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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

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

Judge: Hon. Jon S. Tigar
Date: May 27, 2021
Time: 2:00 p.m.
Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the May 27, 2021 Case Management Conference.

Plaintiffs' introductory statement: There has been a marked reduction in active COVID cases in the prisons, a result of about one-half the population having previously been infected, a relatively high vaccination rate among residents, and relatively low community transmission rates in most of California. As of May 25, there are 11 known cases of COVID among the incarcerated people in CDCR,[1] and the vaccination rate is just over 70%. Unfortunately, the situation among prison staff is far more troubling: there are 134 staff cases currently, and despite repeated and highly-coordinated efforts by CCHCS, CDCR, and others to encourage voluntary vaccination for those who work inside the prisons, only about half of staff have accepted a vaccine. As set forth below, infected and unvaccinated staff members continue to pose a significant threat to incarcerated communities. Accordingly, continued employment inside CDCR prisons should be conditioned on receiving the vaccine, and those who are unable to take the vaccine for religious or medical reasons should be tested for COVID daily.

Defendants' introductory statement: After over a year since the onset of the pandemic, CDCR is pleased to report that there are currently only 11 cases of COVID-19 among incarcerated people in the past 14 days (as of May 25, 2021), with no single institution having more than 6 cases. Only four institutions currently have any active cases of COVID-19 among the incarcerated population, and only two of those four institutions have more than one case. This is an astounding improvement since December 22, 2020, when CDCR peaked with 10,617 active cases of COVID-19 that were new in the past 14 days. Relatedly, CDCR's vaccination efforts, which began in late December 2020, have yielded significant positive results. Currently, 68% of the incarcerated population is *fully* vaccinated, and vaccinations are ongoing.

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[1] According to the CDCR COVID tracker website, six of these cases are at California State Prison, Solano.

In light of these positive and hopeful improvements in CDCR's response to the COVID-19 pandemic, CDCR and CCHCS have commenced a reopening process grounded in healthcare and public health guidance. The Roadmap to Reopening provides a flexible approach to ensuring the safety and wellbeing of inmates and staff as the institutions work towards returning to pre-pandemic operations.

I. VACCINES

As of May 21, 2021, 97% of the California Department of Corrections and Rehabilitation's (CDCR) incarcerated population has been offered at least one dose of the vaccine, and 72% of those offered have accepted the vaccine. This amounts to 71% percent of the incarcerated population having received at least one dose of the vaccine. Vaccination rates of medically high-risk incarcerated people are as follows: over 99% of all COVID-19-naïve patients aged 65 or older have been offered the vaccine, and 90% of patients in this category are fully vaccinated, with another 8 patients awaiting the second dose of the vaccine; over 99% of all COVID-19-naïve patients with a COVID-19 weighted risk score of 6 or higher have been offered the vaccine, and 91% of patients in this category are fully vaccinated, with another 10 patients awaiting the second dose of the vaccine; and 99% of COVID-19-naïve patients with a COVID-19 weighted risk score of 3 or higher have been offered the vaccine, and 83% of patients in this category are fully vaccinated, with another 88 patients awaiting the second dose of the vaccine. Additionally, as of May 21, 2021, at least[2] 49% of staff who work in CDCR's institutions have been given at least one dose of the COVID-19 vaccine. Employees and incarcerated people are still required to wear personal protective equipment and practice physical

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[2] CDCR and CCHCS are working with the Department of Public Health to determine the number of staff who have been vaccinated outside CDCR's system to maintain accurate data. Because individuals may decline to share their medical information, it may not be possible to reflect every vaccinated staff member in this percentage.

distancing even after receiving the vaccine.[3]

Plaintiffs' Position:

Patients

We continue to be pleased with CCHCS's efforts to vaccinate incarcerated people against COVID-19. CCHCS data as of May 21 shows that 98% of the approximately 97,000 people in CDCR custody have been offered a vaccine.[4] It also shows that 69% of the population is fully vaccinated, and another 3% have received one dose of a two-dose regimen, so will be fully vaccinated in no more than 30 days. As previously reported (see ECF No. 3579 at 3:14-17), approximately 90% of those age 65 or older are fully vaccinated, according to the data.

