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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA , et al., Plaintiffs v. ARNOLD SCHWARZENEGGER, et al., Defendants,	NO. C01-1351-T.E.H. **RECEIVER'S FOURTH BI-MONTHLY REPORT**

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I.

INTRODUCTION

The Order Appointing Receiver ("Order") filed February 14, 2006 calls for the Receiver to undertake "immediate and/or short term measures designed to improve medical care and begin the development of a constitutionally adequate medical health care delivery system." Order at page 2-3. In addition, pursuant to page 3, lines 16-22 of the Order, the Receiver must file status reports with the Court on a bi-monthly basis concerning the following issues:

A. All tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion of each task and metric.

B. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.

C. Particular success achieved by the Receiver.

D. An accounting of expenditures for the reporting period.

E. Other matters deemed appropriate for judicial review.

This is the Receiver's Fourth Bi-Monthly Report.[1] He addresses herein issues B though E.[2] Because this report is filed one month prior to the April 17, 2006 anniversary of the Receivership, the Receiver believes it important to summarize the major remedial projects that are underway *and* to place the first eleven months of activities of his Office into context. To accomplish this, issues B and C will be presented in reverse order, the particular successes of the Receiver addressed first, and the particular problems faced by the Receiver discussed second.

The Receiver emphasizes that the contextual summary of remedial efforts should not be considered an outline for the Plan of Action. Rather it is intended to place the Receiver's compliance with the Court's order for "immediate and/or short term measures designed to improve medical care and begin the development of a constitutionally adequate medical health

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[1] Hereinafter the Receiver will file Quarterly Reports. See Order filed February 21, 2007.

[2] The Order Appointing Receiver also requires that the Receiver file a "Plan of Action" within 180-210 days. The Receiver moved to extend this deadline. On December 19, 2006 the Court granted the Receiver's motion. Pursuant to page 3:13 - 15 of that Order, the Receiver reports concerning his progress toward establishing a Plan of Action in Section II.C.3 below.

care delivery system" into an over arching framework. While certain aspects of this framework may become cornerstones of the Plan of Action, the Plan will be far more complete and involve critical elements of remediation (such as information technology, sound fiscal planning, and the establishment of a health care management structure), which remain at the planning stage at this point in time.

II.

PARTICULAR SUCCESSES ACHIEVED BY THE RECEIVER

A. Introduction.

The Receiver's first year of remedial programs can be characterized by five primary elements:

1. The first element of the Receiver's remedial programs has been to erect a temporary foundation for patient care by attacking the more serious flaws in the prison medical delivery system. This foundational program has initially concentrated on the following issues.

a. Establishing competitive salaries.

b. Commencing programs that will establish appropriate and timely recruitment and hiring programs to increase the number and quality of prison clinician personnel.

c. Commencing programs to create a professional clinical environment within California's prisons, corrective actions which range from the type of employee utilized in the prisons, clinical space and equipment, and staff culture (both clinical personnel and correctional personnel).

d. Undertaking, on an aggressive schedule, the complete restructuring of the non-functioning CDCR's health care provider contract procurement, management and payment program, which accounts for more than 400 million dollars of prison medical care expenses annually.

e. Commencing a program for the complete restructuring of the CDCR's dysfunctional and wasteful pharmacy delivery system.

f. Commencing a formal and carefully planned evaluation of prison medical beds

needs, and the construction of approximately 5000 medical care prison beds.

g. Establishing an objective program to provide for custody personnel and staffing and management necessary for adequate health care clinical operations, a critical aspect of correctional support that has not been appropriately managed or funded in the past.

2. The second element of the Receiver's remedial programs has been to establish an initial framework for a sound remedial methodology. This program has five characteristics.

(a) *Pilot projects*. The Receiver is determined to avoid the long-term, entire system "roll-outs" that were characteristic of prior State efforts, which were clumsy and expensive projects that were either never fully implemented or put into place too late and at unnecessary taxpayer expense. Instead, the Receiver has utilized pilots, for example the San Quentin Project, as a method for testing the effectiveness of new programs before statewide implementation.

(b) *Fiscal Stewardship*. Each of the Receiver's corrective actions emphasize the need for businesslike cost containment, consistent with the kind of stewardship that should be expected by California's taxpayers. As reported in his prior Bi-Monthly reports, the Office of the Receiver has vigorously attacked the waste inherent in the State's systems for pharmacy operations, contract procurement process, and the unique Medical Technical Assistant ("MTA") position wherein Licensed Vocational Nurses ("LVN") are deemed Peace Officers and paid Correctional Officer wages. *See*, e.g. *First Bi-Monthly Report* at 7 - 12 (waste of taxpayer funds due to inadequate equipment purchase policies, the failure to implement in-patient dialysis programs in a timely manner, the failure to discipline clinical providers in a timely manner and resulting abuse of "administrative time off," and systemic fiscal problems relative to pharmacy services); *Second Bi-Monthly Report* at 4 - 6 (State Controllers Audit detailing speciality care and hospital contract abuses and the failure by the State to remedy documented problems over the course of years); *Third Bi-Monthly Report* at 2 - 4,

1 (explanation of the approximately $39,000,000.00 annual savings that will result
2 from the Receiver's decision to eliminate the MTA classification and effectuate
3 the MTA/LVN conversion.)
4 (c) *Careful Planning.* The Receiver's remedial efforts to date, and those to come,
5 have taken place within the context of measured short term, intermediate, and
6 long term planning. Indeed, the danger of going too fast with too much is a
7 serious one, and for this reason the Receiver sought and received additional time
8 to complete his formal Plan of Action. The Receiver's intermediate "step back"
9 priorities and the development of his Plan of Action are described below in
10 Section II.C.3.
11 (d) *Employee Accountability.* The Receiver has also previously commented on
12 the problematic nature of discipline within State service. *See*, e.g. *First Bi-*
13 *Monthly Report* at 5:2 - 4 (because of systemic "trained incapacity" "it is virtually
14 impossible to effectively discipline and/or terminate State employees for poor
15 performance, up to and including incompetence and arguably illegal behavior");
16 *Third Bi-Monthly Report* at 21 - 23 (State Personnel Board (SPB) decision to
17 return to active employment an MTA who had been terminated by CDCR for
18 clinical misconduct and dishonesty based on an SPB hearing officer's decision
19 that the clinician was merely "clueless"). The corrective actions necessary to
20 raise California's prisons to constitutional levels will not take place until and
21 unless CDCR employees become accountable for the work they perform. The
22 Receiver describes below the initial program he will be implementing to establish
23 accountability as a job requirement for all employees who serve under his
24 direction.
25 (e) *Coordination with prison health care class action cases.* Shortly after his
26 appointment, the Receiver took the lead in bringing to the attention of the Court
27 potential coordination problems that will invariably arise between the four major
28 class action cases against the California prison system: *Armstrong* (Americans

1 with Disability Act); *Coleman* (Mental Health); *Plata* (Medical); and *Perez*
2 (Dental). On the one hand, to proceed to implement *Plata* corrective actions
3 without communication and coordination would be irresponsible, on the other
4 hand, to allow defendants or counsel to utilize an interpretation of coordination
5 which thwarts the Receiver's attempts to remedy medical care problems is equally
6 unacceptable. As described below, while significant and positive steps have
7 begun to ensure communication and coordination between the class actions, more
8 effort is required from the attorneys for all parties if this effort is to be successful.
9 3. The third element of the Receiver's remedial efforts has been to manage day to day
10 medical care crisis situations. Without question the CDCR medical delivery system is in deep
11 crisis. No one disputes this, the factual underbelly of the crisis has been amply explained in the
12 reports of experts, the briefs of the parties, the Orders of the Court, and the Receiver's previous
13 Bi-Monthly Reports. The Office of the Receiver must deal with, on a daily basis, a wide range
14 of crisis problems including but not limited to inexcusable clinical neglect, illegal and
15 inappropriate specialty contracts, bureaucratic delays effected by the CDCR and certain control
16 agencies, and life threatening staffing and supply shortages.
17 At the same time the Receivership has had to cope with attacks upon its corrective
18 actions. Make no mistake, vested bureaucratic interests and an entrenched, pervasive culture of
19 trained incompetence will continue to attempt to sabotage the Receiver's efforts. While his
20 Office handled most attacks quietly during the past year, some, unfortunately, generated a level
21 of concern that calls for public attention, for example the Department of General Services
22 attempt to thwart the remedial efforts of the Maxor Corporation as explained in Section III.A.
23 below.
24 4. The fourth element of the Receiver's initial wave of remedial programs has called for,
25 by necessity, programs designed to respond to worsening CDCR overcrowding. In this regard
26 the Receiver has repeatedly warned that crisis levels of overcrowding may have an adverse
27 impact on the remedial Process. *See*, e.g. *First Bi-Monthly Report* at 3:15 - 19 (most California
28 prisons operate at 200% of capacity, with no effective relief in sight. Unless and until the living

conditions of some prisons and the overpopulation experienced system-wide is effectively addressed, the Receiver will be impeded in applying systemic and even some ad hoc remedies to the medical care system); *Second Bi-Monthly Report* at 2 - 4 (the State's entrenched unwillingness and/or incapability to effectively discuss, let alone act upon, the crisis in California's prisons underscores the critical importance of the Court and the Receivership in its attempts to assure inmate/patients of their constitutional rights); *Third Bi-Monthly Report* at 4 - 6 (describing the negative impact on the remedial process created by the State's decision to transfer prisoners out-of-state).

The Receiver will not, however, comment on overcrowding in this report. On February 15, 2007 the Court issued an Order in response to plaintiffs' Motion to Convene a Three Judge Panel to Limit Prison Population. In that Order, the Court directed the Receiver as follows:

> "[T]o report to the Court within 90 days of the date of this Order, his best assessment of the manner, and the extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue."

Order at 4:10 - 13.

Given these instructions, the Receiver will defer his findings concerning the impact of overcrowding on the remedial process for the report to be filed in May 2007.

5. The final major element of the Receiver's initial remedial effort has been the formation of a team of dedicated, trained and experienced professionals willing to work long hours on a temporary project (the Receivership) that involves prison reform. Staffing the Office of the Receiver presented major challenges, and has required a very significant recruiting effort. Given the negative perspective with which most health care and correctional administrators view the State of California, and especially the CDCR, the Receiver considers himself fortunate to have assembled a quality team over the course of one year that will be capable of designing and implementing the remedial plan necessary to bring California's prison medical care up to constitutional muster.

