at a local pharmacy.
18. *How will enforcement work for failure to participate in the program?* Efforts will be made to encourage Participation in the COVID-19 Vaccination Program prior to the Implementation Date. Those Covered Individuals who fail to Participate by being Vaccinated or requesting an Exception or Deferral on or before the Implementation

Date will be barred from Physical Presence at University Facilities and Programs, and may experience consequences as a result of non-Participation, up to and including dismissal from educational programs or employment.

19. *I am at high risk for severe illness if I contract COVID-19 (e.g., immunocompromised) and even though I have been vaccinated, I know that no vaccine is 100% effective. Do I have to come to work if my co-workers or Students are not all vaccinated? What accommodations will be made for me?* Please contact your local disability services office to discuss your situation and possible accommodations.
20. *Will the University accept internationally approved vaccines even if not authorized or approved in the United States* Yes, if the vaccine is authorized by the World Health Organization (WHO). The WHO has developed a process for assessing and listing unlicensed vaccines, therapeutics, and diagnostics during public health emergencies. Through that process, a number of vaccines not available in the United States have received Emergency Use Listing (EUL). A document summarizing the status of a wide range of international vaccines can be found online on the WHO's website (click on link to status of COVID-19 vaccines in the EUL/PQ evaluation process). The University will, consistent with CDC and CDPH guidance, accept proof of Full Vaccination with any international vaccine that has been authorized for emergency use by WHO through the EUL process. People who have completed a COVID-19 vaccination series with one of these vaccines *do not need* additional doses with an FDA-licensed or -authorized COVID-19 vaccine, at least initially (but may be subject to subsequent booster requirements). Those who are not Fully Vaccinated generally will be required to receive an FDA-licensed or -authorized Vaccine no less than 28 days after their last international vaccination (but may consult with the LVA or designee to discuss eligibility for a temporary Medical Exemption). In the interim, they will be treated as if they are not Fully Vaccinated.
21. *I was vaccinated in another country, where the government increased the time between first and second vaccines to longer than the CDC and FDA advise. Do I have to be revaccinated?* No. If you have proof of completing a series of any FDA-licensed or FDA- or WHO-authorized vaccine consistent with your country's implementation, you will be considered to have been Fully Vaccinated.
22. *I cannot come back to campus 3-4 weeks before school starts, and I can't access any vaccine in my country. Will I be allowed on campus?* Yes. You will be allowed on campus but will be referred to a vaccine site to get vaccinated immediately, unless you qualify for a University-approved Exception or Deferral. Until you are Fully Vaccinated, you will be subject to the NPIs described in Appendix A: COVID-19 Prevention Strategies for unvaccinated individuals. Additional safety measures may be deemed necessary, depending on the circumstances, by local public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority.

VIII. REVISION HISTORY

First Effective Date: December 14, 2020

Amended: January 15, 2021 (extended from UC Health to all University locations)

Amended: July 15, 2021 (extended to Students, effective Fall 2021; and vaccine mandated at that time for all groups subject only to limited Exceptions and Deferrals)

This Policy is formatted to meet Web Content Accessibility Guidelines (WCAG) 2.0.

IX. APPENDICES

A. COVID-19 Prevention Strategies

B. Vaccine Information Statements [COMING SOON]

   a. FDA EUA Fact Sheet for Recipients and Caregivers (AstraZeneca) [COMING SOON]

   b. FDA EUA Fact Sheet for Recipients and Caregivers (Janssen)

   c. FDA EUA Fact Sheet for Recipients and Caregivers (Pfizer-BioNTech)

   d. FDA EUA Fact Sheet for Recipients and Caregivers (Moderna)

C. COVID-19 Vaccination Program: Responsible Offices.

D. Exceptions and Deferrals

   a. Medical Exemption and/or Disability Exception Request Form

   b. Religious Exception Request Form

   c. Deferral Request Form

   d. Approval of Request for Exception or Deferral Form

   e. Denial of Request for Exception or Deferral Form

Note: The model forms are provided for convenience only and may be adapted by locations consistent with applicable policies and practices.

E. Implementation Guidelines: Exceptions and Deferrals

F. Implementation Guidelines: Employee Compliance

   Compliance Flowchart

UNIVERSITY OF CALIFORNIA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

EMPLOYEE OR STUDENT NAME	EMPLOYEE OR STUDENT ID
JOB TITLE (IF APPLICABLE)	LOCATION
DEPARTMENT	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

This form should be used by University employees and students to request an Exception to the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers; (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or (c) Disability.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution. Fill out Part B to request a Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days. Fill out Part C to request an Exception based on Disability. More than one section may be completed if applicable. Important: Do not identify any diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B). That information is not required to process your request.

Part A: Request for Medical Exemption Due to Contraindication or Precaution

☐ The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

Part B: Request for Medical Exemption Due to COVID-19 Diagnosis or Treatment

☐ I have been diagnosed with or treated for COVID-19 within the last 90 days. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

UNIVERSITY OF CALIFORNIA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

Part C: Request for Exception Based on Disability

☐ I have a Disability and am requesting an Exception to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

Please provide any additional information that you think may be helpful in processing your request. ***Again, do not identify your diagnosis, disability, or other medical information.***

While my request is pending, I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: _____ Date: _____

Date Received by University: _____ By: _____

UNIVERSITY OF CALIFORNIA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

CERTIFICATION FROM HEALTH CARE PROVIDER

The University of California requires that its employees and students be vaccinated against COVID-19 infection as a condition of accessing any University location, facility, or program in person. The University may grant Exceptions to this requirement based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers; (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or (c) Disability, provided that the individual's request for such an Exception is supported by a certification from their qualified licensed health care provider.

HEALTH CARE PROVIDER NAME	LICENSE TYPE, # AND ISSUING STATE
FULL NAME OF PATIENT	DATE OF BIRTH OF PATIENT
PATIENT'S EMPLOYEE/STUDENT/TRAINEE ID NUMBER	HEALTH CARE PROVIDER PHONE/EMAIL
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all University employees:

> *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Please complete Part A of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient. Please complete Part B if this patient has been diagnosed with or treated for COVID-19 within the last 90 days. Please complete Part C if this patient has a Disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. More than one section may be completed if applicable to this patient. Important: Do not identify the patient's diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B) as this document will be returned to the University.

UNIVERSITY OF CALIFORNIA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using *any* of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are:
☐ Permanent ☐ Temporary.

If temporary, the expected end date is: .

Part B: COVID-19 Diagnosis or Treatment Within Last 90 Days

☐ I certify that my patient has been diagnosed with or treated for COVID-19 within the last 90 days.

☐ My patient's COVID-19 diagnosis or last day of treatment (whichever is later) was on .

☐ My patient is being actively treated for COVID-19. The expected end date of treatment is: .

Part C: Disability That Makes COVID-19 Vaccination Inadvisable

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

☐ I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion. The patient's disability is: ☐ Permanent ☐ Temporary.

If temporary, the expected end date is: .

Signature of Health Care Provider

Date

UNIVERSITY OF CALIFORNIA
RELIGIOUS EXCEPTION REQUEST FORM
Accommodation to SARS-CoV-2 (COVID-19) Vaccination Requirement

EMPLOYEE OR STUDENT NAME	EMPLOYEE OR STUDENT ID
JOB TITLE (IF APPLICABLE)	LOCATION
DEPARTMENT (IF APPLICABLE)	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

Based on my sincerely held religious belief, practice, or observance, I am requesting an Exception to the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy as a religious accommodation.

Please identify your sincerely held religious belief, practice, or observance that is the basis for your request for an Exception as a religious accommodation.

Please briefly explain how your sincerely held religious belief, practice, or observance conflicts with the University's COVID-19 vaccination requirement.

Please provide any additional information that you think may be helpful in processing your religious accommodation request.

While my request is pending, I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: _____ Date: _____

Date Received by University: _____ By: _____

UNIVERSITY OF CALIFORNIA
DEFERRAL REQUEST FORM
Deferral of SARS-CoV-2 (COVID-19) Vaccination Requirement

EMPLOYEE/STUDENT NAME	EMPLOYEE/STUDENT ID
JOB TITLE (IF APPLICABLE)	LOCATION
DEPARTMENT (IF APPLICABLE)	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

This form should be used by University employees and students to request a Deferral of the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy during pregnancy.

☐ I am currently pregnant and am requesting a Deferral of the COVID-19 vaccination requirement during my pregnancy. My anticipated due date is: .

While my request is pending, I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: _____ Date: _____

Date Received by University: _____ By: _____

UNIVERSITY OF CALIFORNIA
APPROVAL OF REQUEST FOR EXCEPTION OR DEFERRAL
SARS-CoV-2 (COVID-19) Vaccination Requirement

TO:	EMPLOYEE/STUDENT NAME	EMPLOYEE/STUDENT ID
FROM:	ISSUING OFFICE	ISSUING OFFICE PHONE/EMAIL
	ISSUING AUTHORITY NAME	ISSUING AUTHORITY TITLE
CC:	LOCATION VACCINE AUTHORITY NAME/EMAIL	

On , we received your request for the following in connection with the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy:

- ☐ Exception based on Medical Exemption
- ☐ Exception based on Disability
- ☐ Exception based on Religious Objection
- ☐ Deferral based on pregnancy

For Exceptions: Based on the information you have provided, your request for Exception has been **APPROVED** subject to the requirement that you comply with the Non-Pharmaceutical Interventions specified below. This approval is valid ☐ until ☐ indefinitely. If your approval has an end date and you no longer need an Exception or Deferral at that time, you will have until (eight [8] weeks after the end date) to become Fully Vaccinated and submit proof of vaccination.

For Deferrals: Based on the information you have provided, your request for Deferral has been **APPROVED** subject to the requirement that you comply with the Non-Pharmaceutical Interventions specified below. This approval is valid until you return to work or instruction, as applicable. If you no longer need an Exception or Deferral at that time, you must become Fully Vaccinated and submit proof of vaccination within eight (8) weeks of your return.

You must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of your Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by your Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. You must also comply with the following Non-Pharmaceutical Interventions applicable to your position (if any):

If you have any questions or concerns regarding the above, please contact: .

BY SIGNING BELOW, YOU CERTIFY THAT YOU HAVE BEEN INFORMED OF THE RISKS OF COVID-19 INFECTION, INCLUDING LONG-TERM DISABILITY AND DEATH, BOTH FOR YOU AND FOR OTHERS WHO YOU MAY EXPOSE TO THE DISEASE.

Approved by: _____ Date: _____
(Signature of Issuer)

Accepted: _____ Date: _____
(Signature of Employee/Student)

UNIVERSITY OF CALIFORNIA
DENIAL OF REQUEST FOR EXCEPTION OR DEFERRAL
SARS-CoV-2 (COVID-19) Vaccination Requirement

TO:	EMPLOYEE/STUDENT NAME/EMAIL	EMPLOYEE/STUDENT ID
FROM:	ISSUING OFFICE	ISSUING OFFICE PHONE/EMAIL
	ISSUING AUTHORITY NAME	ISSUING AUTHORITY TITLE
CC:	LOCATION VACCINE AUTHORITY NAME/EMAIL	

On , we received your request for the following in connection with the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy:

- ☐ Exception based on Medical Exemption
- ☐ Exception based on Disability
- ☐ Exception based on Religious Objection
- ☐ Deferral based on pregnancy

Your request has been **DENIED** based on the information we have received to date.

The reason for the denial is the following:

- ☐ You do not qualify for the Exception/Deferral that you requested.
- ☐ Your request is incomplete. We have requested the following additional information from you but have not received it.

- ☐ You are not a Covered Individual as defined by the SARS-CoV-2 Vaccination Program Policy. This means that you are not required to be vaccinated against COVID-19 at this time, so you do not need an Exception or Deferral to the University's COVID-19 vaccination requirement. If you later become a Covered Individual and wish to request an Exception or Deferral at that time, you will need to submit a new request. (Note: The deadlines referenced below do not apply to you.)

Because your request for an Exception/Deferral has been denied, **you have until (14 calendar days from the denial date below) to submit proof that you have received your first dose of a COVID-19 vaccine. That proof must include the date that you received it. You then have until (eight [8] weeks from the denial date below) to submit proof that you are Fully Vaccinated**. If either of the dates above falls on a weekend or University holiday, the deadline for providing the required proof is the next business day that is not a University holiday.

Until you are Fully Vaccinated, you must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of your Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by your Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. You must also comply with the following Non-Pharmaceutical Interventions applicable to your position (if any):

If you have any questions regarding the above, please contact:

Denied by: _____ Date: _____
(Signature of Issuer)

Appendices E, F: Implementation Guidelines

These Guidelines are provided to aid those charged with evaluating, processing, and resolving Personnel requests for Exception and/or Deferral to the University of California Policy: SARS-CoV-2 (COVID-19) Vaccination Program ("Program") and also provide information regarding compliance with the Program.

APPENDIX E: EXCEPTIONS AND DEFERRALS

These Guidelines apply to Covered Individuals who physically access a University Location/Facility or University Program in connection with their employment or appointment and who have requested an Exception to the COVID-19 vaccination requirement based on Medical Exemption, Disability, and/or Religious Objection or who have requested a Deferral of that requirement based on pregnancy.

I. DEFINITIONS

All terms in the "Definitions" section of the Program apply to these Guidelines.

Additional Term:

Decision: The determination of the approval or denial of an Exception or Deferral request.

II. ADMINISTRATION OF REQUESTS

A. Establishment of a Responsible Office

1. Locations should designate a particular office(s) and/or individual(s) to field Exception or Deferral requests and make this Responsible Office known to Personnel.
2. This Office might be different for each type of Exception or Deferral allowed under the Program – e.g. Medical Exemption or Disability Exception requests may be processed by a different Office from the Religious Objection Exception requests.
3. Locations can opt to utilize Third Party Administrator (TPA) Sedgwick to support the administration and review of Medical Exemptions, Disability Exceptions, Religious Objection Exceptions, and/or Deferrals due to pregnancy. If utilizing this option, the Location must still designate a Responsible Office to manage the coordination with Sedgwick.

B. Documentation of the Request

1. The Responsible Office is responsible for reporting all Exception and Deferral requests, approvals, and denials to the Local Vaccine Authority (LVA) at the Location.
2. The Responsible Office should make Exception and Deferral Request Forms

(see Program, Appendix D) publicly available to Personnel and available upon request. Locations utilizing the TPA should provide full name and email address (individually or in a flat list format such as an Excel table) to the TPA; Sedgwick will then reply with the applicable Exception or Deferral Request Form.

3. Either the Responsible Office or TPA should evaluate the Exception or Deferral request using the standardized criteria.
4. The Responsible Office should use the Approval or Denial Form to record the Decision.
5. The Responsible Office will exercise best practice information security procedures and comply with BFB-IS-3 (Electronic Information Security Policy) as well as BFB-RMP-1 (the University Records Management Program) when storing Program records (e.g., Exception and Deferral request forms, approval forms, denial forms, related communications) and when notifying the LVA regarding pending requests for Exceptions/Deferrals and Exception/Deferral Decisions. Program records should be kept confidential and only accessed for Program-related purposes. Program records should not be stored in an employee's personnel file.

C. Standardized Communications and Process

1. All forms and notifications should follow standard templates. Location-specific forms may include consistently communicated modifications such as campus-specific non-pharmaceutical intervention (NPI) requirements, Responsible Office contact information, etc.
2. Communications and forms regarding Exceptions and Deferrals (including request forms, notifications such as a notice of pending request, notice of approval, and notice of denial) should be standardized as much as possible regardless of medium (e.g., digital/e-mail vs. hard-copy) or the office sending the communication (e.g., local Responsible Office or Sedgwick).
3. Communications should be made in a timely fashion, both acknowledging receipt of the request and communicating the subsequent Decision.

D. Pending and Granted Exceptions and Deferrals Require Employee Use of NPI

All forms and references to Exception and Deferral requests should clearly state that, as a condition of Physical Presence, employees are required to comply with the Location's NPI requirements (e.g., face coverings, regular asymptomatic testing) while an Exception or Deferral request is pending or after such requests have been approved. NPI requirements may be amended and communicated to employees subsequently, such as if public health conditions prompt revisions to NPI requirements. See Appendix D of the Program for recommended model form language.

III. DECISION PROCESS

A. The Responsible Office will evaluate all Exception and Deferral requests consistently in both the application of the Guidelines and treatment of similarly situated Personnel throughout the University.

B. The Responsible Office will utilize system-wide training for individuals charged with evaluating Exception or Deferral requests. The Responsible Office will stay up to date on training, which may be amended as new information or changes to conditions (i.e., Public Health) may require.

C. The Responsible Office will contact Personnel in a timely fashion in the event that an incomplete form is submitted or more information is needed in order to evaluate the request.

IV. APPENDIX E REVISION HISTORY

First Effective Date: July 20, 2021

Amended Effective Date: August 11, 2021

APPENDIX F: EMPLOYEE COMPLIANCE

I. SUMMARY

The purpose of the Program is to facilitate the protection of the health and safety of the University community. The Program requires employees to be Fully Vaccinated against COVID-19 before physically accessing the University's Locations/Facilities or University Programs, subject to specified Exceptions and Deferrals.

These Guidelines provide information regarding compliance with the Program by University of California policy-covered staff and Academic Personnel Manual (APM)-covered academic appointees. The University desires a consistent approach for all employee populations, including represented employees, subject to its collective bargaining obligations and applicable collective bargaining agreements.

II. EMPLOYEE REQUIREMENTS BY IMPLEMENTATION DATE

The COVID-19 vaccination requirement applies to UC employees who physically access the University's Locations/Facilities or University Programs in connection with their employment or appointment. As a condition of Physical Presence at a University Location/Facility or in a University Program, all of these UC employees must provide proof of Full Vaccination or submit a request for an Exception or Deferral no later than the applicable implementation date.

III. TIMELINE

The path to full compliance for each employee, including the notices provided, may differ depending upon the date that the employee complies with each compliance step or submits a Request for Exception/Deferral.

IV. REQUEST FOR EXCEPTION/DEFERRAL

An employee seeking an Exception or Deferral must, no later than the applicable implementation date, submit their request to the Responsible Office described in Section II.A of Appendix E. While a request is pending, the employee must, as a condition of Physical Presence, comply with non-pharmaceutical interventions (NPIs) defined by the Location.

A. Request Approved

If an Exception or Deferral is granted, the issuing office must notify the employee and the Location Vaccine Authority of the approval and the associated expiration date, if any. The employee must, as a condition of Physical Presence, comply with NPIs defined by the Location.

B. Request Denied

If an employee has submitted a single request for an Exception or Deferral that has been denied, or requests on more than one ground that have all been fully

considered and denied, the employee ("Non-Excepted Employee" hereafter) will receive a Denial of Request for Exception or Deferral.

1. Employee Chooses to Become Fully Vaccinated

If the Non-Excepted Employee chooses to become Fully Vaccinated, they must provide proof that they have received their first shot within 14 calendar days of the date of denial. This proof must include the date of the first shot.

Until the Non-Excepted Employee is Fully Vaccinated, they must, as a condition of Physical Presence, comply with NPIs defined by the Location.

If the Non-Excepted Employee receives the Johnson & Johnson vaccine, they will be considered Fully Vaccinated two weeks after the date of the first shot. If they receive the Moderna or Pfizer vaccine, they will be considered Fully Vaccinated two weeks after the date of the second shot. Proof of Full Vaccination must be provided no later than eight weeks from the date of the denial.

2. Employee Chooses Not to Start the Vaccination Process

If the Non-Excepted Employee chooses not to receive their first shot within 14 calendar days of the date of denial, the applicable process begins at Section V.A.

V. EMPLOYEE NON-COMPLIANCE

A. First Notice of Non-Compliance (All Employees)

UC employees subject to the COVID-19 vaccination requirement who fail to provide proof of Full Vaccination and who have not requested an Exception or Deferral by the applicable implementation date (or Non-Excepted Employees, who fail to provide proof that they have received their first shot within the 14 calendar days as described in Section IV.B.2) will receive a First Notice of Non-Compliance.

B. Three-Day Period Following First Notice of Non-Compliance (All Employees)

Once an employee has received a First Notice of Non-Compliance, they will have three business days to provide proof of Full Vaccination or to make a request for an Exception or Deferral (or, in the case of a Non-Excepted Employee, to provide proof that they have received their first shot or, if applicable, to make a new request). During these three business days, the employee must, as a condition of Physical Presence, comply with NPIs defined by the Location.

If an employee has not responded within three business days and is a non-Excepted Employee, the applicable process continues below at Section V.D; for other employees, the applicable process continues below at Section V.C.

C. Second Notice of Non-Compliance (Employees Other Than Non-Excepted Employees)

If, after receipt of the First Notice of Non-Compliance, the employee does not submit proof of Full Vaccination or make a request for an Exception or Deferral within three business days, they will receive a Second Notice of Non-Compliance that requires them to submit proof that they have received their first shot within 14 calendar days of the date of the Second Notice of Non-Compliance. This proof must include the date of the first shot.

As described in Section V.B, until the employee is Fully Vaccinated, the employee must, as a condition of Physical Presence, comply with NPIs defined by the Location.

If the employee receives the Johnson & Johnson vaccine, the employee will be considered Fully Vaccinated two weeks after the date of the first shot. If the employee receives the Moderna or Pfizer vaccine, the employee will be considered Fully Vaccinated two weeks after the date of the second shot.

Proof of Full Vaccination must be provided no later than eight weeks from the date of the Second Notice of Non-Compliance.

D. Notice of Continued Non-Compliance

If an employee fails to submit proof of Full Vaccination or make a request for an Exception or Deferral within the period prescribed in the Second Notice (or the First Notice, if a Non-Excepted Employee), the employee will receive a Notice of Continued Non-Compliance stating that the Department will commence a period of progressive corrective action/discipline against the employee.

During the corrective action/discipline period, the employee will be permitted Physical Presence for up to six weeks (at the Location's discretion) and must, as a condition of Physical Presence, comply with NPIs defined by the Location.

The Chancellor or designee may choose to briefly extend the six-week period of Physical Presence for exceptional circumstances, including but not limited to:

- Providing for a non-compliant instructor to continue teaching or mentorship in the best interest of student learning;
- Providing for a non-compliant employee to continue work in order to avoid potential negative impacts on critical University operations due to unanticipated business requirements; or
- For other urgent requirements.

Any corrective action/discipline taken as a result of employee non-compliance will be consistent with the policies or collective bargaining provisions applicable to the specific employee population.

E. Corrective Action/Discipline

1. Policy-Covered Staff

For regular status employees in the Professional & Support Staff (PSS) personnel group, corrective action/discipline is taken in accordance with PPSM 62 (Corrective Action).

For career employees in the Managers & Senior Professionals (MSP) personnel group refer to PPSM 64 (Termination and Job Abandonment). For Senior Management Group (SMG) employees refer to PPSM II-64 (Termination of Appointment).

For employees in the PSS or MSP personnel groups who are not regular status or career, refer to the specific appointment type in PPSM 3 (Types of Appointment).