The data also shows that the COVID vaccine refusal rate among the CDCR population in the last approximately 30 days dropped slightly from approximately 30% to 27%.[5] We appreciate that CCHCS has re-offered, and continues to re-offer, vaccine to those who have hesitated or refused to be vaccinated, and that they are planning an outreach event at Salinas Valley State Prison to promote the vaccine to people who have thus far refused it. (Two of that prison's four main yards have relatively high refusal rates among residents). We also appreciate that CCHCS on May 20 said it was working on guidance or directives for medical providers regarding identifying at each clinical

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[3] As discussed below, the Receiver's office and CDCR have lifted the mask-wearing requirement for those who are outdoors and at least six feet away from others. However, individuals are still required to keep a mask on their person, and must wear it if they come within six feet of another person outdoors.

[4] Almost all who have not been offered vaccine are either out-to-court and thus not physically present in a CDCR prison, or are Reception Center new arrivals pending a vaccine offer. There are approximately 150 listed as not having been offered vaccine who are not in either of those two groups. On May 20, CCHCS said it would direct prisons to determine if those people are mistakenly listed, or need to be offered vaccine.

[5] As of May 11, there were a dozen CDCR "yards" (as sub-facilities within each prison are commonly called) with a population of greater than 500 at which nearly or just over 50% of the residents had refused a vaccine offer.

encounter whether a patient is vaccinated, and discussing and offering the vaccine if the patient is not; ultimately, the hope is that this information will be auto-generated into each primary care note so that the provider does not have to remember to look for this information elsewhere.

The number of active COVID cases, and transmission rates among incarcerated people, remain low. CCHCS reports that 43 fully vaccinated patients have tested positive (i.e., are considered "breakthrough" cases). As of May 20, there were four active breakthrough cases in the prisons statewide, according to CCHCS; two of those had been hospitalized due to COVID-related conditions.

Staff

Even with open (no appointment necessary) availability of COVID-19 vaccine for staff at all prisons in May, and CCHCS's receipt of data regarding vaccinations received in the community, CCHCS reports that only about 50% of prison staff are vaccinated or partially vaccinated (not yet completed their two-dose regimen) against the disease. This is a major concern because, among other things, (1) staff are the primary vector for introducing COVID-19 into the prisons, (2) staff are continuing to contract the virus (with 88 new cases reported in the last 14 days[6]), some of whom are being diagnosed with new, potentially more transmissible, variants of the virus, (3) increased rates of COVID-19 may occur among unvaccinated staff in the future, and (4) COVID cases among staff even now can result in an outbreak among residents, and always result in large numbers of residents being quarantined for exposure, thus greatly limiting their programs and access to healthcare services. It takes just a few active staff cases to put a stop to programming for a large number of patients, including long awaited offsite encounters, which are ultimately postponed due to quarantine.

CCHCS, CDCR, and the CCPOA say they continue to try to convince staff to get

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[6] *See* Cal. Dep't of Corr. & Rehab., *CDCR/CCHCS COVID-19 Employee Status*, https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/ (last updated May 21, 2021).

vaccinated; unfortunately, they have not been particularly successful. We have recently talked with CCHCS, the Receiver, and Mr. Adams of the CCPOA about these efforts, as well as our position that vaccinations should be mandated for staff. On May 21, the Receiver reiterated that he takes seriously the question of whether vaccination should be mandatory for staff and discusses the matter frequently with his own staff. He also stated he would not make a decision regarding mandatory vaccination by the date of the Case Management Conference, and expressed a hope that the parties in this Statement would detail legal arguments, evidence and the pros and cons of mandatory vaccinations for prison staff.