B. Summary of Remedial Progress During the Reporting Period.

The reporting below provides the Court with an update concerning the progress of each aspect of the remedial program described above. What follows is not a summary of the

Receiver's efforts since the inception of the Receivership; the remedial progress completed in prior months has been described in earlier Bi-Monthly Reports. The information below primarily relates to progress achieved since December 2006. The reporting is organized to track the context outline set forth above.

Foundations.

1. *Appropriate Salaries.*

The Court's Order filed October 17, 2006 granted the Receiver authority to direct the implementation, adjustment, and administration of salaries for specific clinician and support classifications and to implement structural changes to the pay system for these classifications. Pursuant to that authority, the Receiver worked with the Department of Personnel Administration to restructure and simplify the salary structure of most *Plata* classifications and to increase the salaries effective September 1, 2006 for thirty-five civil service classifications within the CDCR that are critical to the delivery of constitutionally adequate medical care to the inmate population.

The increased salaries have allowed the CDCR to increase the number of staff in *Plata* classifications by more than 600 between October 2006 and March 2007.

As the next step toward establishing adequate salaries for prison physicians, on February 23, 2007 the Receiver announced salary increases for physicians serving in the prison medical care system. The increases will better compensate qualified doctors, aid in recruitment efforts, and provide improved access to quality care for the State's inmate-patients. The raises were effective March 1, 2007, though they may not appear in paychecks until the end of April due to the complexities of implementing the new pay scales and the workload of staff at the Department of Personnel Administration and the State Controller's office.

The Receiver's new physician salary structure, arrived at in collaboration with the Union of American Physicians and Dentists, creates a three-part range based on categories of board certification. *See* Exhibit 1. Physicians who demonstrate core competency in their practice area,

as demonstrated by "time-limited" board certification, will receive the largest increases. Since 1990, both the American Board of Family Medicine and the American Board of Internal Medicine have been granting time-limited certificates (7-10 years) to physicians who pass their Board examination.

While the total annual cost for the increases is estimated at approximately 5.9 million dollars, an actual net savings in medical care operating expenses is expected over time because as additional State-employed physicians are hired, the CDCR will begin to reduce its reliance on costly contract doctors. On the average, the hourly cost of a State-hired physician is $86.54-$91.16 per hour, contrasted to $250.00 per hour paid to many physician registry contractors.

2. *Professional and Timely Recruitment.*

A comprehensive workforce development plan has been drafted by the *Plata* Workforce Planning and Management Development Section to immediately begin to address the chronic clinician recruitment and retention problems suffered by institutions statewide. Eleven Human Resources staff have been hired within the *Plata* Support Division to implement the initiatives outlined in the workforce plan. Those initiatives include;

Developing an Appropriate Structure – the organizational, general employment, and salary structure of the medical services program,

Creative Recruitment – an ongoing recruitment program is needed to attract the human resources required by the program,

An Efficient Selection and Hiring Process – streamlining and reinventing the selection and hiring processes for the medical services program, to overcome the obstacles presented by the normal State of California/CDCR process.

Staff Development and Succession Management – the training and development of staff must be an ongoing priority.

Individual tactics or strategies falling under the general categories above have been developed and implemented in priority order. For example, in order to effectively recruit and

hire high quality clinicians, there needs to be a hiring process in place that allows for the expeditious hiring of candidates. Therefore, a pilot project was implemented on February 21, 2007, with six institutions with redesigned hiring processes that allows them to hire job candidates within twenty-four hours of participating in a hiring interview. A few days following the pilot kick-off, several prisons reported hiring clinicians within hours of their interview. Previously, the normal CDCR hiring process could take weeks in order to confirm multiple layers of approvals and the delays inherent in multiple pre-employment requirements.

3. *Appropriate Clinical Environment.*

As emphasized above, the establishment of appropriate clinical environments in California's prisons is one of the Receiver's top priorities. To speed this process, as explained in the Third Bi-Monthly Report, the Receiver has assumed personal direction of the CDCR's nursing staff. Progress was made during the reporting period concerning (1) the beginnings of enhanced programs of professionalism for Registered Nurses, and (2) the replacement of the MTA class of employees by the LVN classification of clinician.

a. Registered Nurses and Licensed Vocational Nurses.

i. Introduction.

The Receivership's initial focus has been to develop a vision of what constitutionally adequate nursing care consists of in a prison system; for example, defining the leadership and supervision skills of nurses in order to effectuate a constitutional nursing infrastructure, raising the level of nurse competency through development of a statewide nurse education plan, and instituting a nursing evaluation process.

ii. Nursing Mission, Vision and Philosophy of Care.

Mission: The initial activity of the Receiver's Nursing Executive Team has been to develop an Office of the Receiver nursing mission, vision and philosophy of care statements to guide in the development of a nursing infrastructure which will serve as the backbone of the prison health care system. The nursing mission will be to provide access to timely, appropriate

and ethical patient-centered care in an infrastructure built on respect and interdisciplinary teamwork.

Vision: The Office of the Receiver's nursing vision is to create a case management-driven care infrastructure supported by access to quality care providers that exhibit excellence, professionalism and pride in the nursing care administered to all patients in all facilities.

Philosophy of Care: The Office of the Receiver's nursing philosophy of care is to provide nursing care based on a patient centered infrastructure with access to timely, competent and appropriate care.

The three foundations of nursing leadership have been shared with nursing staff at all prisons throughout the state.

iii. Enhancing Nursing Leadership and Initial Steps Toward the Development of a Prison Nursing Infrastructure.

Prison Directors of Nursing ("DON") attended a three day nursing leadership workshop provided by the Association of California Nurse Leaders and the California Institute for Nursing's Leadership Institute. The results of this workshop are already identified in the facility DONs' ability to work collaboratively with prison health care managers and physicians, to articulate the nursing vision, mission and philosophy to their staff, and to correctly initiate and carry out the disciplinary process. In the past, the CDCR did not provide adequate clinically oriented nurse leadership programs. Rather the primary supervisory training program available for DON's was limited to custody supervision training, sponsored by CDCR.

The Office of the Receiver is currently engaged in a number of personnel related actions that will enhance nursing supervision at the prisons and provide badly needed increases in nursing management in regional locations and the central office.[3] In the meantime, DONs are

[3] For example, the current State job specifications for utilization of a DON at a prison requires the facility to have a Correctional Treatment Center ("CTC") or hospital. Thus, a prison designed for 2500 inmates which now houses more than 7000 prisoner/patients is not eligible for a DON if it does not have a CTC. Given overcrowding and the real life patient workload, the need to manage yard floor nurses, and the significant changes that must be effected at the local level to bring nursing care up to constitutional levels, every prison requires a DON, regardless of the mission or licensing

being appointed to acting positions until these changes can be effectuated.

iv. Improving Education For Clinical Nursing Staff.

The lack of nursing educators at each prison has contributed to ineffective nursing orientation, poor evaluation of the competence of clinical nursing staff (as discussed below), as well as negative patient outcomes. In order to remedy these deficiencies, the Office of the Receiver has formed a Nursing Education Department that focused on several initiatives aimed at improving the delivery of nursing care.

For example, an orientation map has been created for both Registered Nurses ("RN") and LVNs. The LVN map was developed to be used statewide to transition LVNs into a treatment role—a new role within CDCR. In addition, an education program at each institution focused on enhancing evidence-based nursing practices and improving patient outcomes is being developed. The Receiver and his Nursing Executive Team recognize the preliminary nature of these changes. Providing a nursing educator at each prison is necessary to ensure that clinical education is provided regularly on a unit-by-unit basis, and to tailor the level and complexity of the education program to the particular needs of clinical staff. To achieve these goals, the Education Department will need to hire additional nurse educators and administrative support staff. As a first step toward this objective, the existing education programs statewide have now been assessed.

b. The MTA to LVN Conversion.

In the Third Bi-Monthly Report, the Receiver announced his decision to eliminate the Medical Technical Assistant (MTA) classification in the CDCR. The decision was reached after the Receiver concluded that the CDCR's utilization of a joint clinical/peace officer classification, a form of nurse/correctional officer that is not used in any other prison system in the United States, created an environment of unnecessary tension among nursing clinicians in California's prisons, as well as unworkable and overly complex lines of authority. In terms of actual

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level of the institution.

practice, the MTA classification was simply not conducive to the level of quality medical delivery that will be necessary to put the CDCR medical delivery system on the road toward constitutional levels of care. The MTA to LVN conversion will not only improve inmate patient health care delivery but is also estimated to save tax payers approximately $39 million annually.

The conversion, directed by the Office of the Receiver, has been a significant undertaking. Essentially, each prison has been allocated LVN positions to hire and train. After LVNs are in place, an equivalent number of MTAs are provided the opportunity to either: (1) transfer to vacant correctional officer positions or (2) remain in the prison health care delivery system as LVNs or, when appropriate, RNs.

The Receiver is making steady progress in converting MTA positions to LVNs. On December 4, 2006 there were 765 filled MTA positions (out of the 1,212 allocated positions statewide). As of March 2, 2007 there remain 541 filled MTA positions, with 76 of those employees committed to transitioning out of health care delivery and over to CDCR custody and agreeing to attend an upcoming Correctional Officer Transitional Academy (COTA). At this point in time, a total of 200 MTAs have attended or are scheduled to attend a COTA as a result of this conversion process. Also since December 2006, the Receiver has hired 389 LVNs, bringing the total number of LVN positions up to 557.[4] Concerning supervisory positions, there are approximately 43 Senior MTAs and 6 MTA level Health Program Coordinator positions that remain filled statewide. The majority of institutions are hiring Supervising Registered Nurses for these positions.