2. Policy-Covered Academic Appointees

For all faculty, the University policy on faculty conduct is set forth in APM – 015 (The Faculty Code of Conduct). For Senate Faculty, the administration of discipline is set forth in APM – 016 (University Policy on Faculty Conduct and the Administration of Discipline). In cases of disciplinary action commenced by the administration against a member of the Academic Senate, or against other faculty members in cases where the right to a hearing before a Senate committee is given by Section 103.9 or 103.10 of the Standing Orders of The Regents, proceedings shall be conducted before a Divisional Committee on Privilege and Tenure according to Senate Bylaw 336 Privilege and Tenure: Divisional Committees -- Disciplinary Cases.

For all other academic appointees, corrective action is taken in accordance with APM – 150 Corrective Action and Dismissal.

3. Represented Employees

Corrective action/discipline for represented employees is described in the employee's applicable collective bargaining agreement.

VI. APPENDIX F REVISION HISTORY

First Effective Date: July 20, 2021

Amended Effective Date: August 11, 2021 (added timeline; updated language in sections IV.B, V.A and V.B for clarity; added two additional examples in section V.D; and clarified corrective action/discipline for policy-covered staff)

UC COVID Vaccination Policy Compliance

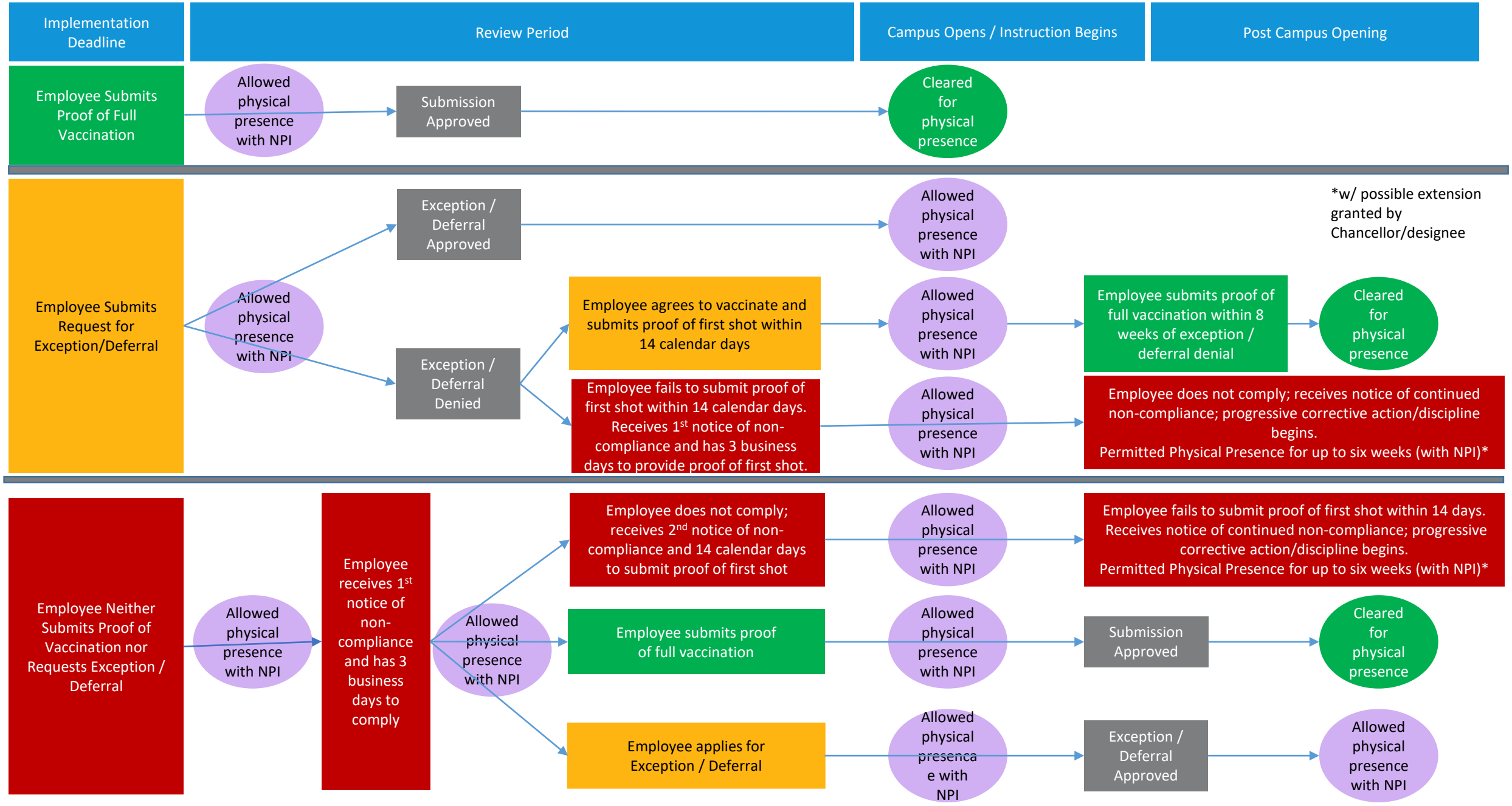


EXHIBIT 55

COVID-19 Vaccination Requirement for K–12 School Employees: Frequently Asked Questions

Background

On August 18, 2021, Governor Inslee announced a directive (Proclamation 21-14.1) requiring all employees working for public and private K–12 schools to be fully vaccinated against COVID-19 or obtain a religious or medical exemption by October 18, 2021.

Who does the order apply to?

The order applies to all employees and contractors working for public K–12 school districts, charter schools, and educational service districts as well as private K–12 schools. In some cases, the order also applies to school board directors, volunteers, and subcontractors. More information is included below. The order does not apply to state-tribal education compact schools or to students.

Will students be required to be vaccinated against COVID-19 to attend school?

No. At this time, students who are eligible to receive the COVID-19 vaccine are not required to be vaccinated to attend school in-person. The State Board of Health has a formal process for setting the immunization requirements for K–12 students in Washington state.

Why was this decision made?

On August 12, 2021, State Superintendent Chris Reykdal sent a letter to Governor Inslee recommending that he issue a COVID-19 vaccine requirement for Washington's K–12 employees, and the Governor took action on that recommendation on August 18, 2021.

The Superintendent recommended this course of action to protect the health and safety of our students, school employees, and families as school buildings reopen for full-time in-person learning this fall. A safer school environment without virus spread provides for a continuity of learning for students and minimizing disruptions due to quarantine or school building closures. With the rapid increase in cases across the U.S. due to the highly contagious Delta variant, those goals are at risk if we don't use multiple layered protective strategies including masks and vaccines (the two most effective strategies).

Are cases really increasing enough to warrant this requirement?

Yes. Between June and July of 2021, the children in our state experienced a 65–80% increase in cases of COVID-19. The increase was highest for those who aren't yet eligible to receive the vaccine (ages 4–10) at 79%; followed by a 66% increase for ages 15–19 and a 59% increase for

children ages 11–14. Especially when so many students aren't yet eligible to receive the vaccine – and the protection against the virus that comes along with it – our education staff must join together to create as strong of a protective barrier as we can.

Can a school district opt out of this requirement?

No. Requirements issued via executive action by the Governor hold the power of law, and school districts must follow the law.

How many employees are working in our state's schools?

Washington state school districts and private schools employ over 160,000 employees.

Applicable Employees, Volunteers, Contractors, etc.

Are school board directors included in this requirement?

In some cases, yes. School board directors who currently or wish to continue to receive a stipend from the district are required to follow the requirements of the order. They should follow the same process for providing proof of vaccination or obtaining an exemption as other district employees. The order does not apply to school board directors who do not receive a stipend from the district.

Are those working for online learning programs included in this requirement?

It depends. The order applies to employees working for a school district in an online learning program. The order does not apply to employees working in an online learning program under contract with a school district unless those employees are likely to engage in work near others while physically present at a school building or other site for longer periods of time.

Are substitute teachers included in this requirement?

Yes. Substitute teachers will need to provide proof of vaccination or obtain a medical or religious exemption by October 18, 2021 to each school district they work for, following the same process as the other employees in the district.

What types of contractors are included in this requirement?

All employees under contract with a school district, private school, charter school, or educational service district and work in-person with others are included in this requirement. The order does not apply to contractors and subcontractors who are only physically present for short periods of time and any moments of close physical proximity to others on-site is fleeting.

What types of volunteers are included in this requirement?

Volunteers included in this requirement include those who engage or are reasonably likely to engage in work near others while physically present at a school building or other district-facilitated site for longer periods of time. The requirement does not apply to volunteers who are

only physically present for short periods of time and any moments of close physical proximity to others on-site is fleeting.

Are visitors included in this requirement?

No. Visitors to a school building, including but not limited to family members and vendors delivering supplies or mail, are not required to be vaccinated against COVID-19. However, visitors do need to follow all other applicable health and safety requirements (e.g., face coverings).

Does this requirement apply to organizations who use district facilities for events outside of school hours?

No. The Governor's order only applies to employees and contractors of the school district, private school, charter school, or educational service district.

Proving Vaccination Status & Storing Information

How can employees provide proof of vaccination?

Employees must provide proof of vaccination by showing their vaccine card, certificate of COVID-19 vaccination, or Washington State Immunization Information System printout. See the Visual Guide to Official Washington State Proof of COVID-19 Vaccination to see what each kind of documentation looks like. Employees should follow the process identified by the district for providing proof of vaccination.

Should the school district retain copies of employees' proof of vaccination?

Each school district will need to decide if it is advisable to retain a copy of an employee's vaccination records based on its business needs. Districts should consider the legal risks associated with retaining such records, as opposed to simply documenting that an employee has shown proof to an appropriate official assigned by the district.

Can employees prove their vaccination status through an attestation?

No. Employees must provide proof by showing one of the documents listed in the Visual Guide to Official Washington State Proof of COVID-19 Vaccination.

Is the district responsible for verifying the vaccination of or providing medical or religious exemptions to contractors and subcontractors?

Not necessarily. A district may choose to verify the vaccination status or grant medical or religious exemptions to contractors and subcontractors themselves, or they may elect to require the employers of contractors to assume these responsibilities. If a district elects to require the employers of contractors to assume these responsibilities, the employer must follow all of the requirements of the Governor's order and provide proof of vaccination or exemptions to the

school district at any time should the district make the request. See subsection 4 of the proclamation for more information.

Will school districts be required to report vaccination and exemption information to the state?

Yes, at a high level. Districts will be required to report to OSPI the number and percentage of their employees who are fully vaccinated or have obtained an approved medical or religious exemption. Districts will not be asked to report any personally identifiable information to the state related to this requirement. OSPI will share more information about how to report this information.

Will vaccination or exemption information be protected?

Yes. School districts have protocols in place for safeguarding confidential medical information. Vaccination or exemption information will meet these requirements.

What if an unvaccinated employee contracts COVID-19 and is recommended to wait 90 days before receiving the COVID-19 vaccine, which would make them miss the October 18 deadline?

If an employee is advised by their medical provider that they should not get the vaccine within a particular timeframe and following that recommendation would cause the employee to miss the October 18, 2021 deadline, the employee must seek an accommodation or would be separated from employment after the deadline. However, they would need to become fully vaccinated as soon as the waiting period ends.

Can employers ask job applicants about their vaccination status?

Yes. It is not a disability-related inquiry under the Americans with Disabilities Act (ADA) to ask an applicant if they have been vaccinated. However, follow-up questions about why a person is not vaccinated should not occur until after a job offer is made since such questions may reveal a disability. See more guidance from the U.S. Equal Employment Opportunity Commission. OSPI recommends districts update their existing and upcoming job postings and offer letters, notify active applicants for open positions about the new requirement, and put a plan in place for verify the vaccination status of new employees.

Exemptions and Accommodations

Who is responsible for reviewing and approving requests for medical or religious accommodations?

At a school district, the Human Resources department should be responsible for reviewing, approving, and communicating approval of medical and religious accommodation requests. The

department should follow a standard process for every request, and should examine each request on its own by analyzing the specific facts surrounding the request.

What qualifies as a "sincerely held religious belief" that may prevent an employee from being vaccinated against COVID-19?

Under federal and state law, "religion" is broadly defined. It includes traditional, organized religions such as Christianity, Judaism, Islam, Hinduism, and Buddhism. The law includes religious beliefs that are new, uncommon, not part of a formal church or sect, individualistic, or only held by a small number of people. Moral or ethical beliefs about what is right and wrong, which are sincerely held with the strength of traditional religious views, may meet the definition of a sincerely held religious belief. However, social, political, or economic philosophies, or personal preferences, are not "religious" beliefs under the law. Please see the Guidance for School Districts on Evaluating Religious Accommodation Requests for more information.

How can employees request a religious exemption?

To request a religious accommodation/exemption, employees must complete the form provided by their school district and/or actively participate in the interactive accommodation process with a Human Resources representative. The Governor's order requires employees seeking a religious exemption to explain the way in which the requirements of the order conflict with their sincerely held religious belief, practice, or observance. Employees should contact their employer to ensure they are utilizing the correct form and process.

Can a district request proof of an employee's religious affiliation?

According to the U.S. Equal Opportunity Employment Commission (EEOC), employers should ordinarily assume that an employee's request for religious accommodation is based on a sincerely held religious belief. If an employer has an objective basis for questioning either the religious nature or the sincerity of a particular belief, observance, or practice, the employer would be justified in seeking additional supporting information. Please see the Guidance for School Districts on Evaluating Religious Accommodation Requests for more information.

Can a district deny an employee's request for a religious accommodation?

Yes. Districts should follow the Guidance for School Districts on Evaluating Religious Accommodation Requests and seek legal advice for assistance.

How can employees request a medical exemption?

Employees should request a medical exemption by following their district's standard medical accommodation process unless the district states otherwise. OSPI is working to develop a template medical accommodation form districts may use.

What kinds of reasonable accommodations could a school district provide an employee who has obtained a religious or medical exemption?

School districts must determine the appropriate reasonable accommodation based on the specific facts surrounding a particular request. Some example accommodations a district may choose to provide to employees with a medical or religious accommodation could include but are not limited to: (1) regular testing for COVID-19; (2) mandatory face coverings, even in the absence of a state or local mandate; or (3) increased distance between workspaces and individuals. Please see the Guidance for School Districts on Evaluating Religious Accommodation Requests for more information.

Can school districts use federal emergency relief funds to cover the costs of accommodations?

Yes. Federal Elementary and Secondary School Emergency Relief (ESSER) funds have a wide range of allowable uses related to supporting students, schools, school staff, and families through the COVID-19 pandemic. School districts may use ESSER funds to cover the costs of medical or religious accommodations related to the vaccine requirement.

For Employees

When do I need to receive my vaccination to be in compliance with the order?

All school employees must be fully vaccinated by October 18, 2021. Individuals are considered fully vaccinated once it has been 14 days since their last dose of Pfizer or Moderna or 14 days since their only dose of Johnson & Johnson. Below is a table with deadlines by which employees must receive their vaccine to be in compliant by October 18, 2021.

Vaccine	Series Dose Requirement	First Dose no Later Than	Second Dose	Completed Series	Fully Vaccinated
Pfizer	2 doses, 21 days apart	09/13/21	10/04/21	10/04/21	10/18/21
Moderna	2 doses, 28 days apart	09/06/21	10/04/21	10/04/21	10/18/21
Johnson & Johnson	Single dose	10/04/21	N/A	10/04/21	10/18/21

Can I go back to work this fall before I am vaccinated?

Yes. If you are not fully vaccinated, you may continue working as you take the time to get fully vaccinated or request a medical or religious exemption. You must be fully vaccinated or obtain an exemption by October 18, 2021 as a condition of continued employment.

What happens if I refuse to get vaccinated?

All employees must be fully vaccinated or have obtained a medical or religious exemption by October 18, 2021 as a qualification of fitness for continued employment. Employees who do not provide proof of vaccination or a medical or religious exemption will be subject to non-disciplinary dismissal from employment for failing to meet the qualifications of the job. There may be continued or additional safety requirements for employees who are granted exemptions.

Are my only options to get vaccinated or lose my job?

No. The Governor's order allows staff to obtain a medical or religious exemption if necessary.

How can I request a medical or religious exemption?

Employees should contact their Human Resources office to learn their district's process, and supporting documents, for requesting a medical or religious exemption.

Will I have any recourse to losing employment?

Any post dismissal dispute over a dismissal action would follow any applicable collective bargaining agreement and/or district policy and procedure.

If I have already been infected with COVID-19 and have natural immunity, do I need to be vaccinated?

Yes. So far, data show it is uncommon to be reinfected with COVID-19 the 90 days after someone was infected, but we don't know how long that "natural immunity" lasts as people can get COVID-19 more than once. In addition, the risks of infection outweigh the risks of immunization. The COVID-19 vaccines offer better protection than "natural immunity" alone and help prevent reinfections. That is why the Advisory Committee on Immunization Practices recommends anyone who previously had COVID-19 get the vaccine.

More Information

As COVID-19 vaccine boosters become available, will school employees be required to get the booster and provide proof to the district?

At this time, boosters are not included in the Governor's order. The only requirement now is for school employees to receive their first and second dose of Pfizer or Moderna, or their only dose of Johnson & Johnson, by October 4, 2021 to be fully vaccinated by October 18, 2021.

Is the vaccine safe?

Yes. COVID-19 vaccines were evaluated in tens of thousands of participants in clinical trials and millions of people in the U.S. have received COVID-19 vaccines under the most intense safety monitoring in U.S. history. More information about the safety of the COVID-19 vaccines is available from the U.S. Centers for Disease Control and Prevention.

Why isn't there an option for unvaccinated employees to undergo regular testing for COVID-19 instead of receiving the vaccine?

Testing is an important mitigation strategy that many school districts are continuing to utilize in partnership with the Department of Health and Health Commons through the *Learn to Return* program. However, testing regimes don't have the same efficacy as widespread vaccination or masking, and will not be a substitute for receiving the vaccine or obtaining an exemption, per the Governor's order.

On what legal grounds can the Governor issue this requirement?

In response to the emerging COVID-19 threat, the Governor declared a state of emergency on February 29, 2020, using his broad authority under Revised Code of Washington (RCW) 43.06. More specifically, under RCW 43.06.220, after a state of emergency has been declared, the Governor may suspend statutes and prohibit any activity that he believes should be prohibited to preserve and maintain life, health, property, or the public peace. Under an emergency such as this, the Governor's paramount duty is to focus on the health and safety of our communities.

Will districts need to delay starting full-time in-person school until all employees are vaccinated?

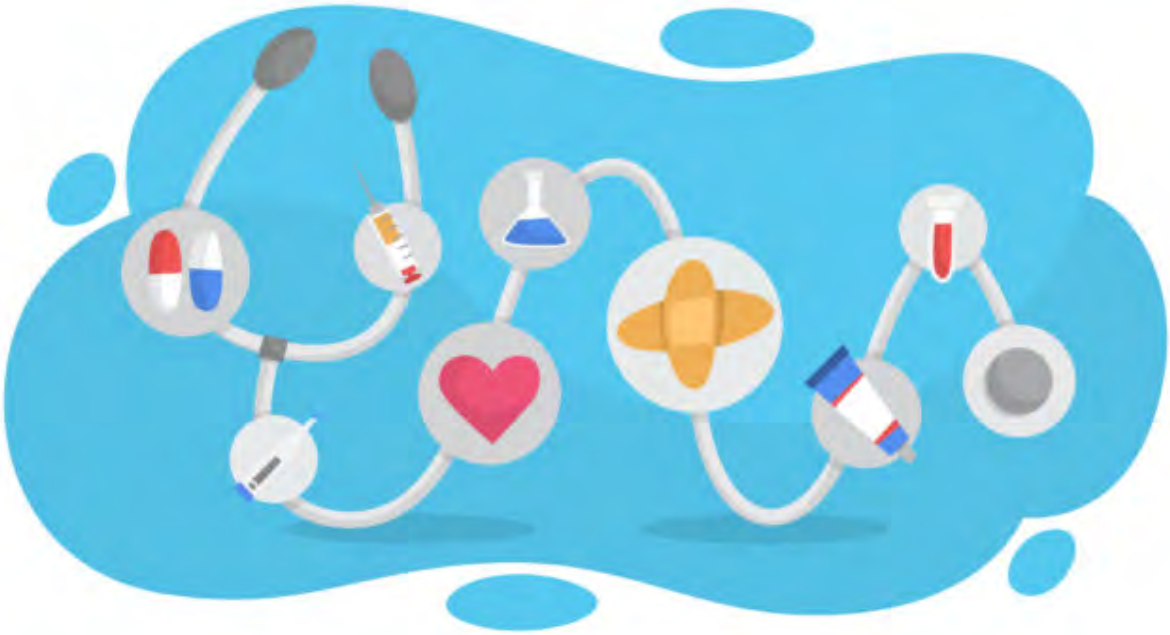
No. School districts should proceed with reopening their school buildings for full-time in-person school regardless of whether their staff are fully vaccinated.

EXHIBIT 56

State-by-state look at colleges requiring COVID-19 vaccines

The complete list of higher education institutions mandating vaccination for the fall 2021-22 semester.

By: Chris Burt | August 27, 2021



Artinspiring/Adobe

These are the colleges and universities requiring COVID-19 vaccinations in some form for the start of the 2021-22 academic year. Some are mandating that faculty and students be vaccinated as well, while some are only requiring that students living on campus receive vaccines.

More from UB: State-by-state college mask mandates

Almost all of those listed below are accepting religious and medical exemptions.