Plaintiffs appreciate the continuing consideration of a vaccination requirement by the Receiver and his staff. The Receiver is best positioned to make a decision regarding this matter, and we understand that additional time is needed to do so, including to consider whether and when other healthcare organizations adopt mandates. We continue to research vaccination requirements, and will provide that information to the Receiver and Defendants as appropriate. At this time, we support the University of California and California State University systems' decision to require vaccination for all faculty, staff, and students, though we do not believe it is necessary to condition the requirement on full approval by the FDA.[7] Hundreds of other colleges and universities have also adopted some level of vaccine mandate.[8] We note that in *Kiel v. Regents of the University of California*, No. HG20-072843, a California superior court recently upheld the UC system's mandatory flu vaccination requirement. Colleges and universities are taking steps necessary to protect their communities, where many people live in congregate settings. People living in California's overcrowded prisons are, in many cases, at much higher risk

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[7] *See, e.g.*, https://ucnet.universityofcalifornia.edu/coronavirus/ student-faqs-covid-19-vaccine-5-4-21.pdf.

[8] *See* https://www.chronicle.com/blogs/live-coronavirus-updates/heres-a-list-of-colleges-that-will-require-students-to-be-vaccinated-against-covid-19.

of harm from the virus than those in college communities, due to their living conditions, advanced age and poor health. If a vaccine mandate is appropriate for university workers, it is even more so for prison workers.

We have great concerns about the plan, which we just heard about this week and is apparently endorsed by Defendants and CCPOA, for a program for one-on-one medical consultation with staff who have refused vaccine. While individual engagement on the benefits of vaccinations is a reasonable strategy, its effectiveness is unknown and there are several problems with its implementation. First, unless medical staff is diverted from patient care duties – which we would oppose for obvious reasons – it is likely to take weeks to hire licensed medical staff to meet with staff at all 35 prisons. It then would presumably take months to meet individually with the tens of thousands of unvaccinated staff. All the while, risks of harm from another surge remain.

Regardless of what further efforts are undertaken to increase staff vaccinations, we believe unvaccinated staff should be COVID-19 tested each day they enter a prison. CCHCS last week indicated they had not yet operationalized or focused on this risk reduction measure.

Defendants' Position:[9] Defendants and the California Correctional Health Care Services (CCHCS) remain committed to vaccinating CDCR's incarcerated population and staff as quickly as possible consistent with public health guidelines. CDCR and CCHCS continue to encourage people who initially declined the vaccine to consider accepting it. Staff and incarcerated people can still request the vaccine even if they initially opted not to accept it.

As reported in the last case management conference statement, CCHCS is conducting open COVID-19 vaccine clinics at each institution for a minimum of five days this month. These clinics will operate during all shifts and will be open to all staff.

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[9] Defendants have not had an opportunity to review and respond to Plaintiffs revisions located at p. 7:4-16.

CCHCS is also considering incentive programs to further encourage vaccine acceptance by staff.

To further incentivize COVID-19 vaccine acceptance, the Receiver announced that fully vaccinated incarcerated people and staff members are excused from routine COVID-19 surveillance testing during the month of May, unless they are symptomatic, a close contact of an active case, subject to Movement Matrix protocols, or will have a dental encounter. CCHCS and CDCR have also resumed use of the one-dose Johnson & Johnson vaccine, which may incentivize incarcerated people and staff who prefer one injection to accept the vaccine.

At the April 29, 2021 case management conference, the Court suggested that a mandatory vaccine policy for CDCR and CCHCS staff should be given a hard look. Defendants continue to consider the advisability of such a policy and monitor state and national trends on this issue. Specifically, an internal workgroup that is led by the Receiver's Office and that includes CDCR and CCHCS officials is continuously evaluating the mandatory-vaccine issue. No decision to mandate vaccinations for CCHCS and CDCR employees has yet been reached, and a number of considerations indicate it would be premature to mandate staff vaccinations at this time. Some of these considerations are addressed below.