While progress has been steady, the transition is not without its challenges. Communication problems have occurred between the medical department at each institution and the institution's personnel office, at times hindering effective communication with LVN applicants. To resolve these issues, the Receiver's staff made field visits to each institution and brokered meetings between medical and custody business office personnel. Of the thirty-three

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[4] As of March 2, 2007 the total for new RN hires since the Receiver's September 2006 salary increases took effect was approximately 262.

prisons, the Receiver's staff have now visited twenty concerning this issue. The remaining thirteen prisons are scheduled for MTA/LVN related visits during the next three weeks. The Receiver continues to monitor this overall process to ensure an orderly transition of MTA's out of health care positions and into correctional officer classifications, including ensuring that MTAs have appropriate access to the correctional officer academy.

c. LVN Recruitment:

The Office of the Receiver has initiated very close oversight of the CDCR's statewide LVN recruitment program. As part of this recruitment program the Receiver, with Court approval, established a competitive salary scale to attract qualified applicants. The Receiver's staff has worked closely with hiring personnel and assists staff concerning the implementation of the Receiver's recruitment strategy which includes onsite institution job fairs, newspaper and internet advertisement and direct mailers to LVNs in the areas where recruitment has been a challenge. In all cases, with the exception of three institutions where the cost of living is high and the pool of available applicants is low, this effort has effectively garnered significant numbers of candidates.

4. *Professional and Cost Effective Management of Clinical Contracts.*

a. Introduction.

The Receiver has previously detailed the serious problems with the CDCR's more than 400 million dollar clinical contract process, which by late 2005 had all but collapsed, jeopardizing patient care and wasting limited public resources. *See First Bi-Monthly Report* at 23 - 26.

In response to the Court's Order re State Contracts and Contract Payments Relating to Service Providers for CDCR Inmate/Patients ("Order re Contracts") issued March 30, 2006, a Project Team was established to effectuate the payment of all outstanding invoices and to develop modified conceptual bidding, procurement and payment processes necessary for the management of all CDCR health care contracts. At the heart of the first phase of contract reform

is the establishment of a new contract IT program which will roll-out in four prisons and for central office contract operations in a Pilot Project unit which reports directly to the Office of the Receiver. See *Second Bi-Monthly Report* at 16 - 20; *Third Bi-Monthly Report* at 23 - 26.

b. Overview of HCDMS.

The new contract management system developed by the Project Team established by the Office of the Receiver is supported by a newly created, computerized state-wide Health Care Document Management System (HCDMS) which will manage all medical contracts, replacing the former paper based system. The HCDMS has three primary components:

(1) Assists CDCR staff by utilizing uniform contract templates for the creation of contracts that do not permit deviation from health care policies and standards.

(2) Stores all health care contracts in a database accessible to all authorized users.

(3) Establishes an effective payment system designed to receive, store, and communicate invoices electronically. By computerizing all contracts and invoices, the HCDMS eliminates the time spent transferring paper copies throughout CDCR and electronically prints invoices with their governing contracts for faster information retrieval.

c. Status of the Pilot Project's IT Program.

"Quality Gate" Reviews of HCDMS were conducted in November and December and additional fine tuning of the system and user training continued throughout January. Since the last reporting period, the HCDMS Team has worked diligently to get the system ready for the pilot test. System configuration was completed, all current contract data was migrated to the new system, contract templates were completed, user training was conducted, and a system to support the pilot was established. Throughout this process Office of the Receiver staff provided the IT support and staff necessary for the completion of the pilot installation.

By February 16, 2007 HCDMS was ready to be tested on a pilot basis at four prisons (San Quentin State Prison, Pelican Bay State Prison, California Medical Facility and Central California Women's Facility) and two Regional Accounting Offices (North Coast and Corcoran).

Currently, the pilot is in its initial stages and is expected to last three to five months. Key aspects of the pilot will be the validation of the new business processes developed by the Project Team when applied to production level operations, identifying and addressing refinements to the new electronic system, and continued training of CDCR contracting staff in the new business practices and electronic system.

System documentation will be updated throughout the pilot as refinements are implemented. At the same time system and business processes will continue to be refined, and without question additional changes to the system will be implemented and testing will begin to measure the effectiveness of the new system. Certain key additions to the system, including the electronic submittal of invoices to the State Controller's Office, are planned for later in the pilot period.

d. Conclusion.

The Receiver emphasizes that this IT conversion, while critical to the future implementation of the Receiver's vision for contract processing, must be kept in context. The use of information technology for contract processing, replacing an antiquated, difficult to manage system that has bordered on total dysfunction, is only the first step toward the necessary radical reformation of every element of State contracting process: negotiations; contract processing; contract formation and terminology; management; communications with involved disciplines including nursing, recruitment, hiring, and personnel; procurement; renewals; and payment. HCDMS will provide significant management improvements, clarification of procedures, documentation consistency of policy, cost savings and efficiency, but the most important changes to contract processing are just beginning.

During the next several months the Office of the Receiver will begin to implement several significant changes in contract process within the Pilot Project including but not limited to the transfer of contract, billing and payment functions from prisons and regional office into the central office, the establishment of streamlined processes, the merger of various functions

previously handled separately by the CDCR's Office of Business Services and the CDCR's Health Care Headquarters, the use of new rate structures, and the establishment of inter-disciplinary teams to evaluate and manage the renewal of all state-wide registry contracts.

5. *Restructuring the CDCR Health Care Pharmacy.*

a. Introduction.

Given the threat to patient safety and the waste of taxpayer resources, the restructuring of the CDCR health care pharmacy was a priority for the Receiver and the Court even prior to the effective date of the Receiver's appointment. See *First Bi-Monthly Report* at 8 - 12; *Second Bi-Monthly Report* at 20 - 22; *Third Bi-Monthly Report* at 26 - 27.

Restructuring of the CDCR pharmacy system remains a priority of the Receivership for the reasons iterated in the Third Bi-Monthly Report,

> It was apparent that the California prison pharmacy system, or more accurately the lack of any system, not only posed a serious threat to prisoner/patient medical care, but also functioned ineffectively concerning the contracting, procurement, distribution, and inventory control of necessary patient medications, including controlled substances.

Third Bi-Monthly Report at 26.

b. The Maxor Project Team.

As explained in prior reports, the Office of the Receiver has entered into an agreement with Maxor National Pharmacy Services Corporation (Maxor) to provide pharmacy management consulting services to implement the Receiver's plan to develop a constitutionally adequate pharmacy services delivery system. The agreement start date was scheduled for January 1, 2007 and it commenced on schedule. Key members of the Maxor team arrived in Sacramento on January 1, 2007 and established an administrative office at 428 J Street Ste 610, Sacramento, CA 95814. The Maxor team was able to recruit and make immediately available, experienced and well qualified correctional pharmaceutical clinicians: Glenn Johnson, MD, Project Manager; Matthew Keith, RPh, BCPS, FASHP, Pharmacy Administrator; Dick Cason, RPh, MS, Senior Pharmacy Consultant; Melanie Roberts, RPh, PharmD, Clinical Pharmacy Consultant; Richard

W. Pollard; Marjory Susan Pulvino, RN, BSN, PhD., and Kaye Cloutier, RN, BSN, MBA. Collectively, the management consulting team has more than 100 years of direct oversight involvement with correctional and commercial pharmacy programs nationwide. The Curriculum Vitae of the initial Maxor Team are attached as Exhibits 2 - 8. An organization chart is provided in Exhibit 9.

c. The Office of the Receiver Interface with Maxor Project Team.

The Receiver's staff was instrumental in transitioning the Maxor Team to take over key CDCR pharmacy functions, and integrating Maxor staff into prison health care administrative operations. Breakout meetings were arranged, security clearances achieved, administrative and operational guidance given and most importantly, the Receiver's direction and priorities were established. These priorities include working closely with the Court experts in the *Coleman* and *Perez* cases. In addition, the Receiver requested and Maxor provided an initial 90 day plan of specific implementation actions which was subsequently reviewed and approved by the Receiver on January 24, 2007. *See* Exhibit 10.

The Receiver anticipates that Maxor's efforts to improve the State's pharmacy procurement, management, and medication distribution processes in a timely manner will require on-going and skilled assistance from the Office of the Receiver relative to many critical functions including personnel policies and practices, information technology system support, and custody support.

d. Implementing Maxor's Road Map to Excellence.

Maxor's Court approved plan entitled "Road Map to Excellence" (Exhibit 11) gives priority to achieving patient safety, evidence-based practice and cost efficiency. Throughout this process emphasis will be placed on ensuring effective *Plata/Coleman/Perez* interfaces. The improvements outlined in the Road Map are organized under seven primary goals. Each goal is supported by specific objectives and time lines for accomplishing those objectives.

Without question, the Maxor Project Team has hit the ground running in California. A

central pharmacy services administration has been established with enforcement authority; a working budget has been established and lines of authority have been drawn for the supervision of all pharmacy services personnel. All initial objectives are on schedule. In addition, an initial audit of CDCR purchases and contract pricing since the initial 2006 Maxor review was conducted. A detailed listing of overcharges in the amount of $299,000 has been sent to the wholesaler. Since November 2005, eligible rebates in the amount of $474,000 for Zyprexa were reconciled and receipt of $343,000 has been confirmed. The additional $131,000 is still being researched to ensure credit was received.

Maxor will issue Monthly Progress Reports which will include numerous appendices designed for tracking purposes. The January 2007 and February 2007 reports are attached as Exhibits 12 & 13.

e. Obstacles to Pharmacy Restructuring.

While Maxor has proceeded with dispatch and professionalism, significant barriers have been identified that may impact the achievement of planned objectives within the expected time frames or require modification of scheduled work products. For example, there is currently no active CDCR process for central operational procedure review and approval; CDCR lacks a central pharmacy information management system (which has contributed to delays in collecting prescription and outcomes data for developing process improvement; current pharmacy utilization data are unreliable and restricted to purchases); and a system-wide inventory audit that was to be conducted during the first quarter of 2007 to establish a baseline for Maxor to evaluate would in actual practice have been inadequate, because the CDCR's pharmacy management system is not capable of accurately and uniformly recording dispensing data.

More importantly, Maxor encountered resistence and an inexcusable pattern of delay on the part of the Department of General Services ("DGS") when Maxor attempted to compare CDCR drug purchases with DGS contract prices and evaluate the fiscal soundness of DGS's CDCR contracts. This problem is addressed in detail in Section III.A. below.