(This list is updated as of 11 a.m. EST on Aug. 28)

CALIFORNIA: Allen Hancock College, American Jewish University, American River College, Berkeley City College, Cabrillo College, California College of the Arts, California Institute of Integral Studies, California Institute of Technology, California Jazz Conservatory, California Lutheran University, California State University (Bakersfield, Channel Islands, Chico, Dominguez, East Bay, Fresno, Fullerton, Long Beach, Los Angeles, Maritime Academy, Monterey Bay, Northridge, Polytechnic University at Pomona, Sacramento, San Bernardino, San Joaquin Delta College, San Luis Obispo, San Marcos, Stanislaus), Chapman University, Claremont McKenna College, College of Alameda, College of the Redwoods, Cosumnes River College, De Anza College, Delta College, Folsom Lake College, Foothill College, Fresno Pacific University, Golden Gage University, Harvey Mudd College, Holy Names University, Humboldt State University, Laney College, La Sierra University, Los Rios Community College District, Loyola Marymount University, Menlo College, Merritt College, MiraCosta College, Moreno Valley College, Norco College, Occidental College, Pepperdine University, Pitzer College, Pomona College, Riverside City College, Samuel Merritt University, Sacramento City College, San Diego Community College District, San Diego State University, Santa Barbara City College, Santa Clara University, Santa Rosa Junior College, Scripps College, Southern California Institute of Architecture, Southwestern College, Stanford University, University of California system (Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, Santa Cruz), University of the Pacific, University of La Verne, University of San Diego, University of Southern California, Whitter College

COLORADO: Colorado College, Colorado School of Mines, Colorado State University system (must have FDA approval in Pueblo), Fort Lewis College, Metropolitan State University of Denver, Naropa University, Regis University, University of Denver, University of Colorado (Anschutz Medical Campus, Boulder, Denver, Colorado Springs), University of Northern Colorado, Western Colorado University

CONNECTICUT: Connecticut State Colleges and Universities (Asnuntuck Community College in Enfield, Capital Community College, Central Connecticut State University, Charter Oak State College Online, Eastern Connecticut State University, Gateway Community College, Housatonic Community College, Manchester Community College, Middlesex Community College, Naugatuck Valley Community College, Northwestern CT Community College, Norwalk Community College in Norwalk, Quinebaug Valley Community College, Southern Connecticut State University, Three Rivers Community College, Norwich, Tunxis Community College, Western Connecticut State University), Connecticut College, Post University, Quinnipiac University, Sacred Heart University, Trinity College, University of Connecticut (Avery Point, Hartford, Stamford, Storrs, Waterbury), University of Hartford, University of New Haven, University of St. Joseph, Wesleyan University, Yale University

DELAWARE: University of Delaware, Delaware State University, Goldey-Beacom College

FLORIDA: University of Miami (employees only)

GEORGIA: Chamberlain University at Atlanta, Clark Atlanta University, Emory University, Morehouse College, Oxford College, Spelman College

HAWAII: BYU-Hawaii, University of Hawaii (with FDA approval, Hawaii, Honolulu, Kapiolani, Kauai, Leeward, Manoa, Maui, West Oahu, Windward)

ILLINOIS: Aurora University, Bradley University, Chicago State University, College of DuPage, Columbia College, DePaul University, Dominican University, Elmhurst University, Knox College, Illinois State University, Lake Forest College, Lewis University, Loyola University Chicago, North Central College, Northeastern Illinois University, Northern Illinois University, Northwestern University, Quincy University, Roosevelt University, School of the Art Institute of Chicago, University of Chicago, University of Illinois (Chicago, Springfield, Urbana-Champaign)

INDIANA: Butler University, DePauw University, Goshen College (with FDA approval), Holy Cross College, Indiana University (Bloomington, Fort Wayne, Kokomo, South Bend, East, Northwest, IU-Purdue University Columbus, IU-Purdue University Indianapolis, Southeast. *But this requirement does not require physical documentation*), St. Mary's College, University of Notre Dame, Valparaiso University

IOWA: Grinnell College, Highline College

KENTUCKY: Bellarmine College, Berea College, Centre College, Transylvania University

LOUISIANA: Dillard University, Louisiana Community and Technical College system, Louisiana State University, Loyola University of New Orleans, Tulane University, University of Louisiana system (Louisiana Tech, Grambling State, McNeese State, Nicholls State, Northwestern State, Southeastern Louisiana, Southern University system, University of Louisiana at Lafayette, University of Louisiana at Monroe, University of New Orleans), Xavier University

MAINE: Bates College, Bowdoin College, Central Maine Community College, College of the Atlantic, Eastern Maine Community College, Husson University, Kennebec Valley Community College, Maine Community College system (Auburn, Bangor, Fairfield/Hinckley, Presque Isle, South Portland/Brunswick, Calais, Wells), Maine Maritime Academy, Northern Maine CC, Saint Joseph's College, Southern Maine Community College, Thomas College, Unity College, University of Maine system (Augusta, Farmington, Fort Kent, Machias, Presque Isle), University of New England, University of Southern Maine

MARYLAND: Bowie State University, Coppin State University, Frostburg State University, Hood College, Johns Hopkins University, Loyola Maryland University, McDaniel College, Morgan State University, Mount St. Mary's University, Salisbury University, St. John's College at Annapolis,

Towson University, University of Baltimore, University of Maryland (College Park, Baltimore, Baltimore County, Global Campus, Eastern Shore, Center for Environmental Science), Washington Adventist University, Washington College

MASSACHUSETTS: Alvernia University, American International College, Amherst College, Anna Maria College, Assumption University, Babson College, Bay Path University, Bentley University, Berklee College of Music, Boston College, Boston University, Brandeis University, Bridgewater State University, Cambridge College, Clark University, College of the Holy Cross, Curry College, Dean College, Elms College, Emerson College, Emmanuel College, Evergreen State College, Fitchburg State University, Framingham State University, Hampshire College, Harvard University, Lasell University, Lesley University, Massachusetts College of Art & Design, Massachusetts College of Liberal Arts, Massachusetts College of Pharmacy & Health Sciences, MIT, Massachusetts Maritime Academy, Mount Holyoke University, New England Conservatory of Music, Northeastern University, Olin College of Engineering, Salem State University, Simmons University, Smith College, Springfield College, Stonehill College, Suffolk University, Tufts University, University of Massachusetts (Amherst, Boston, Dartmouth, Lowell), Westfield State University, Wheaton College, William James College, Williams College, Worcester Polytechnic Institute, Worcester State University

MICHIGAN: Albion College, Grand Valley State University, Kalamazoo College, Lawrence Technological University, Michigan State University, Oakland University, University of Michigan, Wayne State University

MINNESOTA: Carleton College, College of St. Benedict, Gustavus Adolphus College, Hamline University, Macalester College, Minnesota College of Art and Design, Mitchell Hamline School of Law, St. Catherine University, St. John's University, St. Olaf College, University of Minnesota (with FDA approval), University of St. Thomas

MISSOURI: Culver Stockton College, Rockhurst University, William Jewell College, Saint Louis University, Washington University

NEBRASKA: Creighton University, Doane University, Nebraska Wesleyan University

NEVADA: College of Southern Nevada, Touro University Nevada, Nevada State College, University of Nevada-Las Vegas, University of Nevada-Reno.

NEW HAMPSHIRE: Colby-Sawyer College, Dartmouth College, Franklin Pierce University, New England College, Rivier University, Southern New Hampshire University, St. Anselm College

NEW JERSEY: Caldwell University, Drew University, Essex County College, Fairleigh Dickinson University, Kean University, Monmouth University, Montclair State University, Mount St. Mary's University, New Jersey City University, New Jersey Institute of Technology, Princeton University,

Ramapo College of New Jersey, Rider University, Rowan University, Rutgers University, Stevens Institute of Technology, Stockton University, William Paterson University

NEW MEXICO: Central New Mexico Community College, New Mexico Highlands University, St. John's College at Santa Fe, University of New Mexico (Albuquerque, Gallup, Los Alamos, Taos, Valencia County)

NEW YORK: Adelphi University, Albany College of Pharmacy and Health Sciences, Albany Law School, Alfred University, Bank Street College of Education, Barnard College, Cazenovia College, Clarkson University, Colgate University, College of Mount Saint Vincent, Columbia University, Cooper Union for the Advancement of Science and Art, Cornell University, Culinary Institute of America, Elmira College, Five Towns College, Fordham University, Hamilton College, Hartwick College, Hilbert College, Hofstra University, Ithaca College, Jewish Theological Seminary of America, Keuka College, Le Moyne College, Manhattan College, Manhattan School of Music, Manhattanville College, Maria College of Albany, Marist College, Marymount Manhattan College, Molloy College, Mount St. Mary College, Nazareth College, New York University, Pace University, Pratt Institute, Rensselaer Polytechnic Institute, Rochester Institute of Technology, Russell Sage College, Sarah Lawrence College, Siena College, Skidmore College, St. Bonaventure University, St. John Fisher College, St. John's University, St. Joseph's College, St. Lawrence University, Syracuse University, The New School, Touro College (Bay Shore, Dental Medicine, Flatbush, Harlem, Kew Gardens Hills, Law Center, Manhattan, Osteopathic Medicine), Trocaire College, Union College, University of Rochester, Utica College, Vassar College, Wagner College, Wells College.

City University of New York *(pending FDA approval of one vaccine)* (Baruch College, Borough of Manhattan CC, Bronx CC, Brooklyn College, College of Staten Island, Newmark Graduate School of Journalism, Graduate Center, Graduate School of Public Health and Policy, School of Labor and Urban Studies, School of Law, School of Professional Studies, Guttman CC, Hostos CC, Hunter College, John Jay College of Criminal Justice, Kingsborough CC, LaGuardia CC, Lehman College, Macaulay Honors College, Medgar Evers College, New York City College of Technology, Queens College, Queensborough Community College, City College of New York, York College).

State University of New York (Adirondack, University at Albany, Alfred State University, Binghamton University, Bockport, Broome, University at Buffalo, Buffalo State, Canton, Cayuga CC, Clinton CC, Cobleskill, Columbia Greene CC, Cornell University (NY State College of Agriculture and Life Sciences, College of Human Ecology, School of Industrial and Labor Relations and College of Veterinary Medicine), Corning, Cortland, Delhi, Downstate, Dutchess CC, Empire, College of Environmental Science and Forestry, Erie, Farmingdale State College, Fashion Institute of Technology, Finger Lakes CC, Fredonia, Fulton-Montgomery CC, Genesee CC, Geneseo, Herkimer, Hudson Valley CC, Jamestown CC, Jefferson, Maritime College, Mohawk Valley CC, New Paltz, Niagara County CC, North Country CC, Old Westbury, Oneonta, Onondaga, College of Optometry,

Orange, Oswego, Plattsburgh, Potsdam, Purchase College, Rockland CC, Schenectady, Stony Brook University, Suffolk County CC, Sullivan, Polytechnic Institute, Tompkins Cortland CC, Ulster, Upstate Medical University, Westchester CC

NORTH CAROLINA: Bennett College, Brevard College, Davidson College (with FDA approval), Duke University, Elon University, Johnson C. Smith University, Lees-McRae College, Lenoir-Rhyne University, Livingstone College, Methodist University, Queens University, Salem College, Shaw University, Union Presbysterian Seminary-Charlotte, University of North Carolina (all campuses, though students can opt for once-per-week testing instead), Wake Forest University, Warren Wilson College

OKLAHOMA: Southwest Christian University

OHIO: Antioch College, Case Western Reserve University, Cleveland Institute of Art, Kent State University, Kenyon College, Mt. St. Joseph University, Ohio Wesleyan University, Otterbein University, The College of Wooster, University of Akron, Xavier University

OREGON: Central Oregon Community College, Eastern Oregon University, Lewis & Clark University, Linfield University, Oregon Health and Science University, Oregon Institute of Technology, Oregon State University, Pacific University, Portland State University, University of Oregon, University of Portland, Southern Oregon University, Western Oregon University, Willamette University

PENNSYLVANIA: Allegheny College, Bryn Athyn College of the New Church, Bryn Mawr College, Bucknell University, Cabrini University, Carnegie Mellon University, Chatham University, Chestnut Hill College, Community College of Philadelphia, Dickinson College, Drexel University, Duquesne University, Franklin & Marshall College, Gettysburg University, Haverford College, Holy Family University, Immaculata University, La Salle University, Lehigh University, Mercyhurst University, Muhlenberg University, Neumann University, Point Park University, Rosemont College, St. Joseph's University, Susquehanna University, Swarthmore College, Thaddeus Stevens College of Technology, Thomas Jefferson University, University of the Arts, University of Pennsylvania, University of the Sciences, University of Scranton, Ursinus College, Villanova University, Washington & Jefferson College, Widener University, Williamson College of the Trades

RHODE ISLAND: Brown University, Bryant University, Community College of Rhode Island, Johnson & Wales University, New England Institute of Technology, Providence College, Rhode Island College, Rhode Island School of Design, Roger Williams University, Salve Regina University, University of Rhode Island

SOUTH CAROLINA: Furman University, Wofford College

TENNESSEE: Christian Brothers University, Maryville College, Rhodes College, Vanderbilt University

TEXAS: Paul Quinn College, Rice University, Southwestern University, St. Edward's University

UTAH: University of Utah, Utah State University, Weber State University, Westminster College

VERMONT: Bennington College, Castleton University, Champlain College, Middlebury College, St. Michael's College, University of Vermont, Northern Vermont University, Vermont Technical College.

VIRGINIA: Bridgewater College, Christopher Newport University, College of William & Mary, Eastern Mennonite University, Hampton University, Hollins University, James Madison University, Mary Baldwin University, Marymount University, Radford University, Randolph College, Randolph-Macon College, Roanoke College, Sweet Briar College, Union Presbyterian Seminary, University of Lynchburg, University of Richmond (with FDA approval), University of Virginia, Virginia Commonwealth University, Virginia Military Institute, Virginia State University, Virginia Tech University, Virginia Union University, Virginia Wesleyan University, Washington & Lee University

WASHINGTON: Central Washington University, Clover Park Technical College, Eastern Washington University, Evergreen State College, Gonzaga University, Heritage University, Highline College, Pacific Lutheran, St. Martin's University, Seattle Colleges (Central, North, South), Seattle University, Seattle Pacific University, Spokane Community College, Spokane Falls Community College, Tacoma Community College, University of Puget Sound, University of Washington (Tacoma, Bothell, Seattle), Washington State University, Wenatchee Valley College, Western Washington University, Whitman College, Whitworth University

WASHINGTON, D.C.: American University, Gallaudet University, George Washington University, Georgetown University, Trinity Washington University, University of the District of Columbia

WEST VIRGINIA: Bethany College, University of Charleston

WISCONSIN: Alverno College, Beloit College, Carthage College, Lawrence University, Marquette University

To send updates or to discuss reopening strategies for the fall, email reporter Chris Burt at cburt@lrp.com

EXHIBIT 57

Press release

Biden-Harris Administration Takes Additional Action to Protect America's Nursing Home Residents from COVID-19

Aug 18, 2021 Nursing facilities, Policy

The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Centers for Disease Control and Prevention (CDC), is developing an emergency regulation requiring staff vaccinations within the nation's more than 15,000 Medicare and Medicaid-participating nursing homes.

This new requirement is a key component of protecting the health and safety of nursing home residents and staff by ensuring that all nursing home staff receive COVID-19 vaccinations. Over the past several months, millions of vaccinations have been administered to nursing home residents and staff, and these vaccines have shown to help prevent COVID-19 and have proven to be effective against the Delta variant.

"Keeping nursing home residents and staff safe is our priority. The data are clear that higher levels of staff vaccination are linked to fewer outbreaks among residents, many of whom are at an increased risk of infection, hospitalization, or death," said CMS Administrator Chiquita Brooks-LaSure. "We will continue to work closely with our partners at the CDC, long-term care associations, unions, and other stakeholders to advance policies that keep residents and staff safe. As we advance these new requirements, we'll work with nursing homes to address staff and resident concerns with compassion and by following the science."

Today's action is in keeping with CMS's authority to establish requirements to ensure the health and safety of individuals receiving care from all providers and suppliers participating in the Medicare and Medicaid programs. About 62% of nursing home staff are currently vaccinated as of August 8 nationally, and vaccination among staff at the state level ranges from a high of 88% to a low of 44%. The emergence of the Delta variant in the United States has driven a rise in cases among nursing home residents from a low of 319 cases on June 27, to 2,696 cases on August 8, with many of the recent outbreaks occurring in

facilities located in areas of the United States with the lowest staff vaccination rates.

In May, the Agency issued new regulations that require Long-Term Care (LTC) facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) to educate residents, clients, and staff about COVID-19 vaccination and, when available, offer a COVID-19 vaccine to these individuals. These regulations also mandate that LTC facilities report weekly COVID-19 vaccination data for residents and staff to the CDC's National Healthcare Safety Network (NHSN).

CMS will continue to analyze vaccination data for residents and staff from the CDC's National Healthcare Safety Network (NHSN) data as an additional method of compliance monitoring and in keeping with current practice, as well as deploy the Quality Improvement Organizations (QIOs)—operated under the Medicare Quality Improvement Program—to educate and engage nursing homes with low rates of vaccinations.

CMS strongly encourages nursing home residents and staff members to get vaccinated as the Agency undergoes the necessary steps in the rule-making process over the course of the next several weeks. CMS expects nursing home operators to act in the best interest of residents and their staff by complying with these new rules, which the Agency expects to issue in September. CMS also expects nursing home operators to use all available resources to support employees in getting vaccinated, including employee education and vaccination clinics, as they work to meet this staff vaccination requirement.

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EXHIBIT 58

HEALTH AND SCIENCE

Brookdale Senior Living to require Covid vaccine for staff, CEO says

PUBLISHED FRI, AUG 6 20213:49 PM EDTUPDATED FRI, AUG 6 20215:19 PM EDT

Kevin Stankiewicz
@KEVIN_STANK

SHARE

KEY POINTS

Brookdale Senior Living is implementing a Covid vaccine requirement for its staff, CEO Cindy Baier told CNBC on Friday.

The move comes as the highly transmissible delta variant leads to a resurgence in coronavirus cases in the country, including in nursing homes.

“Even though our associate-vaccination rates are increasing, we want them to be even higher,” Baier said.

In this article

BKD UNCH

VIDEO 03:39

Brookdale Senior Living CEO on why it's mandating vaccines for employees

Brookdale Senior Living, a large operator of assisted living and skilled nursing facilities in the U.S., will require its staff to get vaccinated against Covid, CEO Cindy Baier told CNBC on Friday.

The move comes as the highly transmissible delta variant leads to an increase in coronavirus cases in the country, including in nursing homes. Between July 25 and Aug. 1, coronavirus cases among nursing home residents rose 38%, although levels remain far below previous peaks, according to the CDC.

Vaccines are providing vulnerable residents with immunity protection that was not afforded at earlier stages in the pandemic, when long-term care facilities were epicenters for devastating outbreaks. Across Brookdale Senior Living's facilities, which are located in 41 states, 93% of residents are vaccinated, Baier told CNBC. The vast majority of the Brookdale's portfolio consists of assisted living and memory care facilities.

"Given the widespread access of the vaccine, we're in a much better position to handle the pandemic," she said in an interview on "Power Lunch."

Nevertheless, the rise in coronavirus infection levels across the nation still heightens the risk to nursing home residents, many of whom are older and have underlying conditions that make Covid more dangerous to them. Increasing vaccination rates among staff, who come and go from the facility, can play a crucial role in trying to limit the likelihood of an outbreak taking hold.

Covid vaccinations have shown to be effective not only in reducing the chance of getting severely sick or dying from the disease, but studies suggest they also offer protection against infection.

"We want to [have] every Brookdale associate that we can vaccinated. To us, even though our efforts have been ongoing for several months, even though our associate

vaccination rates are increasing, we want them to be even higher," Baier said. "That's why we've chosen to go to a vaccine requirement with limited exceptions."

As of late July, roughly 82% of nursing home residents in the U.S. were fully vaccinated against the coronavirus, according to data compiled by the Centers for Disease Control and Prevention. However, vaccination rates among health-care staff is lower at around 59%. Overall, 49.9% of the U.S. population is fully vaccinated while 58.2% have had at least one shot, according to the CDC.

Earlier this week, Genesis Healthcare — another large U.S. nursing home operator — announced it was requiring workers to receive the Covid vaccine in order to stay employed. Outside of long-term care, a number of other large corporations have recently adopted more strict vaccination policies for employees, including United Airlines on Friday.

The actions are seen as a jolt for the nation's vaccination rate, which had slowed considerably since the spring and prompted U.S. health officials to ramp up their efforts to convince hesitant Americans to get the Covid shots.

Several Southern states that have low vaccination rates have seen upticks in shots administered recently, as Covid delta variant spread intensified, according to a CNBC analysis of CDC data. In Mississippi, Louisiana, Alabama and Arkansas, the weekly average of daily reported first doses more than doubled since beginning of July.

EXHIBIT 59

Find a Location

We understand that finding the right care for your loved one can be difficult. Now you can Chat live with an admissions specialist regarding your unique needs!

Chat with Us

CARES Act Section 3202(b) Notice of COVID-19 Cash Prices

The Coronavirus Aid, Relief, and Economic Security Act (CARES) includes a number of provisions to provide relief to the public from issues caused by the pandemic, including price transparency for COVID -19 testing. Section 3202(b) of the CARES Act requires providers of diagnostic tests for COVID-19 to post the cash price for a COVID-19 diagnostic test on their website. These cash prices are valid during the COVID-19 Public Health Emergency only. Click here to find the cash price as used in the CARES Act COVID-19 diagnostic antigen tests for individuals who seek COVID-19 testing from the Center.

Coronavirus Updates

Dear Patients, Residents and Families,

In December 2020, Genesis began vaccinating patients, residents and employees on a voluntary basis. Through communication, engagement and trust-building, we set high goals for staff vaccination without attempting to impose a requirement. We also communicated with patients, residents and families to stress the importance of receiving the vaccine. We have strongly encouraged vaccination among staff, residents and families and are proud to have achieved above average vaccination, with 85% of our patients and residents and 65% of our staff choosing to get the COVID-19 vaccine companywide.

As we all know, due to age, underlying conditions, or both, our patients and residents are at greater risk of severe illness if they contract COVID-19. This threat can be reduced significantly through universal staff vaccination. Despite vaccination rates above the national average, the growing spread of the Delta variant makes clear that we need to increase our vaccination rates substantially to better protect our patients, residents and employees. With this in mind, today Genesis announced it is adopting a universal vaccination requirement for current employees, personnel, and care partners/vendors across the Company, with compliance by August 23, 2021.

Our move to adopt universal vaccination is an incredibly important decision, and we very seriously weighed the competing concerns before proceeding down this path.While we would have greatly preferred a strictly voluntary process, our commitment to health and safety outweighs concerns about imposing a requirement. We have concluded that this approach provides the safest and most effective course of action to ensure the health and welfare of our patients, residents and staff.

We appreciate your continued support and patience as we continue to navigate this ongoing pandemic. We hope that this decision to require vaccination of staff will provide you with the highest level of confidence in the care and services we provide to you or your loved one. We also hope that you will consider getting vaccinated before visiting your loved one for their protection and yours, if you haven't done so already.

As a reminder, you can visit your Center's web page for daily updates on visitation and vaccination rates at: https://www.genesishcc.com/findlocations.

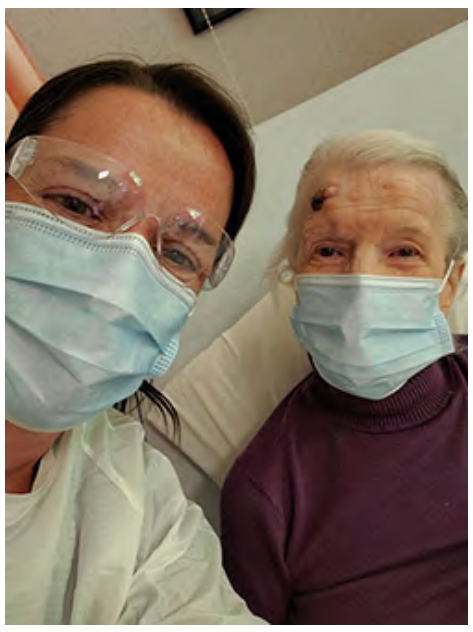
Recent News

- CNN Interview with Genesis Healthcare CEO, George Hager
- Waugh chapel center to convert temporary partial covid-19 rehabilitation center
- Genesis HealthCare's Lisa Barlow Recognized at the White House's National Nurses Week Event
- Powerback rehabilitation in philadelphia converts to partial covid-19 rehabilitation center

Staying Informed

We remain committed to keeping families updated about the situation at our facility, and how their loved ones are doing. Keeping families informed is our top priority.

Thank you, Dick Mackey, nephew of Virginia Bretchel, for sharing his kind words, and for Courtney Wood for sharing this fun selfie!