The Food and Drug Administration has only given available COVID-19 vaccines emergency use authorization. Individuals must be informed that they may refuse a vaccine made available under an emergency use authorization. 21 U.S.C. § 360bbb-3(e)(1)(A)(ii)(III). And the World Health Organization recently identified certain ethical considerations involved in mandating a vaccination that has not yet been formally approved for use by the FDA.[10]

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[10] "COVID-19 and mandatory vaccination: Ethical considerations and caveats," World Health Organization, April 13, 2021, available at: https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-

Moreover, staff continue to accept the vaccine through ongoing incentive programs. Defendants agree with the California Correctional Peace Officers Association's comments at the last conference that recently implemented and ongoing incentives for voluntary vaccine acceptance should be given some time to take effect. Defendants are hopeful these initiatives, along with other previously-reported incentives,[11] will increase acceptance rates among staff. Indeed, since the last case management conference, 2,574 more staff have accepted at least one dose of the vaccine, increasing the percentage of staff at the institutions with at least one dose of the vaccine from 44% to 49%, and vaccine clinics will continue through the end of the month at some institutions. Defendants and the Receiver's office will consider additional measures depending on the success of these programs.

The Receiver's office and CDCR believe it is important to do everything reasonably possible to educate and encourage voluntary vaccine acceptance before mandating a vaccine as a condition of employment. To this end, CDCR and the Receiver's office are developing a program for one-on-one medical consultations with staff who have not yet been vaccinated, based on evidence that such consultations have a significant influence on vaccine acceptance. This program will be implemented in the near future and is supported by CCPOA. (See ECF No. 3591.)

Additionally, the number of active COVID-19 cases among the incarcerated population has been very low for the past two months (11 as of May 25, 2021). These low numbers make a mandatory vaccine policy difficult to justify from a public health standpoint, though Defendants and the Receiver's office remain alert to the possibility of future outbreaks.

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vaccination-2021.1.

[11] Recent incentives include a supplemental-paid-sick-leave program through which full time employees may receive up to 80 hours of leave at their regular rate of pay in addition to any other paid leave to which employees may be entitled, and the creation of the COVID Mitigation Advocate Program. *See* ECF No. 3579 at 7-8.

In a call with the parties on May 20, 2021, the Receiver pointed out that healthcare systems across the country have not universally adopted mandatory vaccine policies—a trend of interest as the discussion on this topic continues within CDCR and CCHCS. The Receiver also explained that unintended consequences of a vaccine mandate, for example, staff attrition, are another major consideration in the decision-making process. Defendants are not aware of any other state prison system that has mandated staff vaccinations.

Because there are significant and myriad challenges to imposing a mandatory vaccination policy, and because Defendants are still exploring incentivizing vaccinations and are now starting to see the positive results of those efforts, Defendants believe it would be premature to implement a mandatory vaccination policy at this time. Instead, like the Receiver, Defendants prefer to focus efforts on implementing measures designed to increase voluntary vaccine acceptance, while continuing to discuss the possibility that the COVID-19 vaccine should be required as a condition of employment. This is consistent with the approach recommended by the World Health Organization in a policy brief on April 13, 2021, which stated that "Governments and/or institutional policy-makers should use arguments to encourage voluntary vaccination against COVID-19 before contemplating mandatory vaccination."[12]

Finally, to the extent this Court may be contemplating an order mandating staff vaccinations, the Prison Litigation Reform Act requires that these forms of less-intrusive and more narrowly-tailored relief be explored before such relief could issue. Indeed, given the Defendants' efforts to date to encourage staff acceptance of the vaccine, Defendants' future plans and ongoing efforts to increase acceptance, the recent successes of these new incentive programs, and in light of the current low number of positive cases of COVID-19 among the incarcerated population, Defendants do not believe that a court order could

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[12] "COVID-19 and mandatory vaccination: Ethical considerations and caveats," World Health Organization, April 13, 2021, available at: https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2021.1.

properly issue at this time.