6. *Planning For Necessary Additional Medical Beds.*

The Receiver has continued with his plans to construct "5,000" multi-purpose medical beds within the next three to five years, a program which has been met with the general support by the Governor, as demonstrated by the $1 billion capital outlay to improve health care facilities (medical and mental health) proposed in the Governor's 2007-08 budget plan. It is not known at this time, as explained further below, what the long-term and short-term bed needs are within the system. Thus, the sufficiency of the Governor's budget proposal cannot yet be determined. But more information will become available in the coming months as the evaluation and planning described below progresses.

An early construction related challenge faced by the Receiver has been the total lack of reliable data on the burdens of chronic disease and physical impairment in the prison population. Without such data, the Receiver cannot properly plan for the facility and programming needs of inmate/patients or plan for delivery of quality medical care at appropriate levels of care. To address this issue, the Receiver engaged Abt Associates to: (1) develop an assessment tool that can be used to assess inmates' health status and assign them to levels of care and programming appropriate to their needs; (2) use this information to describe the current burden of chronic medical illness and functional impairment in the prison population; and (3) using this data on the current morbidity burdens, estimate the long-term and short-term bed needs by level of care and programming so as to inform new facilities construction. To date, the assessment tool has been developed and data collection has begun. The Receiver estimates that the consultant will complete data analysis and report final assessment results, projections and recommendations in July 2007, although preliminary data should also provide helpful insight into the State's real medical bed needs.

Meanwhile, the Receiver sought the assistance of a highly qualified program management firm to advise him concerning his oversight responsibilities concern prison construction, and to provide facilities development expertise for the design and construction of

new medical facilities. It is not the Receiver's intention that the program manager would provide design, construction, or construction management services. Rather, the overall mission of the program manager will be to act as a management resource to the Receiver and to provide broad coordination of the full range of technical resources and management services necessary to implement the planned construction project, including assisting the Receiver in quantifying the capital resource needs for the program. On January 24, 2007 the Receiver issued a Request for Qualifications, soliciting twenty top program management firms directly, and publishing advertisements on various websites (including the Engineering News-Record) and in nearly a thousand weekly bulletins published for various markets around the country. Proposals were due February 23, 2007, and the Receiver received numerous responses from many reputable firms. On March 15, 2007 the Office of the Receiver selected a team of firms (URS Corporation, Bovis Lend Lease, Brookwood Program Management, Lee Burkhard Liu, and Robert Glass & Associates) as the entity with whom the Receiver will enter into contract negotiations for the position of construction program manager.

The Receiver's project to construct 500 "CTC replacement" beds also progressed during the reporting period. After several meetings of the CTC Project Team, following the inspection of numerous private and county facilities, examining options for converting general population housing units into "sheltered living" or "step down" medical housing, reviewing existing CDCR classification criteria which on occasion functions to limit unnecessarily legitimate health care related housing placement options, the Receiver and his staff have reached the following findings:

1. There are no "quick construction" alternatives entirely suitable for prison medical facilities given obstacles to siting, security, and access.

2. There are no County or private medical facilities that are easily and cost effectively converted to prison medical care units.

3. The CDCR has not appropriately managed its licensed medical beds.

4. The CDCR has not appropriately managed its use of acute beds when placing prisoner/patients into community hospitals.

5. Changes in the CDCR classification system are a necessary component to an effective medical care program in the prisons.

6. The State has not adequately studied or planned for medical bed usage and as a result there is no accurate data upon which to base a decision to add CTC or CTC replacement beds at this time.

7. It is fiscally irresponsible for the Receiver to add CTC equivalent beds at this point in time; likewise, it would be irresponsible for the Receiver to approve or go forward with the CDCR's plans for the addition of medical beds.

Therefore, the Receiver has made the decision to fold the 500 bed CTC equivalent bed project into the 5000 bed project. In terms of expenditures, this strategy means that there will be no significant decision made concerning the number or types of prison medical beds that need to be constructed until after the results of the Abt study have been received and analyzed.

7. *The Receiver's Health Care Access Unit.*

One of the systemic problems contributing to the unconstitutional medical delivery system in California's prisons are inadequate numbers of correctional officers assigned to health care delivery, and the failure to manage those officers with necessary clinical priorities in mind.

In order to rectify this problem, to ensure inmate patients access to medical services, the Receiver is developing custody Health Care Access Units. Correctional staff assigned to the Access Units will be responsible for escorting, transporting and the security of inmate-patients to and from medical appointments within the institution and off prison grounds. Working in concert with medical personnel, a scheduling system will be developed that most effectively utilizes custody and health care staff resources and facilitates access to care.

While the principles of the Unit will be consistent statewide, no single cookie-cutter design will work for all prisons. Instead, institutional specific staffing analysis will be

conducted onsite at every California adult institution in order to determine the appropriate staffing necessary to carry out this mission. The prototypical custody Health Care Access Team, however, will be comprised of an Associate Warden for Health Care Services, one to two Lieutenants, two to four Sergeants, a cadre of Correctional Officers and clerical support. Positions will also be created to facilitate the off-grounds transportation details, including the custody coverage for "911" emergency ambulance transports to local emergency rooms.

In addition, at designated institutions, posts will be established to facilitate custody coverage at local community hospitals. To summarize, the exact number of correctional staff necessary at each prison will be determined by that institution's mission (e.g. presence of a licensed medical facility or mental health treatment unit), the physical structure of the prison, custody and security requirements given the classification of the prisoner/patients, and the health care acuity of the population.

Two important points require emphasis concerning the project:

1. Establishing permanent full time Correctional Officer positions to adequately deliver health care in California's prisons will require more staff. The number of officers presently allocated for health delivery is simply inadequate. However, because this function is at present handled primarily on an overtime basis, poorly managed and using officers who are often not familiar with the processes needed for effective clinical services, in actual practice the additional staff projected for the teams may in fact reduce expenses by eliminating overtime and related problems. On the other hand, if the CDCR continues to fail to hire and retain adequate numbers of officers given its ever increasing population, these projected savings may not take place. The Receiver will discuss the problem of Correctional Officer staffing shortages and its impact on the delivery of health care in his May 2007 report to be filed in response to the Court's Order of February 15, 2007.

2. Commencing April 2007, a pilot Health Care Access Unit will begin operations at San Quentin State Prison. After several months of operation, monitoring and evaluation, it is

anticipated that the San Quentin pilot model will be implemented at five additional institutions by July 1, 2009. Similar units will eventually be established at all thirty-three (33) institutions. As stated above, this roll out must be implemented in a thoughtful, prison-by-prison manner. The task of identifying existing resources, determining census and workload, establishing new positions based on overtime expenditures and establishing a new officer post assignment schedules and master rosters for Access Units is very complex. The Receiver emphasizes that both careful planning and attention to detail is required to avoid implementation errors and fiscal waste.

Framework of the Receiver's Remedial Programs.

1. *The Use of Pilot Programs.*

a. Introduction.

The one certainty known by the Receiver when he commenced his duties on April 17, 2006 was that all prior efforts to fix the CDCR's medical delivery system had failed. Worse still, prior efforts did not succeed despite years of litigation, experienced counsel on both sides of the table, numerous Court Orders, and a heavy utilization of correctional experts. Indeed, the very fact that the extraordinary remedy of a Receivership was necessary warranted the Receiver taking a careful, phased approach to his initial remedial efforts. Considering all of these factors, the Receiver made the decision to utilize limited pilot projects as one element of his overall remedial strategy.

b. San Quentin State Prison.

The Receiver announced the San Quentin Pilot Project on April 18, 2006, his second day on the job. It commenced on July 5, 2007 and it continues on a stepped-down basis to this date. A significant amount of remedial work has been accomplished to date; however the project has taken longer than anticipated and has utilized more resources than initially expected. As reported in each of the prior three Bi-Monthly Reports, systemic problems at San Quentin, similar to those at other institutions, are the result of decades of neglect and the interrelated

causes of the problems have made solutions more complex and time consuming than projected.

(i). Project Achievements.

1. A significant amount of remedial work has been accomplished.

2. Many crucial health care functions, e.g. labs, radiology, speciality care appointments, etc. are now being managed in a more timely and competent manner.

3. Important (and time consuming) issues of staff accountability have been addressed, resulting in a significant number of terminations/resignations especially among physicians.

4. New and important programs have been developed, including (A) plan for correctional officer access teams; (B) plan for nurse staffing that considers (1) necessary levels of supervision and (2) relief factors, and (C) an improved reception process.

5. Progress was made concerning (1) a plan for an overall prison health care organizational model and (2) the implementation of a pilot (modified) version of that model.

6. Programs have been implemented for the construction of temporary and permanent clinical space, including a new San Quentin medical center.

7. Crucial lessons were learned concerning remedial action, including:

(ii) Lessons Learned.

The San Quentin Project Team met with the Receiver in January 2007 to discuss the status and progress of the eighteen specific elements of care encompassed by the pilot. The crucial "lessons learned" to date concerning remedial action were discussed at that time and consensus was reached concerning the following:

1. The importance of Warden support and collaboration. The Project Team acknowledged the significant contribution of Warden Robert Ayers to the successes of the project.

2. The depth and scope of the inter-relatedness of serious problems serves to prevent any easy to reach quick fixes.

3. The level of systemic dysfunction and its adverse impact on staff attitudes serves to

prevent any easy to reach quick fixes.

4. Any effective remedial process cannot ignore the adverse impact of CDCR and prison specific culture.

5. While relief in the trenches is critical, given the abject disrepair of the system, change must begin with the highest levels of management and proceed from the top to the bottom.

6. Change will be slower and more difficult than first anticipated.

7. It is essential that the Receiver's San Quentin Team continue to work effectively as an interdisciplinary group.

8. Though there have been significant improvements in the delivery of medical care at San Quentin, no element of the project should be considered as successfully concluded, as further development, monitoring, and auditing of each area is required. The January 2007 element by element narrative and tracking sheet summary for each aspect of the San Quentin Project is attached as Exhibit 14.

(iii.) Progress During the Reporting Period.

Policies and procedures were developed for supply and equipment functions, Outpatient Housing Unit, Laboratory services, and Patient Advocacy, and treatment protocols were implemented for specialty services. Several innovative programs continue their development including: (1) an improved multi disciplinary health care reception process completed on the same day an inmate arrives that includes a mental health, dental and medical screening; (2) a Patient Advocacy process in which RNs respond directly to inmates and resolve medical appeals at the lowest level; (3) a streamlined ordering and approval process making acquisition of medical supplies and equipment faster and easier. In addition, an environmental services program was established to provide the same level of cleanliness and sanitation found in community hospitals. This program will also offer a vocational training opportunity for inmates.