"Even during this time of the pandemic, I'm very happy with the care that she's gotten. The administrator at the facility has had a Zoom call every day to keep everyone updated. The nursing home always calls me whenever there is an issue. I couldn't be happier with the place." – Dick Mackey, nephew of resident Virginia

News Coverage

- Heroes in action
- COVID+ patients leave the facility to return home
- Chester County teen cheering up nursing home residents during COVID-19 outbreak
- First responders show support for nursing home residents

- Canyon transitional rehabilitation center to convert to temporary covid-19 rehabilitation center
- Powerback rehabilitation in piscataway to convert to partial covid-19 rehabilitation center

Resources

Coronavirus timeline

Family Video/Audio Conferencing

Previous Updates

- Coronavirus Update 05/25/2021
- Coronavirus Update 03/19/2021
- Coronavirus Update 02/10/2021
- Coronavirus Update 01/28/2021
- Coronavirus Update 11/24/2020
- Coronavirus Update 10/20/2020
- Coronavirus Update 09/14/2020
- Coronavirus Update 07/27/2020
- Coronavirus Update 06/12/2020
- Coronavirus Update 05/29/2020
- Coronavirus Update 05/13/2020
- Coronavirus Update 05/01/2020
- Coronavirus Update 04/22/2020
- Coronavirus Update 04/08/2020
- Coronavirus update 03/30/2020
- Coronavirus Update 03/25/2020

Genesis HealthCare is a holding company with subsidiaries that, on a combined basis, provide services to skilled nursing facilities and assisted/senior living communities. The Company also specializes in contract rehabilitation therapy, respiratory therapy, physician services, staffing services and accountable care.

Connect and Contact Us

101 East State Street,

Kennett Square, PA 19348

EXHIBIT 60

The Washington Post *Democracy Dies in Darkness*

As breakthrough covid infections rise, nursing home chains require that staffers be vaccinated

Some long-term-care operators are requiring vaccinations for their employees to prevent a repeat of last year's deadly surge of the virus in residential facilities.

Listen to article 8 min

By Christopher Rowland

August 5, 2021 at 2:50 p.m. EDT

211

This article is free to access. Why?

Families got the first worrisome email on July 16. A fully vaccinated resident of the Good Samaritan Society nursing home in rural Clear Lake, S.D., had tested positive for the novel coronavirus, a rare breakthrough infection. In subsequent days, notifications from the nursing home kept coming, each progressively more alarming.

On July 18, with six cases confirmed, a relative responded to the nursing home's email with an emoji of Edvard Munch's painting "The Scream." Then came the first death, on July 20. By Tuesday this week, the facility said it had 14 covid-19 cases and two deaths — all among residents who were fully vaccinated in January.

The outbreak — the largest the national chain has seen among vaccinated residents — helped spur Good Samaritan to impose a vaccine mandate on its 16,000 staffers working in 22 states to try to avoid a repeat of the devastating covid-19 surges in spring 2020 and last winter, which contributed to a total of 185,000 pandemic deaths among people in facilities providing long-term care.

As the threat of the delta variant grows, other large nursing home chains also are beginning to adopt vaccine mandates, including the largest for-profit chain, Genesis HealthCare, which is requiring employees to get their first vaccine shot by Aug. 23. Massachusetts said Wednesday that it is imposing a state vaccine mandate on nursing home staffers. These moves are part of a building wave of requirements in health-care settings nationally.

Good Samaritan's vaccine mandate, announced last month, goes into effect Nov. 1. Good Samaritan is the largest nonprofit long-term-care chain in the nation, with 200 nursing home, assisted-living, and other long-term-care services. It is affiliated with the large Midwestern provider chain Sanford Health, which also adopted the vaccine mandate. Counting Sanford's 46 hospitals and medical network, the system has nearly 50,000 employees who are required to get vaccinated.

Coronavirus infections in nursing homes nationally remain extremely low after horrific waves of infections and deaths during earlier phases of the pandemic. High rates of vaccination among residents of long-term-care facilities quelled that category of outbreaks. Still, nursing home operators said sealing off the chance that unvaccinated workers will

introduce new infections is crucial to preventing another surge.

“Clear Lake is the biggest, most active outbreak we have. You’ve got to plan like this is going to happen, as if it’s going to be just like we saw with the original outbreak,” Randy Bury, the chief executive of Good Samaritan Society, said in an interview. “Most experts will agree we’ve been wrong as much as we’ve been right in trying to predict this virus.”

Good Samaritan’s facility in Clear Lake has about 31 residents, and all have been vaccinated. But fewer than two thirds of the 61 staff members have been vaccinated, which is in line with the national vaccination rate for workers in nursing homes. Six employees of the facility have tested positive during the outbreak, none of them vaccinated, Good Samaritan confirmed.

The crisis shocked family members who had expected that their loved ones would be protected by vaccinations.

“We’ve been scared for all these weeks, basically just praying that our mom doesn’t get covid,” the daughter of an uninfected resident, who spoke on the condition of anonymity to protect the resident’s health-care privacy, said in an interview.

“Even though they were supposed to be masking, I saw people coming in with masks below their noses all the time. I didn’t say anything because my mom was vaccinated, I was vaccinated,” the daughter said. “I’m blaming the people who did not get vaccinated, and I feel they wantonly put these at-risk old people in danger.”

Bury said the episode at Clear Lake was frustrating. Vaccinations have been proved to dramatically stifle covid outbreaks, he said, but not enough staffers have been vaccinated.

“Certainly, Clear Lake was one of the catalysts for us,” Bury said. “We’ve been trying to keep it out, but now we’ve got this more-contagious variant that can break through some of those defenses.”

The rapid spread at Clear Lake suggests that the outbreak was triggered by an unvaccinated staff member coming into contact with multiple elderly residents, Bury said. He said the state of South Dakota, which says on its website that it performs “sentinel” genomic testing to track coronavirus variants, has not confirmed what strain of virus infected the Clear Lake nursing home residents.

Bury added that it is a “logical conclusion” that the delta variant is responsible for the facility’s outbreak. Faced with so many unknowns about the variant’s strength, he said, health systems need to plan for the worst to prevent a repeat of last winter.

Good Samaritan’s Clear Lake facility had avoided outbreaks previously in the pandemic with stringent isolation measures that prevented visits by residents’ families. The introduction of vaccines allowed those restrictions to be eased in March.

Now, a ban on family visits is back in force at the nursing home. Infected patients are quarantined in a “red zone” within the building. Uninfected residents have been ordered to remain isolated in their rooms; bingo is being played over the intercom system, according to the daughter of the woman who has not been infected.

The South Dakota Department of Health is investigating the outbreak and working with the home’s staff to assess testing and protective equipment needs, provide advice on how to halt the spread and review procedures, said agency spokesman Daniel Bucheli.

But South Dakota Gov. Kristi L. Noem (R) is a staunch opponent of vaccine and mask mandates. She indicated her continued opposition to mask requirements in tweets on July 28, saying school administrators should take into account the impacts of masks on learning.

Asked in an email whether the state supports vaccine mandates for staffers in nursing homes, Bucheli wrote back,

Bucheli did not answer emailed questions about whether the state has tested for the presence of delta variant in Clear Lake, citing the privacy interests of the facility's residents and the staff.

About 47 percent of the state's total population is fully vaccinated, which ranks it in the middle of the pack among states.

The Centers for Disease Control and Prevention did not respond to requests for comment and perspective on the South Dakota nursing home outbreak.

CDC data shows that after vaccines crushed the number of viral infections in nursing homes this year, there has been only a slight increase in infections from the very low numbers.

Nursing home infections hit a low of 326 in the week ending June 27, according to CDC data, and climbed back to 1,312 in the week ending July 25. There were 208 deaths in the week ending July 25, up from 121 in the week ending June 27.

At the peak of the winter surge in December 2020, infections in nursing homes reached a peak of 35,000 in a single week, with 6,358 deaths.

A growing number of nursing home and assisted-living operators say now is the time to prevent a more significant surge in the facilities as the delta variant sweeps through unvaccinated populations in outside communities. The industry's trade groups are divided by business model. The group representing nonprofit nursing homes, LeadingAge, has endorsed mandates, while the representative of for-profit and nonprofit operators, the American Health Care Association, said it supports strong vaccination education efforts aimed at nursing home staffers.

One of the factors that made the industry reluctant to impose vaccine mandates on staffers previously was the fear of causing people to leave their jobs. Bury said leaders of Sanford and Good Samaritan Society expect that they will lose some staffers, but he added that acceptance of vaccines among nursing home workers has grown with time.

In New Jersey, CareOne, a for-profit long-term-care chain, is imposing a mandate with a deadline of Sept. 30.

"We hope that people get vaccinated, not terminated, because we're not looking to lose people to the mandate," said Toya Casper, CareOne's chief clinical officer.

But other operators say a mandate could make a shortage of workers throughout the industry even worse. Single-facility and family-owned operators could be especially disadvantaged because they lack the scale of their larger competitors, industry advocates said.

"The challenge for many long-term-care providers is that we are at Defcon 1 when it comes to our staffing crisis," said Brendan Williams, president and chief executive of the New Hampshire Health Care Association. New Hampshire's nursing homes have a 76 percent staff vaccination rate.

"To lose even one vaccine-hesitant worker, let alone several, could be debilitating to a facility's operation," Williams said.

By Christopher Rowland

Chris Rowland joined The Washington Post business team in 2018 after serving as the Washington bureau chief for the Boston Globe, leading coverage of two presidential elections and overseeing political enterprise reporting. He previously covered health care for the Globe in Boston. Twitter

EXHIBIT 61

Welcoming Brighter Days at Sunrise

SUNRISE SENIOR LIVING | MARCH 23, 2021

An update from Sue Coppola, Chief Clinical Officer, and Jenifer Salamino, Chief Operating Officer, regarding updates to visitation, dining, and activities at Sunrise with the arrival of the COVID-19 vaccine.

For the latest updates on our COVID-19 response, please visit our We Are Prepared page.

Dear Sunrise Residents & Families:

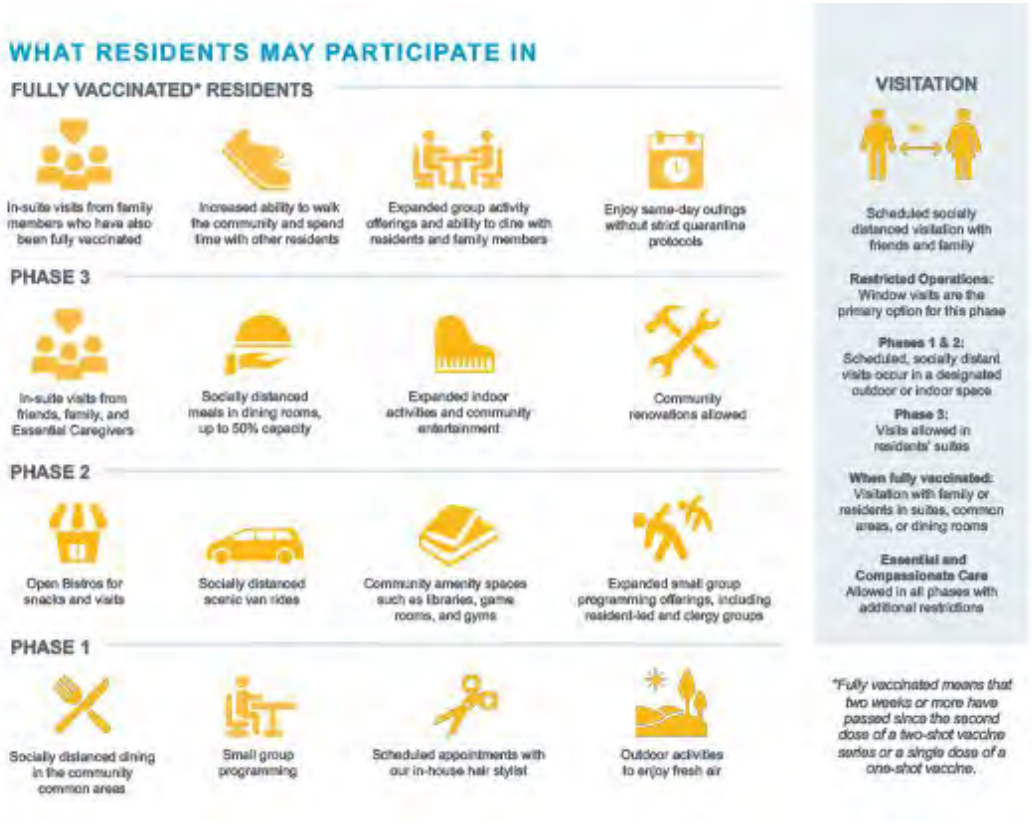
With the start of a new spring season, we have many reasons to believe that brighter days are ahead of us. One of the biggest reasons to be hopeful is the arrival of the COVID-19 vaccine, which is the single most promising tool to help the world end the COVID-19 pandemic. The vaccine gives us reason to look optimistically toward a future that will finally include many of the invaluable personal connections and activities we all miss so much.

At Sunrise, we remain incredibly grateful that our residents and team members were granted priority access to the vaccine, and we're happy to report that many thousands have already taken critical steps to protect themselves and others by receiving the vaccine at community clinics. In addition to rewarding team members with a paid 'Day of Gratitude," we are proud to share that Sunrise has taken the important step of introducing vaccinations as a required and essential job function for all new and current community team members in the U.S. We expect them all to be fully vaccinated against COVID-19 no later than July 31, subject to applicable laws and Sunrise policies. This decision was made carefully with advice from public health officials to promote the safety of everyone in our community. Simply put, increasing vaccination rates is our best path forward to bring back more normalcy into our residents' day-to-day lives.

These changes in our community are already underway. With nearly 90 percent of our current residents fully vaccinated, we are now able to adopt new guidance from public health officials including the CDC. Residents who are fully vaccinated may enjoy more community activities and welcome visitors when the community is in any phase of Sunrise's Phased Resumption of Operations plan. Fully vaccinated residents may:

- Spend time in community common areas, including socializing with other residents who are vaccinated.
- Enjoy day trips out of the community without having to follow strict quarantine protocols upon their return.

local health authorities, laws and regulations may impact and require changes to these operational guidelines.



We know for our residents and families these changes cannot come soon enough, and we look forward to the many more smiles, laughs and even hugs that will soon fill our communities. That said, we know we cannot yet let our guard down in the fight against COVID-19, especially as new variants continue to spread across North America. We will stay vigilant and closely follow public health guidance including continuing to practice infection control protocols such as frequent handwashing, mask wearing and social distancing.

To say this past year has been challenging would be an understatement, but we hope that you – like the dedicated Sunrise team – are excited for the months ahead. We cannot thank you enough for your continued patience, support and trust. It remains our honor to serve you. As always, we encourage you to reach out to your community leadership with questions and feedback.

Wishing you all a happy, healthy spring and nothing but bright days ahead!

Sincerely,

COVID-19 Response

EXHIBIT 62

TUESDAY, MAY 18TH

PRE-REGISTRATION PREFERRED / WALK-INS WELCOME

Where: 1916 – 1924 W Chicago Avenue, Chicago IL 60622

We are closing West Town Bakery & Roots Pizza from 8:30am – 3:30pm to distribute 1,000 Pfizer vaccines for free, regardless of insurance or immigration status. Help us spread the word!

Employee Vaccination Requirement

The Fifty/50 Group has mandated that all employees must be fully vaccinated to remain on the schedule by July 15, 2021 and new employees will have a grace-period to receive their vaccine when joining our company. Exemptions or reasonable accomodations may be given for nursing and expectant mothers, religious preferences, and for certain other protected classicifications as defined by the ADA. We provide incentives as well as periods of paid time off for anyone getting a vaccine or feeling the mild after-effects. Having our entire staff vaccinated will make our restaurants safer for all of our employees, our guests, and it is socially responsible for society. On May 18th, 2021 we hosted an event at one of our restaurants where 99% of our un-vaccinated employees, received their first dose of the Pfizer vaccine. By June 8th, 2021 we anticipate having our employees be 100% vaccinated.

OUR COMMUNITY PARTNERSHIPS

HUMBOLDT PARK HEALTH

As a community based hospital, Humboldt Park Health reinvests back into the community through programs to serve the poor and uninsured, manage chronic conditions like diabetes, health education and promote initiatives and outreach for the elderly. And we work hard every day to be a place of healing, caring and connection for patients and families in the community we call home.

READ MORE

CASA CENTRAL

Casa Central is the largest Hispanic social service agency in the Midwest. Since 1954, Casa Central has delivered evidenced based, award winning programming in response to the needs of the Hispanic community. Through comprehensive, family-centered programming, Casa Central is the conduit through which thousands of individuals build hope for the future while equipping themselves to achieve a sustainable, higher quality of life for the benefit of self, family, community and society.

READ MORE

CHICAGO VACCINE ANGELS

The mission of the Chicago Vaccine Angels has been and remains to assist those who cannot secure their own vaccine appointment either due to: –Age –Lack of technology ability –Lack of home internet –Homebound individuals –Those in frontline careers (including, for example, restaurant staff,

USPS, healthcare teams) – Those living in an underserved Chicagoland community

READ MORE

THE FIFTY/50 RESTAURANT GROUP

Founded in 2008 by Greg Mohr and Scott Weiner

From our very first restaurant in Wicker Park – to our newest Roots in Printer's Row, we've grown through the values and the belief that neighborhood establishments are essential to keeping our communities vibrant and safe; they are the heart and soul of Chicago. The purchase and development of neighborhood real estate, where we own and operate our establishments, helps foster our deep roots to the communities we serve.

Throughout the pandemic, the Fifty/50 has dedicated kitchens and capital to feeding vulnerable populations throughout the crisis while also keeping our people employed to the greatest extent possible. Local restaurants lie at the heart of our neighborhoods' vibrancy and we are proud to have locations as far south as Motor Row and as far north as Lincoln Square with more to come.

FIND OUT MORE

CONTACT US

INVESTOR RELATIONS | JOBS | GIFT CARDS | LOYALTY

EXHIBIT 63

COVID-19 Return to Office: For Contract Worker Suppliers

Cisco's priority is the health and safety of all people located at our sites. As we return to offices, we will share our phased return process and guidelines below. Please check this site regularly for updates.

Messages from CPO and SVP, Alexandra Lopez
June, 2020 | July, 2020 | March, 2021 | April, 2021

Cisco sites in work from home phase and office entry status

Return to office process

Return to office phase 2

Protective measures

Do I need to know and/or maintain vaccination status of my workers?

For workers who access any of the Santa Clara County sites (including Mountain View, Palo Alto, Milpitas, San Jose, and other Santa Clara County offices), suppliers who manage the applicable workers are expected to collect and manage COVID-19 vaccination status.

Beginning July 1, 2021, only vaccinated workers (employees and contingent workers) and all critical workers will be allowed onsite at Cisco campuses, except workers who have not been vaccinated but have approved exceptions (we will share more information on this option with you in the coming weeks). Furthermore, all onsite workers must wear masks indoors regardless of vaccination status.

What measures are in place to protect workers returning to the office?

All contractors will need to complete mandatory online training that outlines the workplace measures in effect before returning to the office. Workers must self-screen to check for potential virus symptoms before going to the office daily via a self-service app. Signage throughout each site will communicate how to navigate the new workplace.

Must face coverings be worn on site?

At least for phase 1 and where permitted by local law, face coverings are a minimum Cisco standard for occupants of Cisco properties while in areas where social distancing is not possible or is difficult. More specific measures or personal protective equipment (PPE) requirements will be compliant with local requirements. Cisco will make required materials available to workers returning to the worksite at Cisco locations.

What cleaning protocols will be in place?

Enhanced cleaning protocols will be in place, including surface cleaning, floor cleaning, localized aerosol misting, and other techniques as required. The frequency of these protocols will vary based on local requirements, occupancy, and by situation.

What happens if a case of COVID-19 is confirmed in my building?

If a building occupant has a suspected or confirmed case of COVID-19, appropriate response teams will be engaged to investigate and deem necessary cleaning, building closure decisions, and communications needs.

If my worker has a suspected case of diagnosed with COVID-19, who do I reach out to?

Please email **cce-casemgrs@cisco.com** as soon as this is known.

If my worker has been in close contact (6 feet for more than 10 minutes) with someone diagnosed with COVID-19 and has been in contact with other Cisco-related personnel (employees, other contract workers, partners or customers), who do I reach out to?

Please email **cce-casemgrs@cisco.com** as soon as this is known.

If I want to inform Cisco of a confirmed or suspected case of COVID-19 related to a Cisco staff member, customer or at a partner site, who do I reach out to?

Please email **cce-casemgrs@cisco.com** as soon as this is known.

Working arrangements

Symptoms self-check app: Cisco Office Pass

IT in the office

Testing Protocol

Contact Us

Work with Us

Cisco Sites

EXHIBIT 64

SAIL SAFE

Sign Up For Special Offers Let Us Call You

You want to cruise. We want to keep you safe. With Norwegian, our leading Health & Safety Program allows you and your loved ones to cruise with the ultimate freedom and confidence. All guests and crew are required to be 100% fully vaccinated so you can safely do what you've always wanted to do on a cruise — EVERYTHING. Let's get back to living life to the fullest, together. Sail Safe. Feel Free.

Benefits of 100% Vaccination Requirements*

- **Cruise Mask-free****
  Breathe freely and witness smiles everywhere you go!
- **No Social Distancing Required**
  Get up close and personal with confidence, everyone on board is vaccinated.
- **All Restaurants & Experiences Are Fully Open**
  Dine in any of our restaurants mask-free, including our self-service buffet. Plus enjoy all entertainment options.
- **No Restrictions on Shore Excursions**
  Feel Free to take the shore excursion you've been dreaming of or explore on your own!
- **No Capacity Restrictions**
  Appreciate the full Norwegian experience — all venues and experiences are entirely open.
- **Surround Yourself in Safety**
  Peace of mind knowing all guests and crew on board are fully vaccinated.

*As government regulations evolve, our health and safety protocols will evolve as needed to ensure compliance. This may mean different protocols from ship to ship based on local requirements.

**On Europe sailings only, currently local government regulations requires all guests to wear masks onboard. Refer to FAQs section for complete details.

Safety
FOR OUR GUESTS & CREW

Safety
ABOARD OUR SHIPS

Safety
ASHORE

Pre-Cruise and Onboard Protocols
SAFETY FOR OUR GUESTS AND CREW

Will all guests be required to be vaccinated prior to the cruise?

What vaccines will be accepted?

Will proof of vaccination be required for all cruises even in the future?

Are guests required to wear masks while onboard?

Are children allowed to sail on your ships if they are not vaccinated?

What documents will be required to show proof of vaccination and when do I provide them?

What completed travel documents do I need to board the ship?

Mandatory Vaccinations Against Covid-19 on Initial Voyages

All guests and crew must be fully vaccinated, at least 2 weeks prior to departure, in order to board. Guest vaccination requirements are currently for all sailings embarking through December 31, 2021– we will follow the science to make determinations on requirements for all other future sailings.

Passengers on ships embarking or disembarking at US ports need to be vaccinated with U.S. Food and Drug Administration (FDA) and/or World Health Organization (WHO) authorized single brand vaccinations.