II. POPULATION REDUCTION

Plaintiffs' Position: CDCR's population continues to slowly increase. As of May 21, per the CCHCS Vaccine Registry, nearly 97,000 were incarcerated. We acknowledge that this total is approximately 25,000 fewer than pre-pandemic levels in March, 2020.

Also on May 21, CDCR reported that as of May 17, 7,663 people in county jail were pending transfer to CDCR. During the first full week of May, nearly 1,000 people were received in the CDCR Reception Centers.

CDCR continues the early release program, begun approximately a year ago, applicable to some who have 180 days or less to serve. Data provided by CDCR appears to show that this program has recently resulted in approximately 100 people per week paroling or being release to community supervision earlier than they otherwise would have been. We continue to believe that efforts to reduce population remain necessary (see ECF No. 3579 at 9:21-11:1).

Defendants below describe revised time credit rules implemented May 1 which permit some incarcerated persons to receive increased good conduct and other credits. We strongly support these revised rules.

Defendants' Position: As Plaintiffs acknowledge, CDCR's population is approximately 21% lower now than it was when the COVID-19 pandemic began in March 2020. Since July 2020 when CDCR announced its COVID-19 early-release programs,[13] 9,013 people have been released early. The vast majority of these people have been released through the 180-day early-release program, which, as Plaintiffs discuss above, is ongoing.

III. CREDIT EARNING

Plaintiffs' Position: As stated above, we strongly support the revised time credit

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[13] *See* https://www.cdcr.ca.gov/covid19/expedited-releases/ for a description of CDCR's COVID-19 early-release programs.

rules described by Defendants below.

Defendants' Position: CDCR passed new credit-earning regulations effective May 1, 2021. Significant credit-earning changes include:

- an increase in the rate at which people serving sentences for violent crimes earn credits for good conduct from 20% (one day of credit for every four days served) to 33.3% (one day of credit for every 2 days served);
- an increase in the rate at which people serving sentences for nonviolent crimes with second- or third-strike enhancements earn credits for good conduct from 33.3% (one day of credit for ever two days served) to 50% (one day of credit for each day served);
- the creation of Minimum Security Credit, through which people assigned to minimum custody workgroups, firefighting camps, or non-firefighting camps will be awarded 30 days of credit after 30 consecutive days of custody; and
- a change in disciplinary practices that previously implemented zero-credit-earning days in response to a rules violation. Under the new regulations, incarcerated people will no longer be disciplined with zero-credit-earning days. Instead, where appropriate, discipline will include limiting incarcerated people from certain privileges for a limited amount of time, but they will continue earning Good Conduct Credits during that time. Loss of privileges could, however, limit a person's ability to earn additional credits through certain programs.

CDCR anticipates that, in addition to incentivizing positive behavior, these new changes will allow more people to reduce the amount of time spent in prison.

Contrary to recent news reports, these new regulations will not result in the early release of 76,000 individuals. Complex and unpredictable variables make reliable projections of the impact difficult. For example, it is impossible to predict when or how many people might be found guilty of a rules violation, how many days of credit may be forfeited as a result, how many days may ultimately be reinstated, and how each person's

release or parole eligibility date may be impacted as a result, if at all. Nonetheless, CDCR's Office of Research continues to study how the new credit-earning regulations might impact CDCR's population. As the regulations are applied and data regarding the actual impact is collected, reliable projections will become more possible.

The most accurate way to determine how these regulations will impact the population will be to track for some period of time the number of people whose release and parole eligibility dates are actually advanced. This will give CDCR evidence on which to base projections of the future impact on the population. CDCR will do this and will provide such data in future Three Judge Panel status reports when it becomes available.