A Medical Records Director was hired to improve the institution's Health Records Department. Additional positions were authorized and filled at the institution, and several

personnel processes were simplified by relocating the activities from Sacramento Headquarters to San Quentin. A plan for nurse staffing was developed and implemented and included appropriate levels of supervision and relief factors. As reported in the Third Bi-Monthly Report, San Quentin continues to work under a pilot version of a new prison health care organizational model based on the recommendations of the Mercer Report, with Jayne Russell of the Office of the Receiver as the Acting Health Care Executive Manager, Dr. Karen Saylor performing the duties of the Chief Medical Officer, Registered Nurse Tonya Church acting as the institution's Director of Nursing, and Giselle Mattison serving as the acting manager of Support Services (with responsibility for support services, including budget, procurement and contracts processes, and Information Technology).

iv. Construction During the Reporting Period.

Significant progress has been made in the design and construction of clinical projects at San Quentin. Some projects have been completed, and the majority are in planning, design and blueprinting stages. The overall conceptual budget for these projects is approximately one-hundred-seventy-five million dollars. The projects identified under the San Quentin Capital Improvement Plan are divided into three packages, involving both temporary structures and permanent construction. Each package was fully described in the *Receiver's Third Bi-Monthly Report*, however, a short description of the planned improvements and the progress made toward completion is discussed below.

Construction Package One.

Package One consists of construction that is necessary to "create space" for longer term projects, modifications to enhance the unacceptable level of services in the aged Neumiller Infirmary Building, and construction of a temporary structure which provides San Quentin personnel access to the basics of an adequate medical delivery system such as office space, parking and supplies. Progress made in the design and construction of Package One is described below:

a. Personnel Offices: The Receiver plans to construct a building to house personnel

offices that will allow for the recruiting, interviewing, examination, and hiring of potential staff under one roof. The conceptual design of the building is complete and working drawings are being developed.

b. Replacement Parking Spaces: San Quentin does not have adequate parking for its staff, nor for escort vehicles to transport inmate patients to needed medical appointments off prison grounds. To address this problem, parking spaces have been added and placed in service. A second group of parking spaces have recently been completed and put into service in March 2007.

c. Relocation of the "Walk Alone" Exercise Yards from Upper Yard to "C" Yard: This relocation is necessary to allow for the construction of temporary clinical offices and examination areas in the Upper Yard in 2007 (see Construction Package Two, below). Bid documents are being prepared to solicit construction bids.

d. Medical Supply Warehouse: Currently, medical supplies are located in various spaces throughout the institution's grounds, including the use of four "Con-X" boxes. A conceptual plan has been designed to construct a single warehouse which will provide for effective storage, inventory control and dispersal of supplies. During the reporting period the decision was made to have the medical warehouse designed to be integrated with the development of a main warehouse as part of an overall San Quentin construction project.

e. Trauma Treatment Area (TTA) Renovations: The project will relocate the TTA from its present location at the northern entrance to the Nuemiller building to within the Nuemiller building's core on the first floor. Construction is ongoing and the renovated TTA is expected to be ready for occupancy by May, 2007.

f. Ventilation Upgrades to North Block: Work is underway to develop a plan to make minor ventilation modifications, better air balancing, and increase the overall cleanliness of the North Block by improving janitorial services.

g. Expansion of the West and East Block Rotundas to Establish Clinical "Sick Call"

Areas: At present, many critical clinic services (e.g. sick call, screening, and assessments) at San Quentin are provided in converted cells and make-shift office space within the prisoner/patient's cell block, resulting in entirely inadequate space and equipment to provide even minimal services. Designs are being developed to utilize the space in the rotundas of East and West Blocks for expanded and better equipped clinical areas.

h. Miscellaneous, Limited Upgrades to the North, AC and Gym Clinics: The scope of work to upgrade these facilities is being developed.

i. Addition of a "Triple Wide" Relocatable Trailer to Provide Needed Office Space for Medical Care Delivery Personnel: The trailers have been procured and are in use.

Construction Package Two.

Package Two consists of three projects. Planning work has begun on two projects and is expected to begin in the next quarter for the remaining project.

a. The Primary Care/Specialty Medical Services Modular to be placed in the Upper Yard: Due to the insufficient space within the Neumiller Infirmary building to support the necessary medical and mental health services needed to adequately care for the San Quentin inmate population, primary care and specialty medical services will be relocated to a temporary modular building in the upper yard. This modular will accommodate the out-patient and specialty clinic as well as medical staff support functions for the Institution temporarily until the new Central Health Services Building is completed.

Programming for this project has been completed and concept design is in the final stages.

b. A Limited and Minor Remodel of the Existing Medical Records Unit: A Director of Medical Records has been recently appointed. She will be an integral team member in defining the temporary space needs for medical records during the construction of the Central Health Services Building. By the Receiver's next *Bi-Monthly Report*, space needs will be defined and the Receiver will report on a timetable for the design and construction of the project.

c. A Limited and Minor Remodeling of the Existing Receiving and Release Modular. Planning is complete and construction is expected to begin in March, 2007.

Construction Package Three.

Construction Package Three involves the construction of a permanent Central Health Services Facility at San Quentin. Included in the Facility will be a 50 bed correctional treatment center ("CTC") and a state of the art correctional reception center to accommodate the mission of San Quentin as a CDCR reception center. The Receiver's efforts to include mental health and dental services has been successful; therefore, this construction will also address the shortfalls of services and space for clinical personnel in the *Coleman* (mental health) and *Perez* (dental) class actions.

Architectural programming has been completed and concept design is in its final stages. This project will use the "Design-Build" delivery method whereby a single entity consisting of an architect, contractor and subcontractors will build the project based on the detailed design criteria furnished by the Receiver. The process to "pre-qualify" Design-Build teams has begun. The Environmental Impact Report required by the California Environmental Quality Act has also begun.

Conclusion.

The Receiver emphasizes that these projects continue to be the result of a collaborative effort between San Quentin clinical personnel, custody personnel, and staff from the Office of the Receiver who worked together to develop the overall plan and the details for each specific project. In addition, the experts in both *Coleman* and *Perez* have been involved with the project and will be invited to participate in future planning discussions. This collaborative process is time-consuming but the Receiver believes that such attention to detail has and will result in better designs, better health care and the best use of limited taxpayer resources.

The Receiver will provide the Court with an update concerning construction at San Quentin in his next *Quarterly Report.*

v. Health Care Access Unit: San Quentin Pilot

As set forth above, the Project Team at San Quentin continues with the development of the pilot program to test the operation of a new custodial Health Care Access Unit. The Unit is being developed to identify custody teams that will be dedicated to the transportation, escorting and security necessary to ensure adequate access to health care at San Quentin. The Health Care Access Unit at San Quentin will serve as a working model, to test for day-to day-practice concerning implementation state-wide during 2008 and 2009.

The Unit will be headed by the prison's Correctional Administrator of Health Care Services, and will include correctional supervisors and officers solely dedicated to ensuring the inmate patients' timely and efficient access to care. The Unit will work closely with the healthcare personnel responsible for the clinical utilization review process, ensuring the timely and efficient scheduling of appointments to specialty services inside and outside the prison. Key to the effectiveness of the Unit will be the collaborative effort of clinical and custody personnel in developing a scheduling system that will ensure all inmate patients access to health care.

(vi.) Reception Center Pilot

Introduction

Essential to enhancing the current delivery of health care at San Quentin is the development of a new reception process to identify the serious health needs of prisoners upon their entry into San Quentin and emphasize timely evaluation, referral, and on-going management of patients with significant health concerns. This new process begins a cycle of patient care that should establish the foundation for solid primary care management. The new approach utilizes interdisciplinary teams of health care professionals and emphasizes the on-going case management of patients in need of chronic care. This stratified approach is consistent with community standards, improves timely access for patients most at risk, and better aligns and allocates resources.

Multi disciplinary approach.

A significant improvement in the reception process has been the integration of several disciplines at intake to ensure comprehensive screening and assessment of patients' health care needs. On the first day of arrival, all inmates will receive physical examinations and oral screenings by a Registered Nurse; mental health screenings, including a written test performed by a mental health clinician; and laboratory testing. The approximately thirty-three percent of the intake population who have significant health care risks and needs beyond routine screening will also be seen on the day of arrival by physicians who are assigned to the Reception Unit. Only those inmates who require follow-up care or who are new commitments to CDCR who require complete dental examinations by a dentist will be rescheduled for health care appointments on subsequent days.

Case management will begin during the reception process to ensure the timely delivery of essential medications and to ensure follow-up appointments are scheduled and attended. Intake Screening and Assessment Policies and Procedures concomitant with medical forms are also being developed to aid intake practices.

Information Technology.

Currently, health care staff at San Quentin do not have access to needed medical information about their patients, resulting in duplicative health care services which are inefficient, costly, and put patients' lives at risk. To facilitate effective practices, a very simple access data base interim tool has been designed. The basic system will track patient information as they move through the reception process—from physical screening, to mental health assessment, to oral screening, laboratory testing, and to physician examinations. As medical information is collected at various points of movement through the system, an information database will be established for the purpose of sharing and retrieving medical information to promote efficiency in service delivery and good quality clinical management. Health care staff will also be able to access pertinent health care information on returning inmates. The Office of the Receiver is currently examining whether to expand this project or await the implementation

of a more sophisticated information technology structure.

Reception Center Construction.

A significant barrier impeding the efficiency of the reception process is the lack of physical space to implement the above plan. Reconstruction of the existing Reception/Receiving area is planned, creating exam rooms, waiting rooms, and supply rooms for medical and mental health staff to perform their required functions.

(2) *Fiscal Stewardship.*

Although the Receiver has not yet assumed responsibility for the healthcare related costs included in the current year allotment to CDCR, nor for those same costs that are being developed as part of the 2007-2008 budget process, the Receiver is monitoring the progress of actual expenditures to date, year-end projected expenditures, and the current year allotment, with all approved changes and revisions. The character and pattern of CDCR expenditures has and will influence the Receivership's remedial initiatives and, as current and future year budgets are developed, those same patterns will help the Receiver to identify additional opportunities for taxpayer savings, ensuring a "better bang for our health care dollar."