How do I know if there are any travel restrictions that could impact my cruise?

How far in advance of sailing will you send guests details on travel requirements and updates on health and safety protocols?

Will I be issued a refund if I am denied entry to the country where the voyage originates (port of embarkation)?

Will any countries visited during the cruise require additional testing to enter the country?

Will I have to sign a COVID-19 waiver to board a ship?

Universal testing & Pre-Embarkation Protocols

All guests will be required to take a COVID-19 antigen test, administered and paid for by the cruise line, prior to boarding and receive a negative result. Guests are also responsible for complying with all local health and safety requirements which may include additional testing.

If one person in our party tests positive, will we all be denied boarding? Will the Company assist with travel arrangements?

Will I receive a refund if I test positive for COVID-19 prior to boarding? What about other members in my party that are denied boarding?

Will NCL offer testing onboard to meet travel requirements for guests flying back to countries that require negative COVID-19 test results to re-enter the country post cruise?

Will guests who are recovered from COVID-19 and have antibodies still be required to be vaccinated?

How will you maintain physical distancing onboard?

Socially Responsible Check-In

We've designed an enhanced, staggered embarkation process and new check-in system to streamline check in for guests by allowing documents to be signed electronically.

Are there any onboard activities that will not be available?

If I test positive for COVID-19 during a cruise and have to quarantine, will I receive a full refund?

What happens if I test positive for COVID-19 upon disembarkation?

If I'm denied boarding at the pier or arrive late, can I board the ship at the next port?

Can I buy travel insurance through Norwegian Cruise Line?

Are there any restrictions on pre-existing health conditions or limitations for guests due to COVID-19?

Controlled Guest Capacity

We will initially control the guest capacity onboard each ship to provide even more space per guest.

Hand Sanitation

All guests will be required to engage in frequent handwashing and hand sanitizer will be prominently placed and easily accessible throughout the ship.

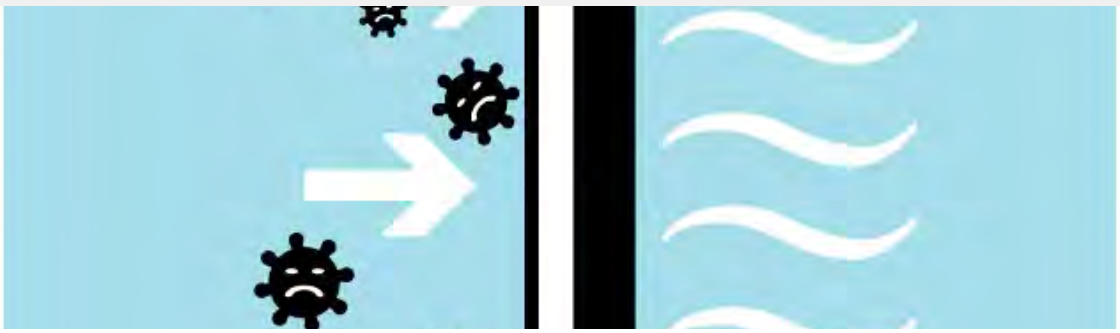
Pre-Cruise and Onboard Frequently Asked Questions **Expand All**

Increased Sanitation, Upgraded Air Filtration, Enhanced Health Services

SAFETY ABOARD OUR SHIPS

Continuous Ship-Wide Cleaning & Disinfection Measures

Comprehensive enhanced cleaning and sanitation protocols, using EPA approved disinfectants, have been implemented throughout the cruise experience.



Upgraded Medical-Grade Air Filters

We are strategically installing medical-grade air filters of the highest filtration grade, MERV 13 or HEPA, capable of removing 99.9% of airborne pathogens, including COVID-19, and implementing new bi-polar ionization technology.

Enhanced Onboard Medical Teams & Health Services

We have improved our onboard medical capabilities with additional staffing relative to capacity and enhanced facilities including new and upgraded equipment and onshore medical institution partnerships.

Dedicated Public Health Officer

All ships will sail with a dedicated Public Health Officer on board that will oversee the day-to-day sanitation and cleanliness of all public areas and accommodations.

Safety Aboard Our Ships Frequently Asked Questions Expand All

What happens if I get sick while onboard?

What testing and treatment capabilities are there onboard?

Destinations, Itineraries & Shore Excursions

SAFETY ASHORE

Strategic Itinerary Development & Shore Partners

We constantly monitor the health environment across the globe and will modify or cancel itineraries to affected areas as needed.

Partners in Prevention

We're partnering with our local destinations and tour operators to extend our comprehensive health & safety protocols to shore.

Beyond the Port

Guests are free to explore ports of call on their own, according to protocols in each specific port, and can purchase shore excursions as they wish. Face coverings may be required in certain settings to comply with local requirements, for example in terminals for embarkation and disembarkation or at ports of call. We will continue to monitor public health guidance, including from the CDC, at the time of your voyage and modify requirements accordingly.

*Due to local government regulations, guests are required to take a Norwegian Cruise Line shore excursion while visiting ports in Italy as guests will not be allowed to explore on their own.

Thorough & Effective Mobilization Plan in Event of Outbreak
MOBILIZATION & RESPONSE

Contact Tracing

If a positive case of COVID-19 occurs, we have various contact tracing methodologies to identify and notify those who may have been exposed.

Isolation/Quarantine

Dedicated isolation and quarantine accommodations will be available if needed.

Debarkation Scenarios

We have developed a thorough mobilization and response plan focused on collaborating with local authorities and coordinating safe passage home for all guests and crew should the need arise. We have also established relationships with onshore medical institutions and enhanced our telemedicine consultation capabilities.

Other Frequently Asked Questions **Are these all of the health & safety protocols that will be implemented during my cruise?** **Expand All**

Do I need to use the Norwegian Cruise Line App for new health and safety protocols?

Can I explore on my own while in port?

Will I be required to take a COVID test to disembark the vessel?

Will I be required to take a COVID-19 test in order to embark on the second leg of a back-to-back sailing?

IT'S FINALLY TIME TO BREAK FREE

Let's get cruising! Check out our first available cruises in The Caribbean and Europe starting this summer.

READY TO SAIL?

Need Help Planning the Perfect Vacation?

1.866.234.7350

EXHIBIT 65

03 AUG

Our Next Step in the Fight Against the Pandemic

Written by **Donnie King** Categorised **People**, **Workplace**

As people have heard, new variants of COVID-19 are more contagious, more deadly and responsible for most cases in America today. In some communities, doctors and hospitals are once again overwhelmed, while the U.S. Centers for Disease Control and Prevention is reporting nearly all hospitalizations and deaths in the U.S. are among those who are unvaccinated. It is abundantly clear that getting vaccinated is the single most effective thing we can do to protect ourselves, our families and our communities.

So today, like many other businesses, we are taking steps to protect all of these things by **requiring all U.S. team members to be fully vaccinated**. Team members must be vaccinated by the following dates:

- All Tyson leadership (officers and above) by **September 24, 2021**
  - All team members in office by **October 1, 2021**
  - All other team members by **November 1, 2021**
  - All new hires must be fully vaccinated prior to their **start date**
  - Team members that are members of a union will be **subject to the results of union bargaining** on this issue

To our frontline team members: once you are fully vaccinated, and verified in our Vaccination Verification Program, you will receive $200 as thank you for doing your part to keep us all safe, subject to ongoing discussions with our unions.

We did not take this decision lightly. We have spent months encouraging our team members to get vaccinated – today, under half of our team members are. We take this step today because nothing is more important than our team members' health and safety, and we thank them for the work they do, every day, to help us feed this country, and our world.

Face book **Twitt er** **Link edIn**

Author

Donnie King

President & CEO at Tyson Foods

Donnie King has over 36 years of experience working in the poultry business for Tyson Foods, both domestically and globally. He first joined Tyson Foods in 1982 and served in poultry plant, complex and supply chain management. He has held a variety of executive leadership positions, including president of North American operations, managing all operational aspects of poultry, fresh meats and prepared foods. He has also been group president of international.

Donnie is a former member of the executive committee of the National Chicken Council's board of directors and a former member of the U.S. Poultry and Egg Association. He has a bachelor's degree in business management from the University of Arkansas at Monticello.

More from this author

JANUARY 11, 2021

Doing Our Part to Help End Human Trafficking

MARCH 6, 2020

Adjusting, Adapting to the Challenge of Coronavirus

COVID-19, **Team Members**

Who We Are

Innovation

Our Brands

Sustainability

The Feed Blog

Careers

Investors

News

Contact Us

EXHIBIT 66

BREAKING | Jul 29, 2021,01:54pm EDT | 23,031 views

Danny Meyer Restaurant Group Will Require Vaccines To Dine And Work In Major Shift For Fine Dining

Carlie Porterfield Forbes Staff
Business
I cover breaking news.

Follow

Updated Jul 29, 2021, 04:52pm EDT

TOPLINE Shake Shack founder and Union Square Hospitality Group CEO Danny Meyer will require all employees and guests dining inside the group's New York and Washington, D.C., restaurants to provide proof they've been vaccinated against coronavirus as new U.S. cases begin to spike again, the restaurateur said Thursday, becoming the first major restaurant group to do so.

Diners at Union Square Cafe in New York. CORBIS VIA GETTY IMAGES

KEY FACTS

"We feel like we have an amazing responsibility to keep our staff members and our guests safe, and that's what we're going to do," Meyer told CNBC's *Squawk Box* Thursday.

Diners will be able to prove their inoculation status by presenting their vaccination cards or with apps like the New York government-issued Excelsior Pass or Clear, Meyer told *The Washington Post*.

He added he believes the vaccine requirement will make more people want to dine at his restaurants due to their commitment to safety instead of pushing potential customers away.

While the "vast majority" of Union Square Hospitality Group employees are already inoculated, Meyers said the small portion still unvaccinated will be given 45 days to make the decision to have the shots or not.

Meyers said the move may help attract employees who want to work in a safe environment, noting that Union Square Hospitality Group is struggling with a staffing shortage along with the rest of the service industry.

Shake Shack, which Union Square Hospitality Group does not own or control, will not fall under the new mandate and has not announced any changes to employee policy.

KEY BACKGROUND

Meyer's famous restaurants include New York's Gramercy Tavern, Union Square Cafe and Washington, D.C.'s Anchovy Social, along with 15 others. An increasing number of bars and restaurants are now asking that customers show proof of vaccination as coronavirus cases pick up in some parts of the country. This week, the San Francisco Bar Owner Alliance recommended that members check vaccination cards upon entry, and hundreds of bars opted in. The practice is already being mandated by the government in many

European countries, like France and Italy, and was recently put into place in Israel after a surge of new infections.

FURTHER READING

Danny Meyer restaurants will require vaccine proof for diners and employees (*The Washington Post)*

Europe Sees Vaccine Passport Explosion For Hotels, Restaurants, Museums And More (*Forbes*)

Hundreds Of San Francisco Bars Set To Require Covid-19 Vaccine Or Negative Test As Industry Group Issues New Recommendation (*Forbes*)

EXHIBIT 67

The New York Times https://www.nytimes.com/2021/08/06/business/united-airlines-vaccines.html

Daily Business Briefing ›

United Airlines will require vaccination, and Amazon revives mask mandates.

By Niraj Chokshi

Published Aug. 6, 2021 Updated Aug. 9, 2021

United Airlines said on Friday that it would require all U.S. employees to be vaccinated against the coronavirus starting this fall. It was the first major airline to establish such a mandate and the latest in a small but growing number of businesses to do so.

Also on Friday, Amazon, the second-largest private employer in the country, and JPMorgan Chase revived mask mandates for vaccinated workers.

“We hope this will only be required for a few weeks,” Amazon, which had been allowing vaccinated employees to go without face coverings, wrote to its warehouse workers on Friday. “Everyone can do their part to speed our return to normal by getting vaccinated.”

JPMorgan, the nation’s largest bank, said unvaccinated employees must be tested at least twice a week and would not be allowed to attend indoor employee events with 25 or more people. The company’s operating committee also said in a memo that the firm “will continue with our previously stated return to the office schedule,” even as many companies, including the financial firms BlackRock and Wells Fargo, have postponed their mandatory return plans.

Amazon had already told its corporate employees that they wouldn’t be recalled to the office until January, pushing back a deadline that had been set for early September. But it has not indicated any changes to its vaccination policy, which encourages but does not mandate immunization.

Hours after United’s announcement, Frontier Airlines, a much smaller carrier, said it, too, would require vaccines for all employees. Frontier’s mandate begins on Oct. 1.

United’s employees will be required to upload proof of vaccination within five weeks of a vaccine’s full approval by the Food and Drug Administration (not the Federal Drug Administration as was reported here earlier) or by Oct. 25, whichever comes first. Those who provide proof by Sept. 20 will receive a full day’s pay, excluding pilots and flight attendants who have already received a union-negotiated bonus for getting vaccinated. So far, about 90 percent of United’s pilots and 80 percent of its flight attendants have been vaccinated, the airline said.

“We have no greater responsibility to you and your colleagues than to ensure your safety when you’re at work, and the facts are crystal clear: Everyone is safer when everyone is vaccinated,” Scott Kirby, the airline’s chief executive, and Brett Hart, its president, said in a memo to their staff.

Employees who fail to comply with the new policy will be fired. And while United will allow exceptions for religious or medical reasons, it will require documentation.

Mr. Kirby first floated the idea of a mandate at an internal forum in January, saying United would be “amongst the first wave of companies” to require vaccination.

Delta Air Lines requires new employees to be vaccinated, but existing employees are exempt. American Airlines is “not putting mandates in place” for employees or customers, its chief executive, Doug Parker, said in an interview with the New York Times columnist Kara Swisher.

Airlines have generally dismissed the idea of mandates for customers. Mr. Parker said in the interview that doing so would create “enormous delays.” Delta’s chief executive, Ed Bastian, said on CNBC this week that it would be “very difficult” to require customers to receive a vaccine that hadn’t yet been fully federally approved.

Lananh Nguyen and Karen Weise contributed reporting.

Niraj Chokshi covers the business of transportation, with a focus on autonomous vehicles, airlines and logistics. @nirajc

A version of this article appears in print on , Section B, Page 5 of the New York edition with the headline: United to Require Vaccines for U.S. Workers, and Amazon Revives Mask Mandate

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Daily Business Briefing ›

- Industries with big recent job gains are vulnerable to the virus surge.
- Washington’s growing interest in crypto shows the industry’s increasing clout.
- Chris Cuomo is taking a birthday week vacation as scrutiny on his brother increases.
- JPMorgan’s punishment for currency rigging ends.

EXHIBIT 68

CORONAVIRUS

Here are the companies mandating vaccines for all or some employees

From United Airlines to Goldman Sachs, a nationwide spike in coronavirus cases is pushing companies to implement vaccine policies for some or all employees.

Aug. 3, 2021, 9:40 AM PDT / Updated Aug. 25, 2021, 7:00 AM PDT

By Haley Messenger

As the highly contagious delta variant of the coronavirus continues to strike communities nationwide, companies are stepping up their vaccine requirements, mandating that some or all employees get vaccinated or provide proof of vaccination.

After the Food and Drug Administration granted full approval to Pfizer's Covid vaccine on Monday, more companies are expected to mandate that employees be vaccinated.

Here is a list of the companies who have already announced their vaccination plans:

Amtrak

The railroad service is requiring all of its 17,500 employees to be fully vaccinated by Nov. 1 or submit to weekly Covid testing, CEO Bill Flynn wrote in a note to employees. Starting Oct. 4, all new hires will also be required to get vaccinated against the virus. "COVID-19 vaccines are safe, effective and lifesaving," Flynn wrote. "They are proving effective against the current surge of variants, especially at preventing severe disease, hospitalization and death. Vaccines are a critical tool to bring the pandemic under control."

Anthem

Employees must be fully vaccinated to enter offices that are open, including the health care insurance company's headquarters in Indianapolis and its office in Atlanta, according to Anthem spokesperson Michelle Vanstory.

BlackRock

Since July 1, only vaccinated employees and visitors to the investment giant have been allowed to return to the office, according to a company memo obtained by NBC News. All U.S.-based employees, regardless of any plans to voluntarily return, were required to report their vaccination status by June 30.

Cisco

The tech and telecoms conglomerate is only allowing vaccinated "critical workers" to come in to the office, and is pursuing a fully hybrid approach. "Whether that means you work five days a week at home and gather with your team for activities and connection every once in a while, or you are in the office five days a week ... every Cisco employee will be hybrid," Francine Katsoudas, executive vice president and chief people, policy and purpose officer, wrote in a memo to employees last week.

Citigroup

Citing the delta variant, the bank announced on Aug. 11 that employees will need to get vaccinated before returning to its offices, according to a LinkedIn post from Sara Wechter, the

bank's head of human resources.

Employees at offices in the New York area, Chicago, Boston, Washington, D.C., and Philadelphia, "will be expected to return at least two days a week and vaccination is required" starting Sept. 13, Wechter said.

CVS Health

CVS said Aug. 23 it is requiring patient-facing and corporate employees to get their shot by Oct. 31, and new hires by Sept. 15. Although the health care giant is asking its pharmacists in retail stores to be fully vaccinated by Nov. 30, it did not mention the same for retail associates, adding that "Other roles at CVS Health are under review and may be added based on updated data and public health guidance."

Deloitte

The professional services firm is requiring employees who enter its facilities to be fully vaccinated by Oct. 11.

Delta Air Lines

The airline announced in May it would be requiring all new U.S. hires to be vaccinated against the coronavirus effective May 17. "This is an important move to protect Delta's people and customers, ensuring the airline can safely operate as demand returns and as it accelerates through recovery and into the future," the company wrote, adding that it would not be "putting in place a company-wide mandate to require current employees to be vaccinated."

DoorDash

Although the food delivery service's corporate employees are not required to come back in to the office until January, those who voluntarily do so before then must show proof of vaccination, the company said.

Equinox

SoulCycle-owner and luxury fitness company Equinox announced Aug. 2 it will begin requiring members, riders and employees to provide a one-time proof of vaccination to enter its facilities and offices starting in New York City in September. "We have a responsibility to take bold action and respond to changing circumstances with urgency. We encourage other leading brands to join

us in this effort to best protect our communities," said Equinox Group Executive Chairman Harvey Spevak in a press release.

Facebook

The social media giant announced Aug. 12 it is pushing back its return to the office until January 2022, citing ongoing concerns with the delta variant.

“Data, not dates, is what drives our approach for returning to the office,” the company said in a statement. “Given the recent health data showing rising Covid cases based on the delta variant, our teams in the U.S. will not be required to go back to the office until January 2022. We expect this to be the case for some countries outside of the US, as well."

“As our offices reopen, we will be requiring anyone coming to work at any of our U.S. campuses to be vaccinated,” said Lori Goler, vice president, people, in an emailed statement to NBC News last week, prior to Thursday's announcement. “How we implement this policy will depend on local conditions and regulations. We will have a process for those who cannot be vaccinated for medical or other reasons and will be evaluating our approach in other regions as the situation evolves."

Ford

Car manufacturing titan Ford is requiring employees who partake in international business travel to be vaccinated, the company said in an emailed statement. It also said it is continuing “to strongly encourage all team members who are medically able to be vaccinated.”

The United Auto Workers labor union said Aug. 3 it would be reinstating a mask mandate at all of its facilities nationwide.

Goldman Sachs

Starting Sept. 7, the investment bank is requiring all individuals who enter its offices, including clients and visitors, to be fully vaccinated against the coronavirus. Fully vaccinated employees will also be required to wear masks in certain areas and undergo weekly testing. Employees who do not get their shot by the September deadline will be expected to continue working from home.

Google

On July 28, Google became the first major tech company to announce a vaccine mandate for its employees looking to return to the office later this fall. "Anyone coming to work on our campuses will need to be vaccinated. We're rolling this policy out in the U.S. in the coming weeks and will expand to other regions in the coming months," Google CEO Sundar Pichai wrote in a memo. Pichai also announced that the company is pushing its return-to-office date back to October.

Jefferies

Financial giant Jefferies will only allow vaccinated individuals into its offices and to outside company events, according to a memo from CEO Rich Handler and President Brian Friedman. "We require that, after Labor Day, anyone who is not fully vaccinated should continue to work from home, which fortunately has proven to be highly effective. We will closely monitor the situation and be ready to pivot and adapt whenever needed," the two leaders wrote in their joint letter.

Lyft

Starting Aug. 2, corporate employees will be required to show proof of vaccination in order to enter offices, according to an internal note obtained by NBC News. "For those who choose to continue working from our offices – which will remain open – our current safety guidance remains in place, including our existing mask requirement and vaccine requirement going into effect August 2," said CEO and co-founder Logan Green. Green also announced that the company is delaying its full return to the office by six months, until February.

MGM Resorts International

Hospitality chain MGM Resorts International asked salaried employees who are not exclusively working from home to get vaccinated by Oct. 15. All new hires who are not exclusively working from home must also get a shot, starting Aug. 30, according to an internal memo from CEO and president Bill Hornbuckle. Unvaccinated employees at the chain's Las Vegas properties will continue to be subject to regular testing and required to pay either a $15 co-pay for on-site or obtain a test from elsewhere and report the results.

Microsoft

The tech company announced Aug. 3 it will require proof of vaccination for all employees, vendors and guests starting in September, adding that it is delaying the full opening for its U.S. offices from next month to Oct. 4. The company did not say in its emailed statement whether the new vaccination policy includes employees who have voluntarily been going into the office since the spring or those working at its retail stores.

Morgan Stanley

Only vaccinated employees are allowed in New York-area offices at this time.

NBCUniversal

NBCUniversal is requiring U.S.-based workers returning to the office later this fall to be fully vaccinated, executive vice president Adam Miller told employees in an email on Aug. 11. Employees will also be required to provide details about their vaccination status. Miller also announced that the company is pushing back its broader office reopening from Sept. 13 to Oct. 18.

Netflix

The streaming service will be requiring vaccinations for casts of all U.S. productions, as well as the individuals who work with them on set, the company confirmed to NBC News.

The New York Times

The New York Times Company CEO Meredith Kopit Levien told staff members via email that it will be requiring proof of vaccination for those who want to go into the office voluntarily. Levien also told employees that the publication would be pushing back its full office return from Sept. 7, without announcing a new set date.

Saks

The fashion company said it is asking employees to get the vaccine before returning to the office this fall. “If we’re asking people to come back, we have to make the environment as safe as we possibly can,” CEO Marc Metrick told The New York Times in May.

Salesforce

The customer-service software giant has only allowed vaccinated employees back to its offices as of May. All employees have the option to work from home until the end of the year.

TJX

The parent company of off-price retailers like HomeGoods, Marshalls and T.J. Maxx is requiring its U.S. "Home and Regional Office Associates" to be fully vaccinated by Nov. 1 and "will provide accommodations for those who cannot get vaccinated due to qualified medical or religious reasons." It is unclear whether the mandate includes employees at the company's retail stores.

Twitter

The social media giant required employees to be vaccinated and show proof of vaccination before voluntarily returning to the company’s San Francisco and New York offices, both of which reclosed last week. In May 2020, Twitter said employees could work from home for as long as they want.