IV. QUARANTINE AND ISOLATION

Plaintiffs' Position: According to CCHCS, quarantine space in CDCR is now used primarily for those who have transferred into or within the prisons. Still, during the week of May 17, CCHCS reports that approximately 650 people were on quarantine to exposure. We believe almost all of these had been exposed to active cases among staff. Quarantine, when appropriate, is a necessary public health risk reduction measure. However, it carries certain costs: those on whom it is imposed generally cannot receive routine medical services, participate in most prison programs, go to visiting, or mix with the non-quarantined, even if socially distanced. The fully vaccinated have a greatly reduced risk of contracting or spreading the virus. Accordingly, the Receiver recently proposed to exempt fully vaccinated people from the 14-day precautionary quarantine when transferring between prisons (those people would continue to be tested for COVID-19 before and after transferring). We support this change, because of the reduced risk of transmission from the vaccinated, and because limits on medical care and programming should occur only when necessary. The exemption also might be an incentive for some to get vaccinated. We understand CCHCS is also considering whether exempting the fully vaccinated from other quarantine requirements, such as when returning from a hospital or when exposed to an active case, can be done safely.

Defendants' Position: Defendants continue efforts to ensure that prisons comply

with the Receiver's isolation and quarantine guidance provided on December 4 and 18, 2020, by closely monitoring the prisons' use of reserved quarantine space. Defendants are also cognizant of the number of people on quarantine and make efforts to avoid placing people on quarantine, except when necessary, to minimize disruption to programming. In a meeting with the parties on May 20, 2021, the Receiver's office stated that healthcare staff is examining each patient currently on quarantine to determine if any of these patients can be removed from quarantine. Additionally, the Receiver's office advised that an alert has been built into the Electronic Health Record System to identify fully vaccinated patients, so that staff can appropriately decide whether to quarantine those patients. The Receiver's office and healthcare staff are currently considering the necessity of quarantining fully vaccinated people, taking into consideration public health guidance and conditions particular to the prison setting.

The first version of the Matrix included pre- and post-transfer quarantine, COVID screening, and COVID testing for all movement, which was "highly successful in minimizing the risk of transfer related COVID transmission." A subsequent revision to the Movement Matrix eliminated pre-transfer quarantine except in certain select situations in which post transfer quarantine was impossible. CCHCS reported that this strategy was "equally successful in preventing transfer related transmission."

Defendants now know that fully vaccinated individuals are less likely to become infected and less likely to transmit infection to others if they do in fact become infected. With that information, and the understanding of the disruption to programming that is a natural result of quarantine, CCHCS provided an updated draft to the Movement Matrix on May 19, 2021, which continues pre- and post-transfer COVID testing and screening but eliminates precautionary transfer-related quarantine for fully vaccinated persons

V. HOUSING UNIT VENTILATION

Plaintiffs' Position: On March 24, Defendants described various measures underway or planned to evaluate and improve housing unit ventilation with regard to minimizing COVID-19 transmission. *See* ECF No. 3566 at 19:5-20:12. Defendants must

complete ventilation system repairs and upgrades as soon as possible, and no later than the start of the next cold weather season, when greater amounts of recirculated air will again be used in housing units.

We continue to ask for specific information regarding these efforts. CDCR counsel recently reported that CDCR headquarters had requested that each prison complete and report on an inspection of its housing unit ventilation systems by the end of this month. Counsel stated that once summary information is prepared and shared with the Receiver and CDCR Secretary, which probably will not occur until July, it can be shared with Plaintiffs. This information, counsel stated, will be used to identify and prioritize ventilation system repairs on a statewide basis. We plan to check in early June whether inspections have been completed and, if so, to request copies of individual reports.

CDCR counsel on May 21 reported on the installation of MERV-13 filters in the prisons. MERV-13 filters may decrease circulation of aerosolized microbes associated with coronavirus; as Defendants state, "[t]he MERV-13 filter is intended to minimize COVID-19 spread within housing units where the [Air Handling Units] recirculate air from within the housing units during months with colder outside air temperatures." ECF no. 3548 at 19:28-20:2.