The CDCR's current accounting and budgeting systems have numerous serious weaknesses. For example, as of the date of this report, financial data available from the CDCR's budget information system is limited to information from the budget period ending December 31, 2006. This two to three month lag is unacceptable in the private sector, whether for profit or not for profit, and it is unacceptable to the Receivership. Financial decisions that need to be made by the Receiver are difficult enough without the lack of timely financial and statistical information adding to that difficulty. Concerning his fiscal operations, the Receiver's mandate is clear: "implement an accounting system that meets professional standards," and an accounting system that produces reports with a two to three month lag does not meet this Court ordered criteria.

As with many of the Receiver's objectives, full realization of a professional, timely, and

transparent accounting system will take time, probably several years. In the meantime, however, the Receiver has retained a skilled Chief Financial Officer, Rich Woods, and with the assistance of Mr. Woods he is in the process of retaining a professional services firm with nationally recognized expertise in public sector accounting, budgeting and financial systems to do the following:

1. Document each of the many shortfalls in the current CDCR accounting and budget system;
2. Identify the "bottlenecks" in current processes;
3. Provide a plan of "work arounds" and interim procedures and processes that will provide more timely and reliable financial reporting.

The Receiver will provide updates concerning the selection of the firm and its progress toward this important first step to addressing the CDCR's broken reporting system in future quarterly reports.

3. *Measured and Timely Intermediate and Long Term Planning.*

a. Intermediate Planning - Receivership Priorities 2007/2008.

Despite the emergency measures describe above, California's prison medical delivery system remains in crisis. There are today a number of critical needs and deficiencies in the health care system for which the Receivership is without the time and resources to immediately address. As the number of Receivership remedial projects have increased, it has become apparent to the Receiver that additional efforts needed to be carefully reviewed and prioritized to ensure proper effective utilization of time, staff, and fiscal resources. To this end, the Receiver held three all-day meetings with Office of the Receiver and key CDCR staff in December 2006 and January 2007. The goals of this "step back" process were four fold:

(1) to identify the current projects and activities underway and to determine which projects should continue;

(2) to identify additional projects or activities that are critical to initiate in the near future;

(3) to identify those important projects that will not be initiated in the near future; and

(4) to prioritize and allocate resources for the selected projects and activities.

At the conclusion of this collaborative process, the following initial list of projects has emerged as the Receiver's 2007/2008 priorities:

1. Resolve ongoing personnel issues with the State Personnel Board and the Department of Personnel Administration.

2. Participate actively in coordinating remedial efforts with the Special Master in *Coleman*, the Court experts in *Perez*, and the Court in *Armstrong*.

3. Oversee Maxor's establishment of a constitutional pharmacy delivery system.

4. Continue the San Quentin Pilot Project and oversee the construction of temporary and permanent health care facilities at the prison.

5. Enhance reporting to the Court, the Inspector General, and the public.

6. Design and implement a long term Plan of Action.

7. Enhance internal communication within the Office of the Receiver through the establishment of standing meetings.

8. Begin the construction of the 5000 medical prison beds.

9. Continue and enhance the speciality provider/hospital/registry contract Pilot Project

10. Establish and maintain a budget for correctional medical care which meets professional standards.

11. Monitor the appropriateness of the salaries of clinical personnel.

12. Continue the implementation of an appropriate and timely clinical recruitment and hiring program.

13. Design and implement a pilot emergency response system utilizing paramedics within eight CDCR prisons.

14. Seek the waiver of state laws and regulations from the Court as necessary to ensure professional and timely contract processing and the appropriate employee accountability.

15. Complete the implementation of the MTA/LVN conversion

16. Design and establish operational management systems to oversee the CDCR's correctional health care personnel.

17. Develop and begin to implement a clinically oriented information technology system to support the CDCR's correctional health care operation.

18. Continue the design of Health Care Access Teams and commence an Access Team roll out in designated pilot institutions.

19. Determine the clinical space, supply and equipment needs for each of California's 33 prisons and develop a plan to meet those needs.

20. Design and implement a peer review system and an enhanced, clinically oriented process to investigate misconduct by health-care workers.

In providing this list, the Receiver emphasizes two points. First, the list set forth above is subject to change. There are several indications that resources do not exist to fulfill each of these activities in a careful, complete, and responsible manner. Second, while staff have been assigned to each project and directed to prepare a project roadmap including the time lines for project completion, certain projects may be commenced in a slow paced manner or as limited pilot efforts prior to system-wide implementation.

b. Planning for the Plan of Action.

On December 12, 2006, the Court modified its February 14, 2006 Order and extended the Receiver's deadline for submission of a Plan of Action until May 15, 2007. The Order instructed the Receiver to report on his progress toward establishing this Plan of Action in each successive Bi-Monthly Report.

As explained in prior Bi-Monthly Reports, while he has commenced taking timely action concerning certain of the more serious aspects of the entirely dysfunctional California Department of Corrections ("CDCR") medical delivery system, the Receiver has, at the same time, attempted to approach the long term systemic changes necessary for constitutionally

minimal prison medical care in a thoughtful, pragmatic, and health care oriented manner. The pervasive absence of appropriate clinical standards, grossly inadequate staffing at both prisons and the central office, inadequate clinical space, an absence of patient management programs, inadequate salaries, and a prison culture which has historically ignored the needs of health care disciplines requires a very carefully developed Plan of Action which, in its implementation, will begin on a solid foundation and proceeds to a workable superstructure. In many important ways the Receiver's Plan of Action will be the very opposite of the earlier remedial efforts in this case, which focused upon installing stain-glass windows on walls erected without adequate support. Anything less than well thought out time phased remedial programming will be irresponsible; it will jeopardize the long term interests of 170,000 prisoner/patients and it will delay the eventual return of California's prison medical system back to the State of California.

Nearly every aspect of medical care delivery within the State's prison system requires substantial reform; in many cases, essential programs or departments are non-existent. The tasks involved in the system's repair are numerous and complex, and following decades of neglect and mismanagement, all of the existing problems cannot begin to be completed in the next one to two years. The following is the initial list of topic areas that will comprise the first stage of the Receiver's Plan of Action. The Plan of Action itself, when it is completed, will contain further detail about the Receiver's remediation strategy with regard to each identified priority.

CDCR organizational structure.

1. Clinical programs.
2. Staffing, clinical oversight, and leadership of reception centers.
3. primary care.
4. emergency response.
5. chronic disease care.
6. medical bed placement, care management, and utilization management.
7. long-term care.

8. public health & infection control.

CDCR administration.

1. Develop smaller administrative regions (3-5 prisons each) and leadership roles.
2. Develop support for isolated or under-resourced prisons.
3. Develop functional and accessible CDCR policies and procedures.

Staffing.

1. Clinical
    a. Nursing
    b. Primary care providers
2. Appropriate clerical support.
3. Appropriate and competitive salaries.
4. Timely and appropriate hiring and credentialing.
5. Staff retention, education & development programs.

Medical service contracts.

1. Establish a cohesive approach to negotiation and rates.
2. Create units, policies, and procedures for management and monitoring of contracts.
3. Analyze utilization data, contract medical expenditures, contracts, and invoicing.
4. Adopt an electronic invoicing process for adjudication and payment.

Specialty services.

1. Overhaul the provision of specialty medical services provided to inmates.

Facilities and space.

1. Review clinical space and reception center space needs at all prisons.
2. Review existing custodial support space needs at all prisons.
3. Implement space additions on site at prisons.

Information technology.

1. Essential infrastructure.

2. High speed network.

3. Information technology support staff.

4. Optimized workflow redesign.

5. Standardized data models.

6. Major clinical and business information technology projects.

Supplies and equipment.

1. Develop modern material management supply chain procurement process.

2. Establish clinical engineering oversight team.

Access to healthcare.

1. Analyze, develop, and implement custody components of patient access.

   a. On-site healthcare appointments.

   b. Community-based healthcare components.

Day-to-day medical operations.

1. Medical hours of operation, including clinics, pharmacies, labs, radiology, and all clinical and support services.

Clinical transportation.

1. Develop a transportation system to ensure adequate and timely medical transportation.

Telemedicine.

1. Improve existing telemedicine processes.

2. Upgrade outdated technical infrastructure.

3. Develop and implement a plan for Telemedicine's central role in providing timely and adequate specialty care.

Finance, accounting, budgeting and reporting.

1. Determine protocols and standard processes for financing the Receivership's initiatives and activities.

2. Develop accounting standards, internal and external controls for the Receivership

acceptable to the Court, the State, and other stakeholders, meeting nationally recognized standards for financial operating transparency.

3. Assess and restructure CDCR's inadequate accounting system.

4. Prepare a budget for the Receivership in light of staffing needs and projects identified in this Plan of Action.

5. Redesign CDCR's budgeting process so that the budget reflects anticipated needs and expenses.

6. Create a new provider contracting model based on best practices from California commercial payers.

7. Develop a responsibility focused financial reporting process and system.

8. Redesign the reporting structure of DHCS's financial staff.

Pharmacy.

1. Support the roll-out of Maxor's pharmacy services plan in every facility.
2. Redesign pharmacy workflow.
3. Training.
4. Information technology.
5. Data analysis.
6. Formulary redesign and oversight.

Ancillary services.

1. Centralize oversight of ancillary services and standardize approach to policies across the system for:

    a. Clinical laboratory.
    b. Radiology.
    c. Dietary and nutrition.
    d. Physical therapy.
    e. Obstetrics.

Healthcare quality.

1. Redesign the CDCR quality and safety infrastructure.
2. Establish and disseminate best practices and innovations.
3. Create quality improvement processes.
4. Redesign the inmate complaint and appeals processes.
5. Redesign the CDCR incident/medical error reporting process.
6. Develop sentinel patient safety event protocols and quality SWAT teams.
7. Improve clinician-patient and interdisciplinary communication.
8. Revise infrastructure and processes for quality improvement and peer review.
9. Adopt a statewide medical staff and peer review structure.

Custody collaboration.