Tyson Foods

The meat and poultry producer announced on Aug. 3 that it is requiring its U.S. corporate workforce to be vaccinated by Oct. 1 and all other employees by Nov. 1, making it the largest U.S. food company to implement this kind of mandate. CEO Donnie King told employees that the company will also provide $200 to frontline team members who get the shot.

Uber

In an internal note obtained by NBC News, CEO Dara Khosrowshahi told employees that starting Aug. 2, they will now be required to be fully vaccinated in order to return to the office. “If you are not vaccinated, you’ll need to work from home until you are fully vaccinated,” he wrote. Khosrowshahi also shared the company’s new return to office date: Oct. 25, 2021. “It’s important to say that this date is a global target, and local circumstances will continue to dictate when it makes sense to bring employees back in a given city,” he wrote.

Union Square Hospitality Group

Union Square Hospitality Group, which operates restaurants in New York City and Washington, D.C., will require vaccinations for staff members and guests. “Beginning the day after Labor Day, we are going to require that 100 percent of our staff members be vaccinated and that any guest who wants to dine indoors will be vaccinated as well,” founder and CEO Danny Meyer told NBC News.

United Airlines

The air carrier is requiring all U.S.-based employees to get vaccinated – and provide proof of their vaccination – either five weeks after federal approval or by Oct. 25, whichever comes first, the company announced in a note to employees on Aug. 6. United previously only required the shot for new hires and is now the first major U.S. airline to implement a blanket policy for all employees. United CEO Scott Kirby said in January that he wanted to make Covid vaccines mandatory for employees.

ViacomCBS

CEO Bob Bakish told employees earlier this month that the media conglomerate is requiring all U.S.-based employees working onsite during its "Yellow Phase" to be fully vaccinated, adding that it is still assessing whether this mandate will continue into the "Green Phase," which is when most staff will be back in the office. Bakish also announced that the company is delaying the start of its "Green Phase" until Oct. 18 at the earliest.

"We will continue to closely monitor the impacts of the Delta variant and the response from schools, governments and other employers as we finalize our plans to return to the office," Bakish said.

Walgreens

The pharmacy giant is requiring workers in its U.S. support offices to be fully vaccinated by Sept. 30, it said in a statement on Aug. 3. Those who do not adhere to the new rule will have to undergo Covid testing. Store associates must wear masks, regardless of vaccination status.

The Walt Disney Company

Disney is requiring all of its new, salaried and non-union hourly employees to get vaccinated before heading to work. “Employees who aren’t already vaccinated and are working on-site will have 60 days from today to complete their protocols, and any employees still working from home will need to provide verification of vaccination prior to their return, with certain limited

exceptions," the company said in part in an emailed statement. "Vaccines are the best tool we all have to help control this global pandemic and protect our employees."

Walmart

Walmart corporate associates, managers and new hires are required to get their shot by Oct. 4, President and CEO Doug McMillon told employees in an internal memo obtained by NBC News. "As we all know, the pandemic is not over, and the Delta variant has led to an increase in infection rates across much of the U.S," he wrote. "Given this, we have made the decision to require all campus office associates and all market, regional and divisional associates who work in multiple facilities to be vaccinated by Oct. 4, unless they have an approved exception."

The Washington Post

Post employees, including new hires, must demonstrate proof of vaccination as a condition of their employment starting when they return to the office on Oct. 18, CEO Fred Ryan told staff in a memo sent out last week. "Even though the overwhelming majority of Post employees have already provided proof of vaccination, I do not take this decision lightly," he said. "However, in considering the serious health issues and genuine safety concerns of so many Post employees, I believe the plan is the right one."

Haley Messenger

Haley Messenger is an associate producer at NBC News covering business, technology and media.

Liat Weinstein contributed.

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF RITA LOMIO IN SUPPORT OF PLAINTIFFS' RESPONSE TO ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION

I, Rita Lomio, declare as follows:

1. I am an attorney duly admitted to practice before this Court. I am a staff attorney at the Prison Law Office, counsel of record for Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify.

2. I am counsel of record in *Armstrong v. Newsom*, Case No. C94-2307 CW (N.D. Cal.), a federal class action lawsuit regarding disability discrimination in California's prison and parole systems. I have worked on the case for the last five years.

3. As part of my duties in *Armstrong*, I regularly interview and correspond with people with disabilities in California prisons. I also regularly speak with California Department of Corrections and Rehabilitation ("CDCR") attorneys and officials who work on ensuring compliance with the requirements of *Armstrong*. I regularly visit prisons to interview *Armstrong* class members and staff to monitor compliance.

4. The United States Department of Justice has said that "COVID-19 has had a devastating and disproportionate impact on people with disabilities." *See* U.S. Dep't of Justice, Statement by the Principal Deputy Assistant Attorney General for Civil Rights Leading a Coordinated Civil Rights Response to Coronavirus (COVID-19) (Apr. 2, 2021), available at https://www.justice.gov/file/1382776/download. That certainly has been true in the California prison system. On February 1, 2021, the Court Expert in *Armstrong* filed a report stating, among other things (and at page 2): "The fact that, to date, *Armstrong* class members have been almost five times more likely to die of COVID-19 than non-class members makes the work of protecting them all the more essential." A true and correct copy of the Court Expert's Fourth Report and Recommendations Regarding Housing of *Armstrong* Class Members During the COVID-19 Pandemic, filed in *Armstrong* on February 1, 2021, at ECF No. 3201, is attached hereto as **Exhibit A**.

5. CDCR assigns Disability Placement Program ("DPP") codes to people it identifies as having certain disabilities related to mobility, hearing, vision, speech, and kidney disease. CDCR separately tracks people with verified and unverified learning disabilities.

6. On August 10, 2021, Alexander Powell, an attorney in the CDCR Office of Legal Affairs, sent me a list of every person in prison with a DPP code and/or documented learning disability as of August 9, 2021, as well as their current housing assignment. Attached hereto as **Exhibit B** is a true and correct copy of the cover sheet, which shows that 10,664 people have documented disabilities and that people with documented disabilities are housed in every prison. (The cover sheet lists the total number as 10,799,

and I subtracted 135 for those people listed as housed in "SACCO" and "SHS," which are not CDCR prisons.)

7. Most of the 10,664 people have physical disabilities. Only 261 people statewide have a verified or unverified learning disability and no DPP code. I determined this by filtering the spreadsheet produced by Mr. Powell, limiting Column I ("LD") to "Yes" or "Unverified," and Column E ("Code") to "(Blanks)," and selecting all but "SHS" and "SACCO" in Column A ("Inst.").

8. Almost 2,000 people in California prisons use wheelchairs. 789 people have a DPP code of "DPW," which means that they are full-time wheelchair users. 1,143 people have a DPP code of "DPO," which means that they are part-time wheelchair users. I determined this by filtering Column E ("Code") on the spreadsheet produced by Mr. Powell to "DPW" or "DPO," and selecting all but "SHS" and "SACCO" in Column A ("Inst.").

9. 285 people have a DPP code of "DPV," which means that they have a significant vision disability that requires them to be housed only in certain prisons. I determined this by filtering Column E ("Code") on the spreadsheet produced by Mr. Powell to "DPV," and selecting all but "SHS" and "SACCO" in Column A ("Inst.").

10. 136 people have a DPP code of "DKD," which means that they require dialysis. I determined this by filtering Column E ("Code") on the spreadsheet produced by Mr. Powell to "DKD," and selecting all but "SHS" and "SACCO" in Column A ("Inst.").

11. Some prisons house a particularly large number of people with documented disabilities, as can be seen on Exhibit B. For example:

INSTITUTION	COUNT
CHCF	1,298
RJD	950
MCSP	921
SATF	822

CMF	761
VSP	661

12. People with disabilities depend on staff for a wide range of disability-related help and often cannot avoid coming in close and sustained contact with staff due to their disabilities. For example, custody staff push people in wheelchairs to and from appointments, including to healthcare appointments.

13. Another example relates to announcements made over the public address system in prison housing units. These announcements, among other things, let people know when the yard is open, when they have a medical appointment, when it is time to shower, and when there have been program modifications. Custody staff in the housing units are responsible for ensuring effective communication of announcements, including to people who are deaf or hard-of-hearing. This often requires personal notification by using written notes or speaking loudly and clearly while in close proximity to the person. This is particularly important in housing units with a lot of background noise that makes it difficult to hear unless someone is close to you.

14. Custody staff also serve as sighted guides to people who are blind or have low vision. Plaintiffs' counsel in *Armstrong* raised concerns earlier in the pandemic that blind and low-vision people were being moved more frequently during the pandemic in response to quarantines and public health protocols, and were not able to safely and independently navigate their new living environments without assistance. As a result, on January 14, 2021, Defendants issued a memorandum requiring staff to offer and provide orientation to people designated DPV upon transfer to a new housing environment. The memorandum stated (at page 1): "Without initial guidance from sighted individuals, DPV individuals may have difficulty familiarizing themselves with and navigating new living environments. . . . [T]hey may be unable to identify Americans with Disabilities Act (ADA) workers or staff for help, or to locate critical areas of their living environment such as their bed, dayroom area, toilet, shower, water fountains, doors, recreational areas, law

library, and dining hall." A true and correct copy of the memorandum entitled, "Situating Blind and Low-Vision Individuals to New Living Environments During the COVID-19 Pandemic," and dated January 14, 2021, is attached hereto as **Exhibit C**.

15. Staff may be required to help people with disabilities, including those who are blind, those with upper extremity disabilities, and those with limited literacy, read and write, including personal correspondence, CDCR forms (such as a request for medical attention or grievance), and CDCR paperwork (such as disciplinary paperwork).

16. Custody staff play a particularly important role in accommodating people with disabilities housed quarantine and isolation units. This is because by memorandum dated August 14, 2020, CDCR said that incarcerated ADA workers would not be allowed to work in quarantine and isolation units. The memorandum stated (at page 2): "In an effort to minimize the spread of COVID-19, for housing units and areas designated for isolation/quarantine, services will be provided by staff within the housing unit." The memorandum noted (at page 1) that people with disabilities might "need help reading and writing, navigating during yard time or to appointments, cleaning their bed area, and carrying meal trays." A true and correct copy of the memorandum entitled, "Americans with Disabilities Act Worker Program for Duration of COVID-19 Pandemic," and dated August 14, 2020, is attached hereto as **Exhibit D**.

17. On July 20-23, 2021, I visited California State Prison, Sacramento ("CSP-SAC"), as part of an *Armstrong* monitoring tour. I was joined by Prison Law Office investigator Gabriela Pelsinger. During the tour, Ms. Pelsinger and I toured various parts of CSP-SAC, including housing units, and directed CDCR staff to take photographs of certain areas and people. Attached hereto as **Exhibit E** is a true and correct copy of a photograph taken by CDCR staff at our direction during the tour of a man with a walker being escorted in a housing unit by an officer, which was produced to me in redacted form by Andrea Moon, Deputy Attorney General, on July 28, 2021.

18. The Court in *Armstrong* ordered that Defendants ensure safe, accessible housing for people with disabilities during the pandemic and that Defendants set aside a sufficient number of accessible quarantine and isolation beds. *See* ECF Nos. 3015 & 3072, *Armstrong v. Newsom*, Case No. C94 2307 CW (N.D. Cal.). As part of the parties' efforts to ensure an appropriate number of accessible beds were set aside, Sean Lodholz, Deputy Attorney General, sent me an email with a link to a PDF entitled, "Corrected DPW and LL numbers," on September 3, 2020, with photographs and information about the accessibility of certain housing units at several prisons, including the California Substance Abuse Treatment Facility and State Prison, Corcoran ("SATF"). A true and correct copy of one page of the PDF, which included a photograph of open-tier dormitory housing on Facility A at SATF, is attached hereto as **Exhibit F**.

I declare under penalty of perjury that the foregoing is true and correct. This declaration is executed in Palo Alto, California, this 30th day of August 2021.

/s/ Rita Lomio
Rita Lomio

INDEX OF EXHIBITS

TO DECLARATION OF RITA LOMIO

Exhibit	Description
A	Court Expert's Fourth Report and Recommendations Regarding Housing of *Armstrong* Class Members During the COVID-19 Pandemic, *Armstrong v. Newsom*, No. CV 94-2307 CW (N.D. Cal. Feb. 1, 2021)
B	Disability Inmate Counts (Aug. 9, 2021)
C	Memorandum from Connie Gipson, Director, Division of Adult Institutions, to Associate Directors *et al.*, Situating Blind and Low-Vision Individuals to New Living Environments During the COVID-19 Pandemic (Jan. 14, 2021)
D	Memorandum from Connie Gipson, Director, Division of Adult Institutions, to Associate Directors *et al.*, Americans with Disabilities Act Worker Program for Duration of COVID-19 Pandemic (Aug. 14, 2020)
E	Photograph of Patient with a Walker Being Escorted by Custody Staff in Housing Unit, CSP-SAC (July 2021)
F	Photograph of Dormitory on Facility A, SATF (Aug. 2020)

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Court Expert

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

JOHN ARMSTRONG, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. CV 94-2307 CW

FOURTH REPORT AND RECOMMENDATIONS REGARDING HOUSING OF *ARMSTRONG* CLASS MEMBERS DURING THE COVID-19 PANDEMIC

I. Introduction

In the 0 days since the Court Expert's last report, there have been substantial developments regarding COVID-19 and the California prison system. CDCR experienced an enormous rise in infections, peaking at around 7 0 new cases per day and over 10,000 active cases figures many times higher than previous surges. Those numbers have now improved dramatically, with cases steadily declining since reaching those highs.

CDCR has also reported encouraging data on vaccinations. To date, over 10,000 incarcerated persons have received at least one dose of a vaccine. The vaccine acceptance rate among the general population is 74 among those aged or older, the acceptance rate is 90 . Over three- uarters of individuals with COVID risk scores of 3 or above have received

one or both doses. Overall, roughly of the population has either received at least one dose of the vaccine or has had COVID and recovered.

While these numbers are encouraging, it is important to remember that over 47,000 incarcerated people have contracted the virus to date. Of those, 192 have died. The *Armstrong* population has been especially hard hit. Class members make up roughly 11 of the prison population, and they do not appear to be contracting the virus at higher rates than others they make up roughly 12 of active cases and 11 of resolved cases. However, *Armstrong* class members have died at a far greater rate than the general population of 192 deaths to date, a stunning 3 101 individuals have been class members. The fact that, to date, *Armstrong* class members have been almost five times more likely to die of COVID-19 than non-class members makes the work of protecting them all the more essential.

II. Adequacy of pandemic response plans for *Armstrong* class members (1-2)[1]

As discussed above, CDCR has made progress in containing the spread of COVID-19 in its facilities, and both infection and death rates have fallen since the surge of cases in December. The availability of a vaccine and the high acceptance rates reported by CDCR are likewise encouraging, and the Court Expert is optimistic that vaccination will further reduce the rate of spread of the disease, particularly among *Armstrong* class members. However, the Court Expert believes it would be premature at this point to modify the approaches to containment and monitoring developed by the parties. To date, most of the incarcerated persons who have been vaccinated have received only one of the two doses necessary for full efficacy, and it is yet unknown when CDCR will receive sufficient vaccine doses for its entire population or how new variants of the coronavirus will respond to the currently available vaccines. Moreover, the infection and death rates remain high and of great concern, with an average of 107 new infections and nearly one death per day.

[1] As in previous reports, the sections below correspond to the numbered paragraphs in the Court's September 9 order (Dkt. 3072), in which the Court set forth the categories of information on which the Court expert was to provide updates.

Adequacy of isolation and quarantine space for class members. As set forth in previous reports, Defendants have implemented a methodology for calculating the number of uarantine and isolation beds that must be accessible to class members with DPW and lower lower classifications. That methodology is two-fold. Institutions where *Armstrong* class members are housed in shared spaces must have at least as many DPW and lower lower isolation and uarantine beds as there are inmates re uiring DPW and lower lower beds in the two largest congregate living areas (the congregate approach). Institutions where such individuals are housed in individual cells and not congregate living areas must have accessible isolation and uarantine beds in proportion to the class member population (the proportional approach) thus, an institution with 1 DPWs must ensure that at least 1 of its isolation and uarantine beds are DPW-accessible. As described in the Court Expert's last report, the congregate approach can yield an insufficient number of beds where an institution houses a large number of class members but only a small number of them in congregate housing. Accordingly, the Court Expert recommended that the parties meet and confer regarding institutions where Plaintiffs believe application of the proportional approach will better ensure available of isolation and uarantine beds for class members. Currently, there are sufficient DPW and lower lower isolation and uarantine beds at each institution under the methodology that the parties have agreed should apply at each institution. However, Plaintiffs raise two concerns with respect to the ade uacy of the set-aside space.

Designation of quarantine vs. isolation space. Plaintiffs believe CDCR's current response plans are insufficient in that they do not re uire institutions to provide a sufficient proportion of uarantine beds among the beds set aside for uarantine and isolation. Plaintiffs note that in August 2020, CDCR and CCHCS's Public Health Workgroup wrote that the point of the method proposed by the public health experts is to identify and respond to an outbreak at the earliest onset which means most of the space will be for uarantine . Public Health Workgroup Recommendations (Aug. 17, 2020). Pointing to that recommendation, Plaintiffs ask the Court Expert to recommend that at least 1 of the isolation and uarantine beds that are accessible to class members be reserved for uarantine, rather than isolation.

As the Court Expert wrote in his previous report, this issue pertains to the entire prison population, not only *Armstrong* class members, and it is therefore appropriate to address it in *Plata* rather than here. The methodology applied under *Plata* does not re uire Defendants to identify and set aside separate isolation and uarantine space. The *Armstrong*-accessible housing is a subset of that designated in *Plata*, not a separate and additional group of beds. Thus, the *Armstrong* Court cannot order CDCR to dedicate *Armstrong*-accessible beds to uarantine space without disturbing the methodology applied by *Plata*. The Court Expert recommends that Plaintiffs either raise this issue in *Plata* or continue to address it on an institution-by-institution basis, as they have done to date.

Equitable division of quarantine space. Plaintiffs raise a related concern about the extent to which *Armstrong* class members have une ual access to the safest type of uarantine space. As noted in the Court Expert's last report, the parties agree that the safest place to uarantine is in a single-person cell with a solid (rather than barred) door. The parties have met and conferred about how to ensure that class members have e ual access to such cells. In November, Plaintiffs proposed a methodology pursuant to which CDCR would calculate the percentage of the general population that could be housed in single-cell uarantine, compare it to the percentage of the DPW and lower lower populations that could be so housed, and ad ust the available space to ensure e ual access. In early December, defendants responded with a letter in which they provided examples to illustrate why they believe Plaintiffs' approach is unrealistic. Defendants suggested instead that the parties evaluate and address Plaintiffs' concerns in this regard on an institution-by-institution basis.

The Court Expert believes Defendants have demonstrated that Plaintiffs' proposal, while straight-forward on its face, would be difficult to implement given the subgroups to which the methodology would have to be applied (for example, one might need to apply the methodology based on a proportional approach for general population class members but a congregate approach for SN class members) and the fact that calculations would need to be reperformed in response to changing populations. Because Plaintiffs have not shown that Defendants'

concerns are misplaced, the Court Expert declines to recommend that Defendants implement Plaintiffs' proposed methodology.

However, this does not change the fact that Defendants have an obligation to ensure that class members are treated e ually, including in their ability to uarantine in single cells with solid doors. Plaintiffs have identified six institutions (SOL, CCWF, CMF, MCSP, SATF, and VSP) at which they believe class members are currently disadvantaged in this regard. As an example, CMF has 2 DPW class members in its two largest communal housing spaces and 72 DPW-accessible isolation uarantine beds. It thus has sufficient set-aside space under the congregate approach. However, Plaintiffs report that only 2 of the DPW-accessible beds are in single cells with solid doors, while CMF has enough celled uarantine beds to house its entire non-DPW population. The Court Expert agrees that Defendants have an obligation to ensure that class members have e ual access to single-cell, solid-door uarantine space and recommends that the parties meet and confer to address any deficiency at CMF and at the other institutions identified by Plaintiffs, as well as at any other institutions with a deficiency of this sort.[2] The Court Expert notes that the obligation to obligation to identify such discrepancies does not lie solely with Plaintiffs and that CDCR must also work to identify and remedy instances of une ual access to preferable uarantine space prior to an outbreak.

Separate isolation and quarantine spaces for specific populations. As described in the Court Expert's last report, Plaintiffs have raised concerns about the need to designate separate isolation and uarantine space for different security classifications and for certain populations, such as those housed on special needs yards (SN). Plaintiffs believe that the failure to designate separate spaces may be contributing to some individuals' refusal to move to uarantine or isolation during an outbreak. The Court Expert's view remains that this issue is

[2] Plaintiffs raised concerns about specific institutions in a January 27, 2021 letter, meaning that Defendants did not have an opportunity to respond to those particular concerns prior to issuance of this report. Accordingly, while the parties should discuss Plaintiffs' concerns, the Court Expert does not in this report make any findings about the allegations in Plaintiff's letter and does not make specific recommendations with regard to CMF or the other five institutions described in the letter.

appropriately raised in *Plata*, not *Armstrong*. However, at institutions where CDCR has already designated separate spaces for different populations, it must ensure that each such space has sufficient housing for *Armstrong* class members in each of the separate spaces. Defendants report that the proportional or congregate approaches have been satisfied in each such space and that they will continue to evaluate and address Plaintiffs' concerns on an institution-by-institution basis.

III. Notification of changes in housing designations (3)

CDCR's November , 2020, directive (Tracking of Isolation uarantine Units for *Armstrong* Class Members) implements the Court's re uirement that Defendants give notice within 72 hours if they designate substitute or additional uarantine and isolation space at any institution. Dkt. 3072, 3. As of late January, however, Plaintiffs noted that Defendants did not appear to have actually ever provided the re uired notice under the directive. Defendants have since updated their procedures to ensure the notice is sent on time.

IV. Ad ustment of Set-Aside Space (4)

Defendants must develop a reliable process . . . to ensure that ade uate accessible uarantine and isolation space is set-aside in advance of *Armstrong* class members transferring into the institution, and in response to any changes in disability codes or movement within an institution. Dkt. 3072, 4.

Due to the surge in infections, CDCR paused intake in November 2020. Intake has now resumed, and CDCR has implemented processes designed to ensure that receiving centers have sufficient accessible space in uarantine to house arriving *Armstrong* class members. Plaintiffs have expressed concern that there is a lack of accessible space at intake centers, giving rise to the possibility of class members either being housed inaccessibly or being forced to spend longer in county ails awaiting intake, with the concomitant risk of potential exposure to the virus. They note that at N SP, one of only two reception centers for men, there are no accessible units designated for precautionary uarantine of new arrivals, and there are very few such units at WSP, the other available reception center. The parties should discuss Plaintiffs' concerns, and Defendants should implement changes to CDCR's intake procedures as necessary

to prevent disadvantaging class members transition from local facilities. Because Plaintiffs' concerns were raised too recently for Defendants to provide a response prior to the filing of this Report, the Court Expert does not make any findings. However, given the importance of this issue, the Court Expert recommends the parties meet and confer on this matter promptly and report to the Court Expert any unresolved issues.