According to the CDCR, only eight of its 35 prisons have installed MERV-13 filters in all housing units. An additional 13 are scheduled to complete installation of the filters in June, and two others are scheduled to do so later this summer. At nine prisons, a schedule for installation is to be determined; CDCR says its Headquarters is "coordinating" with these prisons "to identify and resolve delivery issues . . . impacting filter installation." At two prisons, MERV-13 filters cannot be installed, and apparently installation will not be attempted at one prison (DVI), due to the plan to close it in September.

We believe this review should also include an assessment of the appropriate population density in CDCR's dormitory-style housing units. On April 27, the Receiver issued a memorandum revoking the directive he issued in April 2020, requiring CDCR to

house those in dormitories in cohorts of no more than eight people, separated by six feet from all other cohorts. When we asked why the Receiver decided to revoke this rule, CCHCS on May 24 explained: "This direction has become outdated by subsequent developments and updates released by the CDC." We agree. As was made clear by the massive COVID-19 outbreaks in CDCR's dormitories in 2020, placing those in dorms into cohorts separated by six feet does not prevent COVID-19 transmission. It is now well understood that COVID-19 can spread via inhalation of very fine respiratory droplets and aerosol particles, at distances greater than six feet from an infectious source. The risk of such transmission is greater in enclosed spaces with inadequate ventilation or air handling, where the concentration of exhaled respiratory fluids can build-up.[14]

But, the fact that the cohorts were unsuccessful does not mean there should be *no* rules regarding distancing and population density in the dorms. We have suggested that as CDCR conducts its review of each prison's ventilation system, CDCR also review the ventilation of the dorms, to determine how many people can safely be housed in each dormitory in the event of another COVID-19 surge. The review conducted by experts of the Substance Abuse Treatment Facility and State Prison, Corcoran (SATF) in December 2020 (*see* ECF No. 3566 at 17-19) included such an assessment for SATF's dormitories. Unfortunately, on May 24, CCHCS informed us "[t]here is no plan to have the Ventilation Workgroup recommend population densities for dorm housing."

We are concerned by this response. Now that the Receiver has rescinded the 8-person cohort rule, we believe CDCR will increase the population density in the dorms. Indeed, it seems this is already happening: when we asked about the dorms at California Rehabilitation Center (CRC), on May 5, CCHCS explained that because CRC is no longer "required to maintain the 'COVID Capacity' in each dorm that was established at the

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[14] *See* CDC, *Scientific Brief: SARS-CoV-2 Transmission*, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html (last updated May 7, 2021).

beginning of the pandemic," CRC was "in the process of compacting housing units." We do not think CDCR should increase the population density in the dormitories before determining what population can safely be housed in each dormitory in the event of another COVID-19 surge.

Defendants' Position: [15] CDCR's efforts to inspect prison ventilation systems are underway and Defendants are providing Plaintiffs with updates as the information becomes available. Presently, over a third of the housing units use MERV-13, or higher, ventilation filters. Thirteen institutions are scheduled to receive upgrades to MERV-13 filters in June 2021, two more institutions by August 2021, and nine more at a future date to be determined.

VI. RESUMPTION OF SERVICES

Plaintiffs' Position: Now that active cases among incarcerated people have decreased, and prisons have or soon will enter the least restrictive phase of CDCR's and CCHCS's "RoadMap to Reopening," CCHCS has turned more attention to the necessary task of ramping up medical services that have been limited for months. CCHCS has directed the prisons to continue social distancing in medical clinic waiting areas, and to clean holding cells and exam rooms between each appointment. Those measures may necessarily reduce the number of appointments that can be provided. More than 6,600 Primary Care Provider (PCP) appointments were overdue as March 15, 2021, the date for which CCHCS most recently provided such information. In comparison, on January 31, 2020, there were approximately 2,700 overdue appointments, with a significantly larger total patient population.