1. Develop and implement statewide training plan for all levels of custody operations related to clinical operations.

2. Develop and implement a training plan for health care staff regarding custody operations that ensures their safety and security.

Employee Accountability.

1. Design and implement improved systems for investigations, peer review, and employee discipline processing.

Transparency.

2. Design and implement systems to ensure the appropriate transparency concerning the Receiver's remedial efforts and the functioning of prison medical care.

Communications.

1. Continue outreach to public through the media and other targeted constituents including policy makers and prison and community groups to reiterate the importance of the goals of the Receivership.

2. Maintain an inmate patient relations program to handle incoming correspondence to

the Receiver from inmates and their families.

3. Maintain and expand CPR web site to service requests for public information about the Receivership.

Metrics.

In additions to describing remedial processes, the Plan of Action will include metrics, objective and detailed measurement designed to provide the Receivership with the necessary information to manage California's prison medical delivery system, and to identify systemic problems so that corrective actions and program objections can be implemented in a timely manner.

4. *Holding Employees Accountable for Their Actions.*

a. Introduction.

As stated in the Receiver's prior reports, the problems within the State's dysfunctional prison medical care delivery system is not limited to disorganization, staffing shortages, inadequate salaries, poor management, and a crisis mentality response to long term problems. Dysfunction also pervades the CDCR's culture, and includes an almost total failure to hold health care staff to appropriate clinical, ethical, and work standards. During the past reporting period the Office of the Receiver commenced four different programs designed to make inroads into the serious cultural problems which adversely impact the delivery of adequate medical care.

b. Evaluation of Nursing Competency.

Although required by State regulations, the CDCR had no formal process for the evaluation of the clinical competency of prison nursing staff. Most local health care managers had been unaware of this requirement and, even if aware, most prisons lack clinical educators to carry out performance reviews. In the past, and at the present, evaluation of the clinical competency of nursing staff only occurs when there is an unexpected death. This clearly does not meet the regulatory requirements for regular performance reviews nor accepted community standards of care. To remedy this situation, a statewide method of evaluating nursing

competency is in the process of being developed by the Statewide Nursing Educator.

c. Limitations on Administrative Time Off ("ATO").

The CDCR practice of placing employees on ATO for months and even years has been brought to an end, at least those employees associated with the delivery of medical care. On February 7, 2007 the Receiver issued a policy limiting the use of paid leave. On that same date he ordered the termination or immediate return to work of all thirty-one employees on ATO status. It is fiscally irresponsible and poor management to place employees on paid leave when there is work that can be performed without jeopardizing prison security or patient safety. All medical employees who had been on ATO as of February 7, 2007 have either been returned to work (on assignments where they cannot jeopardize patient care) or separated from State employment.

d. Investigation and Discipline Reform.

i. Introduction.

Currently, CDCR medical and custodial managers lack sufficient knowledge about when an investigation of health care related misconduct is warranted and how to request an investigation. No consistent reporting structure exists when misconduct is identified and there is a lack of appropriate staffing devoted to medical investigations and discipline. Furthermore, there is a lack of understanding by health care management of the number and type of investigations as well as information on the investigations' outcomes and resulting disciplinary measures.

ii. Plan to Reform the Investigation and Discipline Process.

The Office of the Receiver is in the process of meeting with the Office of Internal Affairs ("OIA"), the Employment Law Advocacy Team ("EAPT"), and the Bureau of Independent Review ("BIR") of the Inspector General's Office to develop a multi-faceted program to reform the process of investigating misconduct by health care employees. A major component of the plan will be the formation of a Central Management Committee comprised of medical experts

including surgeons, physicians, nurses and mental health professionals. Prior to an investigation being assigned, the Committee would develop a plan to address the specific clinical/non-clinical issues in the case.

The Plan also calls for modification to the current investigative protocols, including case management, the central intake process, and the tracking of cases through completion of the investigation. It will require that whenever an unexpected inmate death occurs (other than those caused by inmate on inmate violence) an autopsy will be performed, including the head. Determinations will be made, at the completion of the investigation, concerning whether there was a systemic problem which contributed to the cause of death; a training program for health care staff and correctional staff working on or assigned to health care issues; and modifications to the existing employee discipline matrix as it pertains to misconduct by medical personnel. To ensure the timely disposition of investigations, the plan establishes time parameters for completion of each part of the investigative and discipline process. It is anticipated that OIA will establish a special unit to handle only health care related misconduct, as will EAPT.

iii. Statewide Tracking System.

In order to better understand the frequency and type of misconduct occurring at CDCR institutions, the Receiver has implemented a statewide system to track the health care related investigations of misconduct by health care and correctional staff. The type of investigations tracked by the new system include personnel complaints from employees, allegations of fiscal waste by employees, allegations against employees which are handled by the Office of Internal Affairs such as smuggling of contraband into an institution, failure to follow procedures, discourteous treatment of fellow employees or inmates and other performance related issues.

The system requires all prisons to submit a monthly Investigation and Discipline Audit Report ("IDAR") on all cases involving medical employees, providing information concerning the number, type and outcome of investigations. Although institutions have had difficulty reporting this information in a timely manner, the Investigations and Discipline Coordinator is

working cooperatively with the appropriate CDCR officials to resolve the issue.

e. Professional Practice Executive Committee Reform.

i. Introduction.

As defined in Business and Professions Code section 805(a)(1)(D), the Professional Practice Executive Committee ("PPEC") serves as the State's peer review body for the Division of Correctional Health Care Services, reviewing allegations of clinical misconduct and neglect, investigating the allegations, and taking action to protect patient safety.

ii. Shortfalls of the Existing CDCR PPEC System.

In the twenty months of its existence, the PPEC has met approximately seventy-seven times, reviewing over 300 allegations of clinical misconduct and neglect. Allegations derive from a variety of sources, including death reviews, referrals from the Office of Internal Affairs, referrals from physician managers in the field, inmate appeals, and Quality Improvement in Correctional Medicine (QICM) Program results. In many cases, when reviewing these allegations, the committee took no further action (13%), made referrals for training (13%) or nursing review (8%), or requested additional information (10%). The committee initiated peer review investigations approximately 42% of the time, imposed provider monitoring about 7% of the time, and issued credentialing file alerts 7% of the time.[5]

From June 2005, the CDCR implemented a statewide policy to govern a centralized peer review process and provide due process to the physicians and mid-level providers subject to peer review. Through February 2007, the PPEC committee initiated over 110 peer review investigations, restricted the privileges of 5 physicians, and completely pulled from patient care 43 practitioners. Of the 43 physicians and mid-level providers whose privileges have been suspended:

1. Eighteen practitioners have a hearing date scheduled or are awaiting a hearing date to contest the revocation of their clinical privileges;

[5] Data are from an analysis of PPEC actions during Fiscal Year 2005-2006.

2. One practitioner has completed the full hearing process;

3. Eighteen practitioners have separated from state service, either through dismissal, resignation, or retirement;

4. Two practitioners returned to clinical care, with monitoring imposed;

5. Four cases were initiated very recently and are still pending.

iii. The Future of Peer Review: Professional Practice Policy Revisions.

The original PPEC process addressed only peer review. It did not take into consideration the due process issues required during the discipline of State civil servants. Therefore, absent a second, time consuming, and expensive investigation and prosecution before the State Personnel Board ("SPB"), it is impossible to terminate the employment of dangerous medical providers (when a provider is deemed to be a danger to patients and PPEC determines there is no effective remediation or training, privileges must be suspended, restricted or revoked). In actual practice, a pattern developed where PPEC revoked practicing privileges, an action that led to the provider's removal from patient care, but the provider has remained a CDCR employee, often receiving his or her full salary while on ATO. In practice, the CDCR "dual" process presents an unacceptable and cumbersome situation in which the potential exists to have an employee removed from their duties, yet remain a fully paid State employee.

iv. Reforming the PPEC Process.

In order to remove a dangerous physician from employment both the State's administrative termination procedures and PPEC's professional action must be taken. To develop such a program, the Office of the Receiver has commenced directing an effort to design a new policy and process, one which incorporates both civil service and peer review due processes. The preparation of the new PPEC program, a priority for the Receivership, has involved both the Union of American Physician and Dentists and the State Personnel Board and calls for designing a clear and definitive process for professional practice discipline. The goals

of the policy are as follows:

1. Effective and Timely Discipline.
2. Patient Protection.
3. Preservation of Due Process Rights of the Employee.
4. Linking Maintenance of Privileges to Employment.

An initial draft of the plan has been fashioned and distributed to interested parties for comments. These comments are currently being reviewed and incorporated into a new policy. This policy will address the goals listed above and ensure standardization of the process. The Receiver anticipates that the new process will be presented to the Court for approval by April 2007.

f. Conclusion.

The Receiver has encountered many loyal, hard working, dedicated State employees during his inspections of prisons and his meeting at CDCR headquarters. He has also, however, observed situations where State employees are not performing adequately. The Receiver remains committed to providing CDCR medical care employees with the appropriate compensation (a process which has already begun) and working conditions (a process which will take longer to implement but which is of no less importance). In addition, as explained above, improved training and organization will be provided, over time, to both clinicians and support personnel. However, hand in hand with these improvements will be the requirement for a higher level of employee accountability. The lives of prisoner/patients lies in the balance, and the Receiver will not tolerate the continuation of a long-standing culture of failure and irresponsibility from any member of the medical care team who serves under his direction.

(5) *Coordination with Coleman, Perez, and Armstrong.*

(a) Introduction.

An initial and important priority for the Receivership involves efforts to coordinate the *Plata* remedial process with the remedial work necessary in the *Coleman* (Mental Health), *Perez*

(Dental), and *Armstrong* (Americans With Disability Act) class action cases. There are numerous sound reasons why coordination must remain a priority for the Receiver and his staff, including:

1. The plaintiffs in *Plata* are the same plaintiffs in the other class actions. CDCR prisoner/patients will benefit from coordinated medical, mental health and dental treatment.

2. Certain health care functions, for example adequate information technology, adequate medical records, adequate pharmacy services, appropriate clinical space and treatment centers, and adequate numbers of trained correctional escort teams, represent crucial remedial plan elements for all of the class action cases. Addressing these problems in a coordinated fashion is necessary in terms of appropriate fiscal stewardship, efficiency and effectiveness.