V. Architectural and non-architectural modifications (5-7 and 10-15)

As described in the Court Expert's previous reports, the parties have established a procedure for documenting and evaluating, through consultation with experts, the architectural modifications Defendants have made to render isolation and uarantine space accessible to class members. The process continues to work effectively, and the Court Expert commends both parties for their efforts.

The Court Expert is also pleased to report that the parties have made significant progress on non-architectural accommodations, an issue the Court Expert previously found had received inade uate attention. *See* Dkt. 3142, at 7. The parties worked together to draft a memorandum on this sub ect, which was finali ed and disseminated in mid-January. That memorandum (COVID-19 Non-Architectural Accommodations for Americans with Disabilities Act Class Members) provides guidelines on issues such as availability of trape e bars, electrical outlets, TDD TT devices, and magnifiers and Braille materials. The memorandum also sets forth a process for interviews of randomly selected class members to assess whether re uired accommodations are in fact being provided and written follow-up by the institutions on any deficiencies.

Defendants have also finali ed and disseminated a memorandum entitled Situating Blind and Low-Vision Individuals to New Living Environments to address the needs of DPV class members. That memorandum, also prepared ointly with Plaintiffs, provides instructions on issues such as designating sighted individuals who are trained to assist new DPV arrivals and identifying preferred beds for DPV individuals, and it provides deadlines by which institutions must conduct orientations and document the specific needs of DPV class members.

VI. Housing of *Armstrong* class members, including rehousing of displaced class members (16, 18)

As noted in the last report, CDCR has issued a directive (Procedures for Reviewing and Reporting Housing for *Armstrong* Class Members During COVID-19) aimed at ensuring that class members are appropriately housed and that they receive necessary accommodations in the event they are placed in nontraditional housing (such as gyms and chapels) or in areas that are not designated for their DPP code. That directive re uires, *inter alia*, that class members be interviewed within 24 hours of such placement to ensure that their needs are being accommodated, that institutions collect and report on numbers of class members in non-designated and nontraditional spaces, and that class members not be placed in more restrictive housing (e.g., placing a class member with level two security classification in a level four facility) or in administrative segregation solely because there is no other accessible housing available.

As of the last reporting date (January 22), there were over 310 class members not housed in accordance with their DPP codes and approximately 0 class members not housed in accordance with their lower lower designations. These figures are of concern. It is obviously preferable for class members to be housed in areas designated for their code, rather than for CDCR to have to provide accommodations and monitoring to ensure their needs are being met in a non-designated bed. The pandemic has necessitated the housing of individuals in locations not designated for their disability, and the sooner the number of mis-housed class members can be reduced and class members returned to designated housing, the better. In the meantime, while Defendants have been conducting and producing the re uired interviews of mis-housed class members, Plaintiffs have raised concerns that the process is at times incomplete or inaccurate. In particular, Plaintiffs believe that in many instances, class members were mis-housed despite the availability of appropriate beds. The parties should continue to meet and confer regarding deficiencies identified by Plaintiffs and address the needs of individual class members as they arise.

VII. Other matters

On July 20, 2020, the Court ordered defendants to develop and implement a plan to ensure that the ADA worker program can safely and effectively function without undue risk of transmission of COVID-19. Dkt. 301 , 1. The ADA worker program is not within the scope of matters on which the Court Expert is re uired to report. However, Plaintiffs have raised concerns with the program that implicate safe housing for *Armstrong* class members.

Based on a monitoring tour of SAC, Plaintiffs have alleged that ADA supervisors are not aware of their duties with respect to the ADA worker program and of the applicable re uirements regarding PPE. Of direct concern to *Armstrong* class member housing, Plaintiffs also allege that supervisors appeared unaware of the directive that staff, rather than ADA workers, assist class members who are in uarantine supervisors also appear not to be following the re uirement that ADA workers not travel between housing units but assist only those class members in their own units. The Court Expert recommends that the parties continue to meet and confer on this issue to ensure that ADA workers do not inadvertently contribute to the spread of the disease in the facilities.

VIII. Conclusion

The Court Expert recommends that the Court order a further update in 0 days.

Dated February 1, 2021

Respectfully submitted,

s
Edward W. Swanson
SWANSON McNAMARA LLP

Selected Institution(s): ASP, CAC, CAL, CCC, CCI, CCWF, CCWF-RC, CEN, CHCF, CIM, CIM-RC, CIW, CMC, CMF, COR, CPMP, CRC, CTF, CVSP, FCRF, FOL, HDSP, ISP, KVSP, LAC, MCSP, NKSP, NKSP-RC, PBSP, PRCCF, PUCCF, PVSP, RJD, SAC, SACCO, SATF, SCC, SHS, SOL, SQ, SQ-RC, SVSP, VSP, WSP, WSP-RC

Inmate Type: DPP and/or Learning Disability

Disability Inmate Counts

Run By: ladjrs

Date Run: 08/09/2021 01:42 PM

Institution	Inmate Count
ASP	103
CAC	40
CAL	51
CCC	25
CCI	100
CCWF	235
CCWF-RC	9
CEN	54
CHCF	1,298
CIM	477
CIW	141
CMC	344
CMF	761
COR	282
CRC	60
CTF	455
CVSP	135
FOL	86
HDSP	204
ISP	61
KVSP	209
LAC	429
MCSP	921

Disability Inmate Counts

Run By: ladjrs

Date Run: 08/09/2021 01:42 PM

Institution	Inmate Count
NKSP	41
NKSP-RC	77
PBSP	77
PVSP	68
RJD	950
SAC	113
SACCO	109
SATF	822
SCC	86
SHS	26
SOL	470
SQ	323
SVSP	365
VSP	661
WSP	44
WSP-RC	87
	10,799

State of California Department of Corrections and Rehabilitation

Memorandum

Date: January 14, 2021

To: Associate Directors, Division of Adult Institutions
Wardens
Americans with Disabilities Act Coordinators
Class Action Management Unit Correctional Counselor IIs

Subject: **SITUATING BLIND AND LOW-VISION INDIVIDUALS TO NEW LIVING ENVIRONMENTS DURING THE COVID-19 PANDEMIC**

The directives listed below are designed to ensure that blind and low-vision individuals are able to effectively and safely navigate their living environments during the COVID-19 pandemic. For purposes of this directive, "blind and low-vision individuals" shall be defined as those individuals who have a DPV code as identified in *Armstrong v. Newsom*. The requirements outlined in this directive are intended for individuals who have a DPV code, DNV code, or individuals who, because of a vision impairment, request the type of assistance identified as being available in this directive. For purposes of this directive, "orientation" shall be intended to mean an introduction to the living environment, location of necessities, and a conversation with the Americans with Disabilities Act Coordinator (ADAC), or their designee, who will document the individual's needs on a CDCR Form 128-O (attached).

BACKGROUND

Without initial guidance from sighted individuals, DPV individuals may have difficulty familiarizing themselves with and navigating new living environments. Depending on the nature and extent of their disability, they may be unable to identify Americans with Disabilities Act (ADA) workers or staff for help, or to locate critical areas of their living environment such as their bed, dayroom area, toilet, shower, water fountains, doors, recreational areas, law library, and dining hall. It is critical that DPV individuals receive orientation from an individual who has reviewed instructional materials on how to provide it.

DESIGNATED STAFF

The ADAC, or their designee, shall offer and provide orientation to DPV individuals upon transfer to a new housing environment. The ADAC, or their designee, shall review Exhibit A and the videos set forth in Exhibit B before providing individual orientations.

ADA WORKERS

ADA workers also may be designated to provide new environment orientation, with the exception of completing the CDCR Form 128-O, to DPV individuals housed in new living

environments when staff are unavailable and ADA workers are available. ADA workers may not assist in isolation or quarantine units. ADA workers may, however assist in non-traditional housing when a DPV individual is placed into a new unit that is not designated as isolation or quarantine. They must first review Exhibit A and Exhibit B and may perform orientation services only under the supervision of institution staff.

IDENTIFICATION OF PREFERRED BEDS

The ADAC or designee shall review, identify, and document which beds in each housing unit are most suitable for DPV individuals. In making this determination, the ADAC or designee, shall consider whether a bed is accessible to areas that the DPV individual will need to access frequently including toilets and showers; whether there are obstructions, protruding or overhanging objects in the path of travel; whether a bed is situated in a low-traffic area of the unit; and whether the location facilitates the individual's ability to obtain assistance from staff. The beds that are most suitable for DPV individuals should be documented in the Armstrong binder of each housing unit.

PLACEMENT OF BLIND AND LOW-VISION INDIVIDUALS IN NEW ENVIRONMENTS

When a DPV individual is moved to a new housing unit, the institution must perform the following actions. This applies regardless of whether the individual arrived from a different institution or from a different unit within the same institution, yard, or building.

I. Bed Placement

The institution must take the DPV individual's disability into consideration when making bed placements including a review of those beds identified as most suitable for DPV individuals.

II. Orienting to New Environments

The ADAC, or designee, shall offer an initial orientation session to each DPV individual who is transferred to a new housing unit as soon as possible after the individual arrives at the new housing location, and no later than 24 hours after the individual arrives. Subsequent orientation sessions for a DPV individual who requests them shall be scheduled as soon as possible.

The ADAC, or designee, shall be responsible for ensuring that such orientation is timely offered and provided to all eligible people. In addition to offering orientation sessions to all individuals designated DPV, housing staff shall ensure that any individual who requests an orientation session due to a vision disability, regardless of DPP code, receives one within 24 hours of their

request. Staff shall also identify individuals who appear unable to independently navigate their living environment, inform the ADAC or designee, and the ADAC, or designee, shall offer an orientation session to that individual within 24 hours of being advised. The CDCR Form 1824s may also be used to request an orientation. If a DPV individual arrives late at night or there is otherwise not enough time for a full orientation, the ADAC, or designee, shall on the same day as the individual's arrival, offer them an abbreviated orientation to include certain critical areas such as showers, toilets, and sinks and how to request assistance from staff and ADA workers. The full orientation shall be provided as soon as possible, but no later than 24 hours after placement.

The ADAC or designee, at various times, shall interview DPV individuals about the orientation and identify any areas for improvement.

III. ADA Worker and Staff Assistance

Blind and low-vision individuals may require assistance from ADA workers and staff throughout the day, including serving as sighted guides, helping clean bed areas, carrying items including meal trays and drinks, and reading and writing. However, these individuals may have difficulty finding ADA workers or staff when they need help due to their disability.

The same day that a DPV individual is moved to the new housing unit, the ADAC or designee shall interview the DPV individual using the CDCR Form 128-O to determine if they may need assistance. If there is not sufficient time for a full interview, the ADAC or designee shall, on the same-day as the individual's arrival, conduct an abbreviated interview with the individual to determine their immediate needs. A full interview shall be conducted as soon as possible, and no later than 24 hours after the new housing placement. All portions of the CDCR Form 128-O are to be reviewed and completed when an orientation is conducted.

Designated staff will review the Armstrong binder, understand the accommodations needed for the DPV individual, and ensure that the identified accommodations are provided. The plan to provide these accommodations must be communicated to the DPV individual.

When institutions return to pre-pandemic functioning, an amended memorandum will issue regarding the orientation of blind and low-vision individuals that will contain additional information.

If you have any questions, please contact Landon Bravo, Correctional Administrator, Class Action Management Unit, at (916) 322-6562 or landon.bravo@cdcr.ca.gov.

CONNIE GIPSON
Director
Division of Adult Institutions

Attachments

cc: Kimberly Seibel
Charles W. Callahan
Adam Fouch
Landon Bravo
Chantel Quint
Jillian Hernandez
Francesca Jacobo
Megan Assenza

EXHIBIT A

Primer: Situating Blind and Low-Vision Individuals to Living Environments

INTRODUCTION

Without help from sighted individuals, blind and low-vision individuals may struggle to familiarize themselves with new living environments upon their arrival. Depending on the nature and extent of their vision disability, they may be unable to identify ADA workers or staff for help and be unable to locate critical areas of their living environment, such as their bed, dayroom area, toilet, shower, doors, and chow hall. This document is a primer on how to situate a blind or low-vision individual to a new living environment. The primer lays out basic principles for how to conduct such an orientation, divided into several categories.

SAFETY

- Before you begin orienting an individual, survey the housing unit to make a note of any potentially hazardous places that a blind or low-vision person may not be aware of. Common hazards include elevation changes, jutting out walls, water fountains, phones, overhanging objects, pillars, staircases, chairs, and cracks in pavement or tiles. Consider removing clutter from known walkways if possible.

- While surveying the housing unit before the orientation session begins, keep an eye out for features of the living environment that you can point out to the individual whom you will be orienting.

DIFFERENT LEVELS OF NEED

People, including those designated "DPV," can have a wide range of vision disabilities. Some may not be able to see anything at all. Others may not be able to see only in low- or high-light situations. Others may not be able to see clearly things that are more than a few inches or feet away. Others may be able to read without assistance but may not have much peripheral vision, putting them at risk of bumping into staircases and other objects; they often describe their vision as like "looking through a straw." And others may have vision that changes day-to-day. Glasses can help some people see better, but not always well enough to safely navigate based on sight alone.

- Start your session by asking the individual questions about their functional vision and their ability to navigate an environment. Remember that among the individuals you orient, their needs will greatly vary. The key is to determine, at the beginning of your first session, what level of familiarity the individual has both with general navigation as a blind or low-vision person and with the layout of their new living environment.

- To get a better sense of the individual's needs, here are few questions you should ask:

- Can you see color? (If so, you may be able to point out features in the environment that stand out by color.) Do you have trouble distinguishing between objects that are the same color? (If so, it might help to paint protruding objects different and bright colors.)
- Do you have trouble seeing in low-light or high-light environments?
- Do you have limited peripheral vision?
- Can you see things better close up or far away?
- Are you pretty good with cardinal directions (north, south, east, and west), if someone informs you that you are facing in a particular direction and which direction you are walking? (This can be a helpful way of situating an individual to their environment, as discussed below.)
- Do you know how to use your white cane? Are you familiar with trailing or the protective techniques? (If yes to any of these questions, the individual may be more able to navigate their environment independently **if** they are first properly situated to it.)
- How long does it generally take you to become familiar with a route? Do you have trouble remembering how to get somewhere after one or two times of being guided there? (If so, the individual may require multiple orientation sessions after the initial session.)

Remember: Ask lots of questions! It is not rude to ask a blind or low-vision person what they can or cannot see, feel, hear, etc. This is all part of the orientation. The more you can learn about the person's perceptions, the better you will be at assisting them.

- In addition to orienting newly arrived individuals with DPV codes, be on the lookout for individuals who may require orientation but do not have this code. If you or others notice that an individual is bumping into people or things, missing drop-offs in elevation, probing with their foot to find the beginning of a staircase, getting disoriented or lost, looking down at the ground frequently, or trailing their hand along a wall to keep track of where they are as they are walking, this person may require orientation.

WHITE CANES

White canes are used by blind and low-vision individuals to determine the location of physical objects in their path of travel. For many individuals, a white cane can greatly enhance their independence and ability to navigate the prison.

If an individual does not have a white cane, housing staff should ask them if they need one, and if they do not know what a white cane is, staff should describe it to them. If the individual expresses a need for a white cane, or if an individual who has a white cane expresses a need for training on how to use it, housing staff should inform medical staff immediately. The structure of an orientation may vary based on whether an individual uses a white cane or not.

PROTECTIVE TECHNIQUES

When a blind or low-vision individual is adjusting to a new living environment, they may be unaware of certain objects obstructing their path of travel. When the individual whom you are orienting is not using a white cane (for example, it is common for blind and low-vision individuals not to use a white cane in their living quarters) and is moving in open space (for example, along a wall), encourage them to use the "upper hand" and "lower hand" protective techniques. The first involves placing one's hand in front of one's face, with the palm facing outward, preventing one's head from bumping into overhanging hazards. The second involves the opposite hand outstretched in front of the individual's midsection with the wrist flexed downward to protect their fingers. These two techniques, combined, offer full protection from the waist up.

START WITH THE BIG PICTURE, THEN GET INTO DETAILS

- Begin your orientation by having the individual use the "upper hand" protective technique, discussed above, and walk along the perimeter of the overall space, along each wall, pointing out to them any points of interest along the walls. It is important for the individual to get an overall picture of the space in their mind before exploring more detailed structures. Once the individual has a general overview of the spatial layout of the entire housing unit, orally guide the individual in the area immediately surrounding their bed. Have the individual identify where different fixed objects are relative to the bed, including lockers.

- Encourage the individual to practice "trailing" in the area immediately surrounding their bed. Trailing is a technique that blind and low-vision people can use to become familiar with their environment. It involves the individual "trailing" or running the back of one hand along a wall of a given space, while walking forward along the wall, to make mental notes of the space's layout; with the individual's other hand, they should use the "upper hand" protective technique.

- After the individual has a sense of the "big picture," start to practice detailed routes from point A to point B around the housing unit. Start with small, easy routes, and gradually build up to longer, more complex routes. It is difficult to learn even one route after only one attempt, so you may need to practice the routes repeatedly.

SENSORY AND SPATIAL CLUES

- Sensory: As you guide the individual around their housing unit, encourage them to pay attention to their other senses, such as sound and touch, to identify where they are. For example, you may note that the amount of noise changes when you move from one room to the next, or that you can hear the space open up when you enter the intersection of two hallways or when you enter a large room from a hallway. Additionally, alert the individual to any tactile domes or other tactile indicators that your housing unit has

installed for the benefit of blind and low-vision individuals, and if you or the person you are assisting notice that any particular location where a tactile indicator would be helpful, raise this with the ADAC or designee so one can be installed promptly.

- Spatial: Keep the individual aware of the space around them by (1) pointing out cardinal directions (e.g., "Now you are walking north so the dayroom is on your left" or "You're leaving the East Wing, heading west toward the chow hall.") or clock-face directions (e.g. "The chow hall is at your 2 o'clock"), depending on which method the individual prefers, and (2) identifying landmarks in the living environment. When you identify landmarks, focus on unique things—ideally fixed in place—that will stand out. You can also point out non-permanent landmarks, known as "clues," which can be moved but will often be located in a particular spot; for example, a rubber mat that is placed a particular doorway entrance. Avoid pointing out objects, like a chair, that are common throughout the unit or are indistinguishable from one another. You can also encourage spatial awareness by having the individual use the trailing technique, described above, while they count the number of doors that they pass with their hand before reaching a certain location, like their cell. Make sure to continue checking in with the individual about where they are in relation to landmarks around them as they move through the space. Feedback is key.

PRACTICE

- Even if an individual is familiar with the general layout of an institution or housing unit, they may be unfamiliar with how to navigate specific routes (e.g., the route from their bed to the shower, sink, or toilet). Practice important routes multiple times to ensure that the individual can travel from point A to point B without a guide, and ensure that they identify landmarks along each route.

- Remember that equal time should be taken to learn reverse routes (point B back to point A). Do not assume that once an individual becomes proficient in one direction that they will immediately be able to do the same in reverse

- **One orientation session may not be sufficient to situate an individual to their new living environment.** If necessary, schedule follow-up orientation sessions to practice and build on what you taught in your first session.

ADA WORKERS AND STAFF

Blind and low-vision people may require assistance from ADA workers and staff throughout the day, including serving as sighted guides, helping clean bed areas, carrying items including meal trays and drinks, and reading and writing. Often times, however, they may have difficulty due to their disability finding ADA workers or staff when they need help.

- Interview the individual regarding when they anticipate needing assistance, including for meals and laundry exchange, and communicate these responses to the ADA workers and housing officers in the housing unit and ensure a plan is in place to make sure those services are provided going forward and that the plan is communicated to the individual with a disability.

- Introduce the individual to ADA workers and housing officers in the housing unit and explain to the individual how they can request unscheduled assistance when necessary and find ADA workers and housing officers.

EXHIBIT B

The following online videos demonstrate some general approaches to situating a blind or low-vision individual to a new space. These approaches will need to be modified for each new environment. Beneath the first two videos, which deal with the basics of orientation, are a few takeaways from the videos to keep in mind.

Room Familiarization: Part 1
Link address: https://www.youtube.com/watch?v=OiPXNpjGlqE

Notes

- Instructor starts with a perimeter exploration of each wall. Instructor points out unique features along each wall that distinguish it from other walls (i.e., pointing out that a large whiteboard sits along one wall).

- Instructor has the student put their hand out to protect their face as they're exploring.

- Instructor gives the student plenty of freedom to explore on their own (with their cane, hands, etc.) and simply offers input as needed. Often this input is in the form of questions

to encourage the student to discover on their own (which aids learning and mental mapping).

- Instructor simply describes objects as the student encounters them and points out important features the student might've missed.

- When explaining the location of important points of interest, the instructor uses very simple language and describes the objects as well as their location in relation to the student's body (i.e., "it's on the right" or "it's above you").

- The student's main feedback for environmental information was tactile. This includes not only things the student could feel with their hands, but also things under foot (like the wire cover) and things contacted with the cane (the trash can).

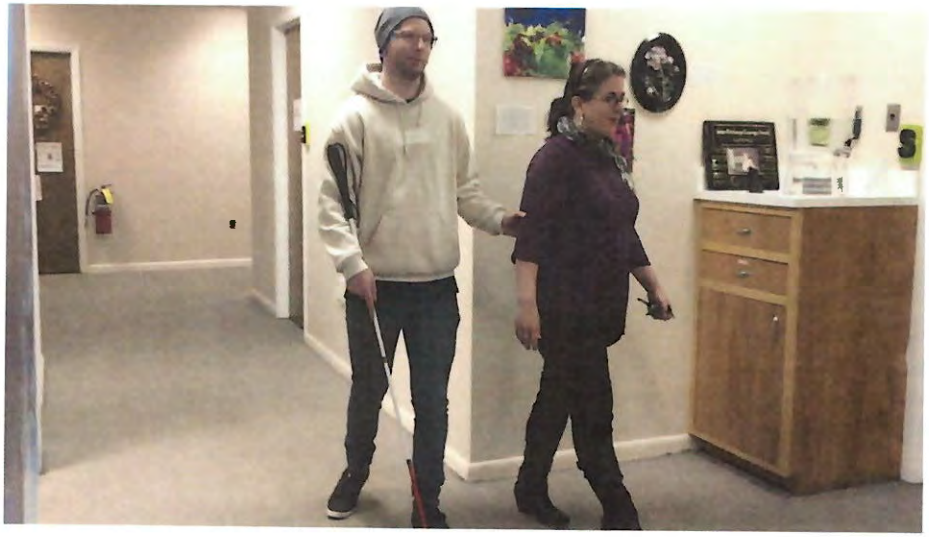
Room Familiarization: Part 2
Link address: https://www.youtube.com/watch?v=8o_EhEaL31A
Notes

- Now that the student has an idea about the size and layout of the space, the Instructor and student now explore the center of the room.

- Student puts their back to the wall and explores the room in a systematic grid pattern. Exploration should be done in some kind of systematic way that ensures the student covers the entire room. Doing it in a systematic way helps with creating a mental map and maintaining orientation.

- Student uses an area free of clutter to explore features of the room with cane.