There are also substantial backlogs of specialty and diagnostic service appointments. CCHCS recently said there are more than 9,000 overdue specialty service appointments, which is nearly 20% of the total pending. It also reports more than 1,000

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[15] Defendants have not had an opportunity to review and respond to Plaintiffs revisions located at p. 15:26-17:4.

overdue cancer-screening ultrasounds for end stage liver patients. CCHCS says it has directed prisons to focus on the highest priority overdue services, and then those for patients who have been waiting the longest. We believe other necessary specialty services have been deferred during the pandemic, and will now need to be ordered.

Defendants' below state "[p]rison administrators anticipate full implementation of all aspects of" the Integrated Substance Use Disorder Treatment (ISUDT) program "in the summer of 2021." We hope this means both the group therapy and clustered housing elements of the program (see ECF No. 3579 at 17:26-18:3). As of April 28 (the most recent date for which full data has been provided), CCHCS said nearly 9,900 incarcerated people were receiving medication assisted treatment (MAT) for a substance abuse disorder. There were 4,500 pending an initial addiction medicine PCP appointment to be considered for MAT, with nearly 3,900 of those appointments overdue, with approximately 1,250 of those pending for more than six months. We continue to strongly support the ISUDT program, which is necessary to save lives, and continue to monitor CCHCS's efforts to reduce the initial appointment backlog and restart the non-MAT elements of the program.

To observe how medical services are being provided as clinics reopen, we have requested to visit San Quentin, a delegated prison, in June, and also plan to visit California State Prison – Solano next month.

Defendants' Position:

Healthcare Services for the Incarcerated Population

CDCR continues to partner with the Receiver's office to safely return healthcare services to their pre-pandemic frequency. This is now possible because the number of active COVID-19 cases has remained quite low for about two months.

Integrated Substance Abuse Treatment Program

In 2019, CDCR completely restructured its approach to substance use treatment through its Integrated Substance Use Disorder Treatment (ISUDT) program consistent with the most current evidence-based treatment strategies. The ISUDT program offers

services like cognitive behavioral interventions, medication-assisted treatment, supportive housing, and enhanced support for incarcerated people transitioning back into the community.

Concerned about the increased risk of overdose during the pandemic, CDCR continued a phased implementation of ISUDT program elements while also combatting COVID-19 in 2020. Prison administrators anticipate full implementation of all aspects of ISUDT in the summer of 2021.

As part of CDCR's commitment to increasing transparency and evidence-based decision making, members of the public interested in tracking the progress of the ISUDT program can now access program information in a series of reports available on an online Dashboard at https://cchcs.ca.gov/isudt/dashboard/. The Dashboard provides program performance and outcome measurements and draws from a group of large databases each day to provide near-real-time information. More report views and program metrics will be added to the Dashboard as ISUDT implementation continues.

Adjustment to COVID-19 Personal Protective Equipment Protocols

CDCR and CCHCS recently adjusted personal protective equipment protocols for incarcerated people and staff. Stringent mask-wearing and physical-distancing remain in place, with the exception that incarcerated people, staff, and visitors, regardless of whether they have been vaccinated, are no longer required to wear masks outdoors as long as they maintain at least six feet of physical distance from all other people. They must, however, keep a mask on their person and wear it if within six feet of another person. Detailed, updated personal protective equipment and physical distancing requirements for incarcerated people and staff are set forth in a May 10, 2021 memorandum attached as **Exhibit A** to this statement.

VII. OIG REPORTS REGARDING FACE COVERING AND PHYSICAL DISTANCING MONITORING

The parties received the Office of Inspector General's report on Face Covering and Physical Distancing Follow-Up Monitoring after 10:00 a.m. on May 25, 2021. The parties

are in the process of reviewing this document. It is attached as **Exhibits B** at the OIG's request.

DATED: May 25, 2021

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