Sighted Guide Technique
Link address: https://www.youtube.com/watch?v=AuGb4yge-ys



How to do Protective Techniques
Link address: https://www.youtube.com/watch?v=9Q9bUI5wr-

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION CDCR 128-O

INMATE CDCR # HOUSING

The inmate has a Disability Placement Program (DPP) code of DPV (severe vision impairment).

The inmate was moved to (unit/bed) _____ on (date) _____.

The inmate ☐ declined / ☐ accepted a detailed orientation of their new housing unit assignment and various institutional areas to ensure it is safe and accessible.

Inmate signature: _____. Date signed: _____.

If accepted: the orientation was provided on _____ (date).

If declined: Reason why_____ _____ _____.☐ The inmate requested additional orientation sessions. (If yes, describe plan for additional sessions in Orientation Comments field below.)

The inmate received orientation, in accordance with the guidelines set forth in **Exhibit A** (primer on how to orient a blind or low-vision individual), to the following areas:

Area (N/A if Not Applicable)	Staff Initials	Area (N/A if Not Applicable)	Staff Initials
☐ HU restrooms	_____	☐ R&R (property/packages)	_____
☐ HU showers	_____	☐ yard	_____
☐ HU dayroom	_____	☐ equipment	_____
☐ HU entrance/exit	_____	☐ benches	_____
☐ HU emergency exits	_____	☐ tables	_____
☐ officer podium/station	_____	☐ restroom(s)	_____
☐ CDCR forms in HU	_____	☐ drinking faucet(s)	_____
☐ inmate phones	_____	☐ visiting	_____
☐ library	_____	☐ medication distribution area	_____
☐ canteen	_____	☐ medical building(s)	_____
☐ dining hall(s)	_____	**COLLECTION BOXES**	
☐ education area(s)	_____	☐ CDCR Form 7362	_____
☐ gymnasium	_____	☐ CDCR Form 602/1824	_____

ORIENTATION COMMENTS:

Interview

☐ The inmate was interviewed regarding when they anticipate needing assistance (e.g., meals and laundry exchange). A plan was put in place to ensure staff and/or ADA worker assistance for such scheduled activities going forward. Describe in Interview Comments field below.

☐ The inmate received instruction on how to request unscheduled assistance when necessary from ADA workers and staff including how to locate or get their attention throughout the day. Describe in Interview Comments field below.

☐ The inmate was introduced to ADA workers and staff in the housing unit.

INTERVIEW COMMENTS:

☐ Chrono completed by: (Staff Name and Date) _____

☐ A copy of this chrono was forwarded to the Americans with Disabilities Act Coordinator (ADAC). (Initials and Date) _____

☐ Copy was received by the ADAC. (Initials and Date) _____ (ADAC/designee)

☐ Copy forwarded to Records for scanning into ERMS. ☐ Copy uploaded to CAMU Mailbox.

Instructions:

This chrono shall be used to provide and document orientation each time an inmate with a DPV code is housed within a new housing unit, facility, staging area, or institution.

Inmates with disabilities are entitled to reasonable accommodations. Please inform the inmate that the purpose of this orientation is to ensure their new housing assignment is safe and accessible. Requests for disability accommodations will not result in rules violations or adverse transfers within the institution or to another institution. **Please assure inmates requesting disability accommodations that they will not receive a Rule Violation Report, be moved to administrative segregation, or be subject to an adverse transfer within the institution or to another institution for requesting disability accommodations.**

It is imperative that blind or low-vision individuals be given a detailed orientation of their new housing assignment, in accordance with the guidelines set forth in **Exhibit A**, to ensure they are familiar with areas within their housing assignment and outside of the housing unit. The designated staff member shall document that the inmate has been oriented to designated areas, including the path of travel to each of the designated areas.

The designated staff member will complete the form on page 1 documenting that orientation has been provided (or, if applicable, declined). Not Applicable (N/A) is an appropriate entry only if an inmate is provided meals, medication, or other necessities in-cell and does not require orientation to a specific path of travel. Additional space for comments is provided at the top of page 2. The designated staff member will complete the form on page 2 documenting that the interview has been conducted.

Upon completion of this chrono, please forward to the institution's Americans with Disabilities Act Coordinator (ADAC). Upon receiving the chrono, the ADAC will provide a copy to Records to be scanned into ERMS and a copy shall be uploaded to the CAMU mailbox.

State of California | Department of Corrections and Rehabilitation

Memorandum

Date: August 14, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Americans with Disabilities Act Coordinators

Subject: **AMERICANS WITH DISABILITIES ACT WORKER PROGRAM FOR DURATION OF COVID-19 PANDEMIC**

The California Department of Corrections and Rehabilitation (CDCR) has an obligation to provide access to its programs, services, and activities for all inmates and parolees with disabilities, as required by Federal Law, the Americans with Disabilities Act (ADA), and the Armstrong and Clark Remedial Plans.

Oversight

All CDCR institutions are required to have an ADA Inmate Assistance Program. The purpose of this program is to provide inmates with disabilities the assistance they require to access CDCR's programs, services, and activities. The institutional ADA Coordinator shall provide oversight to ensure inmates with disabilities are receiving all required assistance, and all requirements below are being addressed and met. The ADA Coordinator or designee, shall continuously monitor the institutional ADA Worker program to ensure appropriate assistance is being provided and a sufficient amount of Personal Protective Equipment (PPE) is available for workers, or volunteers, to safely conduct their required duties. The ADA Coordinator shall regularly evaluate the needs of ADA inmates to determine the appropriate number of ADA Workers and to ensure inmates requiring assistance are able to access programs, services, and activities. For example, the ADA Coordinator shall consider how many people in the housing unit need help reading and writing, navigating during yard time or to appointments, cleaning their bed area, and carrying meal trays. The ADA Coordinator shall also consider when a large number of people in a housing unit would require assistance, such as during meal times, and ensure that there is sufficient staffing during those peak times to meet the needs of the ADA inmate population. The ADA Coordinator should consider the needs of all inmates who require disability-related assistance, including inmates in the Developmental Disability Program (DDP).

The expectation is that the ADA Coordinator is immediately notified by the area supervisor or manager if there are an insufficient number of ADA Workers available. In this instance, the ADA Coordinator shall create additional ADA Worker positions as well as seek volunteers. Additionally, during supervisor/manager mandated tours of housing units, individuals requiring assistance will be queried to ensure appropriate assistance is being provided. Supervisors or managers shall immediately report any concerns regarding the ADA Inmate Assistance Program to the ADA Coordinator. The ADA Coordinator shall regularly meet with individuals requiring assistance to ensure appropriate assistance is being provided to them.

Implementation
Institutions are required to develop and implement a plan to ensure the ADA Worker Program can safely function during the COVID-19 pandemic. Therefore, for the duration of the COVID-19 pandemic, ADA Workers are authorized to assist inmates housed within their building or unit around the institution, but shall not assist other inmates housed outside of their own building or unit. ADA Workers assigned to program areas other than their building or unit may only assist inmates from their building or unit in these assigned program areas. Each building or unit that houses inmates with disabilities shall have a minimum of one ADA Worker assigned. The exceptions to this requirement are restricted housing units such as Administrative Segregation Unit (ASU), Mental Health Crisis Beds (MHCB), Psychiatric Inpatient Program (PIP) and Administrative Security Housing Unit (SHU). Restricted housing units (ASU, MHCB, PIP, SHU) provide a higher staff to inmate ratio ensuring staff assistance will be readily available to those who need it.

Isolation/Quarantine
In an effort to minimize the spread of COVID-19, for housing units and areas designated for isolation/quarantine, services will be provided by staff within the housing unit. Each isolation/quarantine housing unit will be evaluated daily by the unit supervisor to ensure adequate staffing is available to provide necessary assistance to inmates with disabilities.

Screening
If an ADA Worker is not available to assist a DPP inmate, volunteers may be utilized. Inmates will be preliminarily screened using the criteria within the memorandum titled *Revised Americans with Disabilities Act Inmate Assistance Program*, dated, June 25, 2020 and temporarily placed in a recognized inmate assignment as an ADA Worker pending committee action. Inmates shall also be screened to determine if the inmate has symptoms of influenza-like illness (ILI) in accordance with the memorandum titled *Screening of Critical Inmate Workers*, dated April 10, 2020. Under no circumstances shall an ADA Worker or volunteer who is not positive for COVID-19, or showing symptoms of ILI, assist an inmate who has a positive and unresolved case of COVID-19; nor shall an ADA Worker or volunteer who is currently positive for COVID-19, or showing symptoms of ILI, assist any inmate who has not tested positive for COVID-19 or symptoms of ILI. Due to these restrictions, inmates exhibiting symptoms of ILI, or who have had a positive test for COVID-19, shall be provided assistance by staff to ensure their access to programs, services, and activities.

Training
Please ensure all ADA Workers and volunteers are provided training consistent with the California Prison Industry Authority (PIA) Healthcare Facilities Maintenance (HFM), *Porter COVID-19 Training* curriculum. Additionally, newly assigned ADA Workers will receive the

required mandated ADA Worker Program Training consistent with the memorandum titled, *Revised Americans With Disabilities Act Inmate Assistance Program,* dated June 25, 2020. Volunteers will receive an overview of the required training by a supervisor. This required training instructs volunteer ADA workers on how to appropriately assist inmates to or from programs, services, and activities, including the sighted guide technique, the proper way to help someone in a wheelchair navigate the prison environment, and what type of assistance they are, and are not, allowed to provide. Additionally, volunteer ADA Workers will be trained on how to assist with conveying staff announcements, including ducat lists and other activity lists made via the public address system. Assigned ADA Workers will be able to provide all other forms of assistance consistent with the above referenced memorandum.

PPE

All ADA Workers and volunteers who provide assistance to inmates with disabilities are required to wear face coverings (surgical masks) that completely cover the nose and mouth, and to wear non-sterile disposable gloves at all times while assisting inmates with disabilities. Staff members providing assistance to inmates with disabilities are required to follow CDCR guidelines outlined in the memorandum titled, *COVID-19 Personal Protective Equipment Guidance and Information,* dated April 6, 2020. Gloves must be disposed of immediately after each inmate interaction, and new gloves must be worn prior to each new inmate interaction. ADA workers are required to wash and sanitize their hands before and after coming into contact with each inmate who they are assisting. ADA Workers are also required to thoroughly clean the area of any appliance (wheelchair, walker, etc.) they touch while assisting ADA inmates before and after each contact. Areas shall be designated for ADA Workers to access cleaning supplies and hand sanitizer as needed to complete their assigned duties. Additionally, to maintain compliance with social distancing guidelines, areas will be designated to allow ADA Workers to conduct tasks, such as completing forms and reading documents, while maintaining a distance of six feet whenever possible. When an ADA worker must come into close contact with a disabled inmate to provide assistance, such as when an ADA worker serves as a sighted guide, the disabled inmate shall also be provided with gloves and a surgical mask.

Reporting Requirement

Please provide proof of practice on a weekly basis, no later than close of business, Fridays electronically to the following staff:

- Adam.Fouch@cdcr.ca.gov
- Landon.Bravo@cdcr.ca.gov
- Amanda.Jaravata@cdcr.ca.gov
- Sam.Malhi@cdcr.ca.gov.

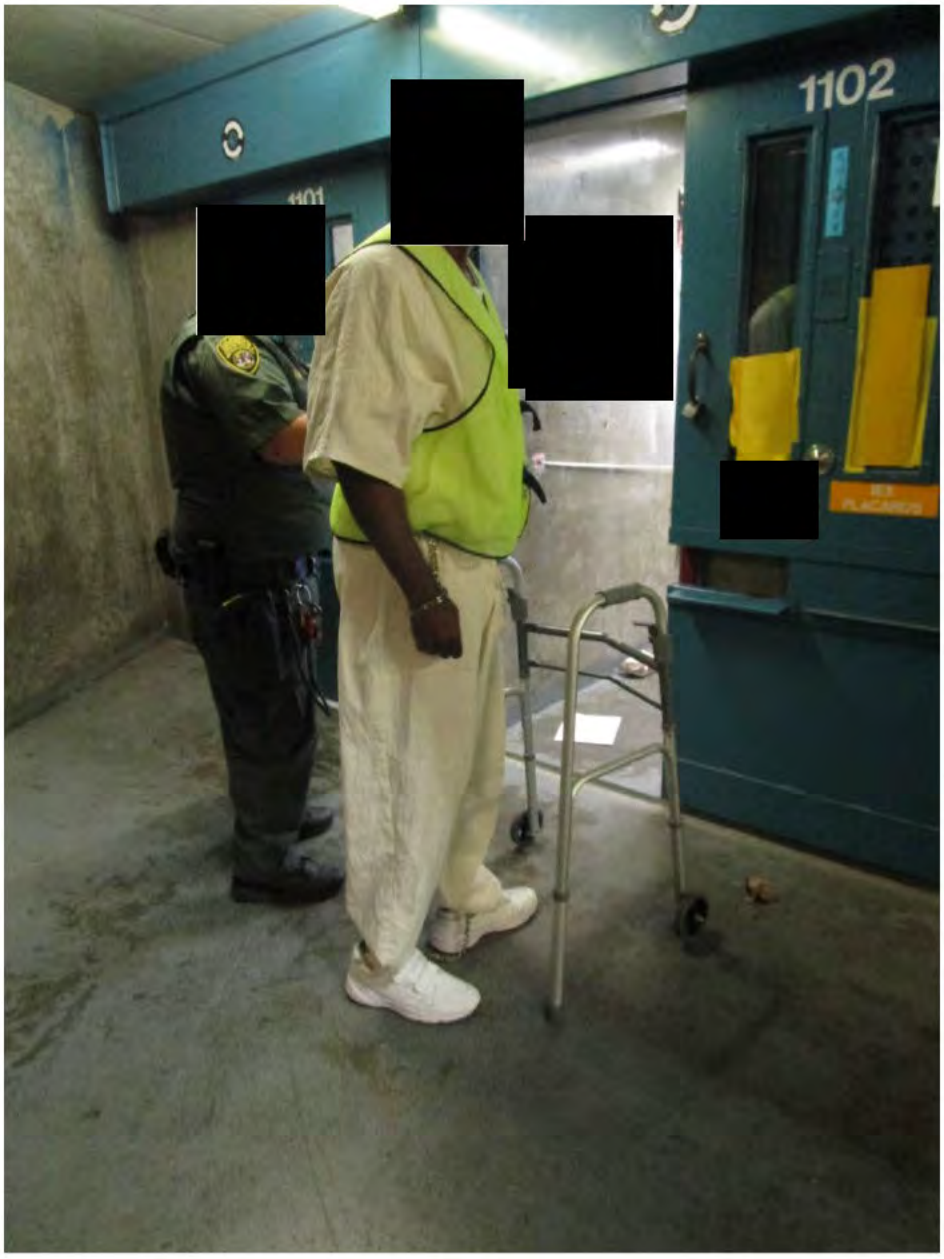
The health and safety of all individuals within the institution is our top priority. Please work together at the institution to standardize the process provided above.

If you have any questions, please contact Landon Bravo, Correctional Administrator, Class Action Management Unit, at (916) 322-6522, or Landon.Bravo@cdcr.ca.gov.

CONNIE GIPSON
Director
Division of Adult Institutions

Attachments

cc: Kimberly Seibel
Charles Callahan
Adam Fouch
Landon Bravo
Chance Andes
Amanda Jaravata
Sam Malhi

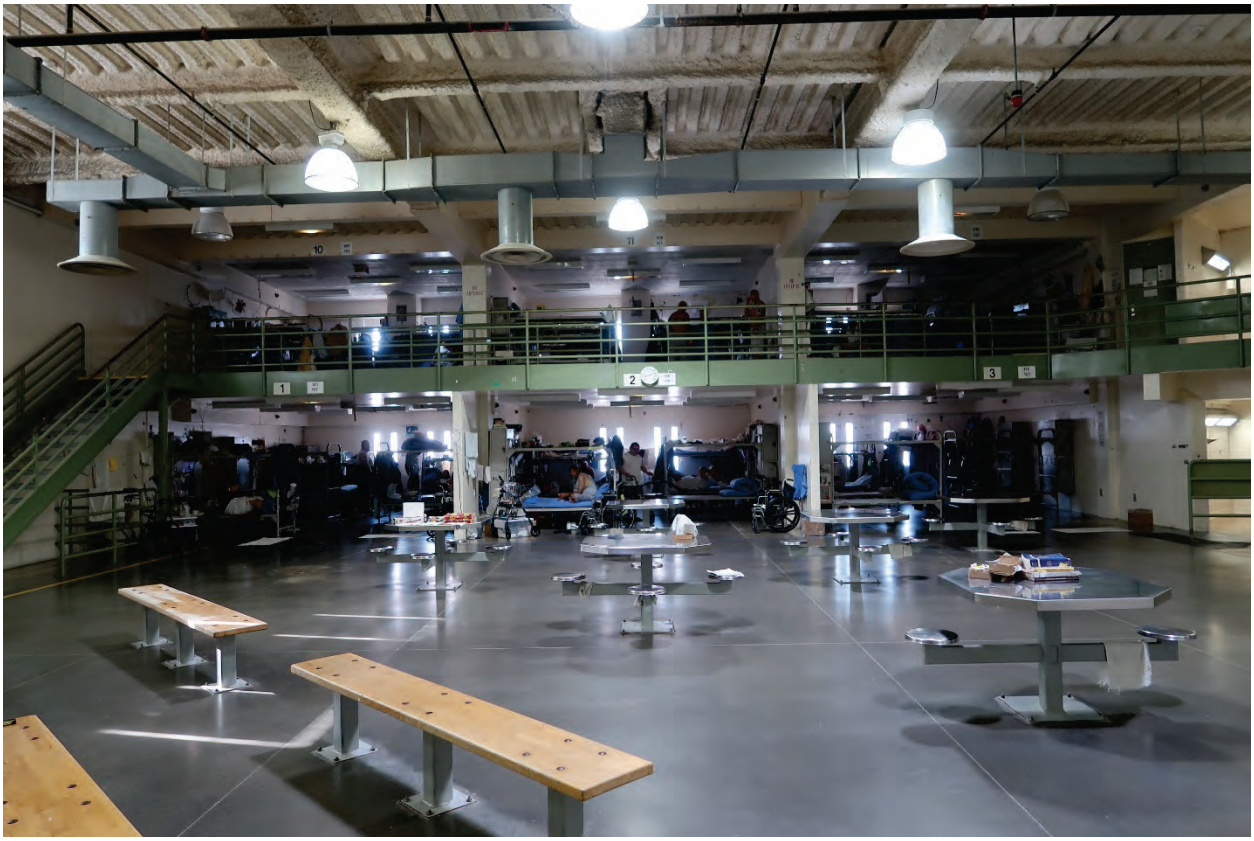


Facility A-1 Inmate

Facility A, Building 3-‘A’ Section Dayroom with 3 Lower Tier Pods

Each POD currently houses 7-8 man ‘Cohorts’ Due to Covid. Beds 1,2,6 & 7 in each POD are DPW for a total of (36)

As of 8-27-20, A3 has zero DPW inmates



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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM., et al.,

Defendants.

Case No. 4:01-cv-1351 JST

DECLARATION OF SARA NORMAN IN SUPPORT OF PLAINTIFFS' RESPONSE TO ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION

I, Sara Norman, declare as follows:

1. I am a lawyer admitted to practice in this State and before this Court. I am one of the lawyers for the plaintiff class in this action. I have personal knowledge of the matters herein and if called upon could so testify.

2. I am lead counsel in *Clark v. California*, No. 3:96-cv-01486-CRB, a class action on behalf of people with developmental disabilities in the California Department

of Corrections and Rehabilitation (CDCR). The program that CDCR has developed for this population in response to this lawsuit is called the Developmental Disability Program (DDP). There are approximately 1300 people in the DDP, and they are housed at most CDCR prisons.

3. As part of my duties on the case, I regularly speak to people in the DDP; I estimate that I have spoken to at least several hundred a year for more than 10 years. I also speak regularly with CDCR staff who work on the DDP, including administrators and auditors in Sacramento as well as DDP officers, sergeants, counselors, and clinicians at the various prisons that house large numbers of people in the program. Many of these conversations happen on DDP compliance reviews. I attend approximately five to seven compliance reviews each year (in person when possible, remotely during the pandemic) in which we jointly review and assess the DDP at individual institutions side by side with auditors from CDCR. Each compliance review includes dozens of interviews of DDP staff as well as people in the DDP.

4. The hallmark of the DDP is the identification and provision of adaptive supports. Each person in the DDP is given an individualized list of the adaptive supports that staff must provide. Attached as Exhibit A is the current listing of the adaptive supports listed as options in CDCR's Electronic Health Records System.

5. As Exhibit A demonstrates, these supports range from activities of daily living (prompt people to shower, brush their teeth, attend appointments, and take medication) to behavior (monitor for isolation and acting out) to communication (simplify, deescalate, remind). People in the DDP often need help understanding the

rules and reading and writing forms like sick call slips and grievances. Many need to be monitored to protect them for theft or verbal or physical abuse.

6. Many of these supports cannot be provided without close contact with staff – usually, custody staff. For example, reminders to shower and to brush teeth cannot be given over the loudspeaker; they are required to be given through personal contact, and staff are required to log both the prompt provided and the disabled person's response. Staff cannot help someone to read or write, or redirect them when they are agitated, or "[m]onitor for wearing clean clothes" without being close at hand. For people who are vulnerable to abuse by others, staff are required to have individual, confidential conversations at least monthly to enquire in private about such concerns. In my experience, these conversations can sometimes take a significant amount of time.

7. In sum, it is impossible to meet the basic needs of people in the DDP without frequent close contact with custody and other staff. Based on my observation and experience, frequent close contact is occurring on a daily basis with this population.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on August 24, 2021, at San Francisco, California.

/s/ Sara Norman

Sara Norman

EXHIBIT A

Revised EHRS Options - Adaptive Support Needs

Reading and Writing

1. Offer to read/write CDCR forms/paperwork
2. N/A
3. Other:

Communication

1. Slow simple language/repeat as needed
2. Give one or two step instructions
3. Redirect to deescalate when agitated
4. Requires frequent reminders
5. N/A
6. Other:

Activities of Daily Living

1. Prompt to brush teeth
2. Prompt for canteen
3. Prompt for ducats/med line
4. Monitor for wearing clean clothes
5. Prompt for laundry exchange
6. Prompt & extra time: cell cleaning
7. Prompt & extra time: finish tasks
8. Prompt & extra time: meals
9. Prompt & extra time: showers
10. N/A
11. Other:

Behavior/Social Interactions

1. Prompt to correct behavior*
2. Prompt to go to yard/dayroom
3. Coach in steps if learning new task
4. N/A
5. Other:

* Must specify behavior

Rules and Procedures

1. Assist to understand rules/procedures
2. Assist adjusting to new environments
3. N/A
4. Other:

Revised EHRS Options - Adaptive Support Needs

Victimization*

1. Vulnerable to victimization
2. Vulnerable to pressuring/teasing
3. Monitor for theft: food/canteen
4. Monitor for theft: packages/property
5. N/A
6. Other:

*Must conduct a private one-on-one interview.