3. The Receiver, by the inherent nature of the drastic remedy of a Receivership, will be able to garner resources, experts and staff to expedite critical health care remedies such as information technology roll-outs in a faster and more efficient manner than available to the experts and Special Master in the other class actions.

4. The utter disrepair of the CDCR's medical system is not that different from the almost absolute failure by the State to provide dental care, nor the slow progress providing an adequate mental health program, nor the apparent inability to provide adequate programs for disabled prisoners. Fixing this mess requires careful planning and the setting of systemic priorities. It is critical, therefore, that coordination take place among the class actions to ensure that the remedial priorities and programs of one case does not disrupt the remedial priorities of the other cases.

(b) Coordination During the Reporting Period.

The Office of the Receiver has engaged in several coordination processes during the reporting period including involving all disciplines (medical, mental health, and dental) with the new reception process at San Quentin State Prison, involving all disciplines in the construction planning and floor plan layouts of the new Medical Center to be constructed at San Quentin, and

attending coordination meetings with the Deputy Special Master in *Coleman* and the Court experts in *Perez*. While at its initial stages, a process of cross-case communication has begun that involves not only formal meetings but also informal discussions between *Plata* remedial team leaders and the Court experts in other cases. With time, the Receiver anticipates that this process will become more extensive so that coordination considerations become second nature to all involved in the process of improving the CDCR's health care systems.

As of the date of this report, there appears to be general consensus among the Special Masters and Court experts that the Receiver should manage, through *Plata,* certain large scale state-wide remedial programs including information technology, medical records, pharmacy, the construction of 5000 prison medical beds, the overall organization of prison health care management, and the health care access units. What is now under consideration is how best to handle various health care service functions performed at the CDCR's by State employees including, for example, Telemedicine, credentialing, procurement of equipment, and health care related prisoner/patient appeals. Preliminary meetings concerning these issues were the subject of an all day meeting between the Receiver's Chief of Staff, the Deputy Special Master in *Coleman*, and the Court experts in *Perez* last month. The Receiver will be meeting with the Special Master in *Coleman* and the Court experts in *Perez* to discuss these issues on the date of the filing of this report, Tuesday March 20, 2007.

(c). Coordination Problems.

Problems arose concerning the efforts by the Receiver, Special Masters, and Court experts to coordinate the class actions during the reporting period. Primarily these problems were created by the attorneys involved in the cases, counsel for the plaintiffs and counsel for the defendants. For example, plaintiffs submitted proposed orders in one of the cases without discussing or coordinating the consequences of the orders with the Receiver, despite the fact that the order proposed by plaintiffs contained specific instructions to the Receiver. In another case, counsel for defendants failed to take timely action to coordinate a remedial program at San

Quentin State Prison, creating a situation whereby either: (1) the new reception process, designed to both reduce costs and improve care, will be delayed or; (2) the new reception process will proceed forward without the inclusion of dental screening, necessitating expensive additional custody escorts and delaying care to the patient.[6]

Effective coordination will be very difficult to achieve unless and until counsel for the parties put aside their differences, discontinue their present "monitoring" mode of compliance review and begin a new "work together to solve problems" approach. The Receiver, in an attempt to encourage improvement in the coordination efforts of counsel, has initiated and will continue to meet on a monthly basis with attorneys for plaintiffs and defendants in the same room, at the same time, to specifically address problems with coordination. Because the Prison Law Office represents the plaintiffs in all class actions, and the Attorney General represents the State in all cases, there is no reason why the Prison Law Office lawyers and the Deputy Attorney Generals assigned to *Plata* cannot adequately address coordination issues that may arise in conjunction with the other class action cases.

C. The Management of Day-by-Day CDCR Operations.

1. *Introduction.*

In the Third Bi-Monthly Report the Receiver informed the Court that:

> In April 2006, when the Receivership began, the decision was made to allow the State to retain direct management over the daily operation of the prison medical delivery system. Near the end of this bi-monthly reporting period, however, the Receiver made the decision to begin to assume direct management over several elements of the CDCR medical delivery system, including direct management of CDCR physician and nursing operations.

Third Bi-Monthly Report at 7:7 - 12

Numerous reasons were cited to support the decision, including the recognition that: (1) with the State's bureaucratic, political, and fiscal restrictions, no one individual, no matter how talented and dedicated, is able to manage the CDCR's combined medical, mental health, and

[6] This San Quentin reception center related problem is discussed in Section III.B. below.

dental programs; (2) conflicts between class action priorities had diverted the CDCR's Division of Correctional Health Care Services ("DCHCS") management's attention away from *Plata* remedial needs; (3) day to day crisis situations had arisen which, because they were not resolved by health care management, required time consuming attention from the Office of the Receiver; (4) poor service, inadequate staffing, and a lack of responsiveness to remedial plan requirements from the CDCR's Support Service Division relative to medical contracts processing, recruitment, hiring, and human resource transaction processing; and (5) the fragmentation of nursing management.

Despite the fact that the Receiver assumed direct management over all CDCR primary care providers and nurses, operational problems within DCHCS have continued, and the CDCR's Support Services Division has not improve its services. Therefore, near the end of this reporting period the Receiver took steps to assume direct management over all aspects of *Plata* related services, removing Peter Farber-Szekrenyi from all responsibility concerning CDCR medical care and announcing the formation of the Plata Support Division, a new unit of the CDCR dedicated to prisoner/patient medical care delivery support.

The Receiver is fully aware that by assuming direct management of medical care operations his Office must assume many important day-to-day prison management tasks; nevertheless the Receiver is equally convinced of the following:

1. Office of the Receiver staff, now that the assembly of his remedial team nears completion, are more capable of directing daily CDCR medical operations than State officials.

2. The periodic crises encountered by medical clinicians require timely and adequate responses which are best managed by the Office of the Receiver.

3. The remedial process will be more effective if long term project implementation merges as closely as possible with daily operations.

4. Providing direction for State employees concerning the daily operation of medical delivery in California's prisons will help ensure the eventual return of the prison medical

delivery system to the State.

2. *The Plata Support Division.*

The Plata Support Division has been established to provide administrative support for the reform initiatives spearheaded by the Receiver. At this point in time the Division is comprised of Human Resources, Fiscal, Business Services and other support functions departments. Each of these departments within the Plata Support Division is working collaborative with the Office of the Receiver to meet the changing needs of California's prison system as remedial measures are implemented.

The Personnel Services and Staff Development Department has implemented new recruiting and hiring programs to implement numerous Receiver initiatives to improve the retention of medical staff (including creating new or revising current job classifications, implementing salary increases for specified classifications, designing a new hiring and on-boarding processes, establishing training programs for institution personnel staff and for new supervisors, and improving the credentialing process of medical staff). Once fully staffed, this Department will assume full responsibility for all Human Resources related functions for the 'Plata' classifications, removing those functions from the CDCR's Support Services Division.

The Plata Workforce Planning and Development Department is working to recruit and hire additional health care professionals to fill the many vacancies that exist throughout California's prison system. To date, this Department has filled four of fourteen of its vacant positions and projects that those positions will be filled by mid to late April. Eleven of these positions will be in Sacramento with three in the field. To ensure that proactive steps are taken on a daily basis to fill health care professions vacancies in an expeditious manner, a pilot for 'One-Day Hiring' was rolled out February 22, 2007. In the week following the rollout, one prison was able to hire a nurse within four hours.[7]

[7] The new hiring programs implemented under the direction of the Receiver have already demonstrated some initial success. For example, there have been 262 new Registered Nurses hired since October 1, 2006.

The Plata Fiscal Department has provided necessary support services to the automated medical contract/invoicing pilot which went live on February 20, 2007. Details of this important pilot program are discussed in section II.B.4.

The Plata Support Division, under the leadership of Director Richard Kirkland, is in the process of reviewing all CDCR functions involved in the delivery of medical care, including, but not limited to, telemedicine, licensing, health records, appeals, space planning, procurement, and capital outlay. These and related functions will be reorganized to effectively meet the needs of the medical care system and coordinate with mental health, dental and custodial operations. The Receiver will report about what health care functions will be managed in the Plata Support Division for all health care functions, and which functions will remain in CDCR to be processed for the other class action cases, in his next Quarterly Report.

3. *The Medical Care Delivery Crisis at Avenal State Prison.*

Recent events at Avenal State Prison ("Avenal") are illustrative of one type of crisis situation which the Office of the Receiver must address on a regular basis. Three inmate deaths at the prison in December 2006, all of which involved inadequate care and a lack of physicians at the prison, has necessitated multiple interventions by the Receiver.

When it opened in the rural Central Valley in 1987, Avenal was designed to house 2,500 inmates and the medical care model was "sick call," which occurred in traditional "yard clinics" that could accommodate pill lines, nurse screening, and simple visits with a physician or mental health provider. Today Avenal houses 7,500 inmates of whom 1,200 are over the age of 55. Many of these prisoner/patients are in wheelchairs, and many have diabetes. However, all are still being treated in those same yard clinics using a sick call model that lacks additional personnel, space or any systems for tracking and managing chronic illness. The resulting problems are numerous and serious. For example, results of laboratory tests, if the tests are done as ordered, only haphazardly find their way into medical charts, and medications ordered often fail to coincide with the medication lists used for medication distribution in the pill line because

of communication breakdowns in the physician-nurse-pharmacist paper flow.

In December 2006, when the deaths occurred, the nurse practitioners and physician assistants delivering the bulk of care lacked adequate physician supervision because of significant turnover in the physician staff and leadership for several years. By January 2007 the situation worsened, there was a complete breakdown in medical care coverage.

In response, several physicians were diverted from nearby institutions. In addition, at the request of the Receiver, physicians and midlevel providers from the University of California, San Francisco, began to provide part-time coverage and began to organize systems for chronic care, and, at the same time, the Receiver had already ordered the creation of fifty additional State clinically related health care positions.

The Receiver and his team inspected Avenal on February 1, 2007. It was evident that Avenal, like other California prisons, lacked adequate correctional officers to provide transportation of inmates to medical care appointments within and outside of the prison. The Receiver subsequently ordered the creation of twenty new custody positions to help fill that gap. The Receiver's team has also begun plans for the construction of additional clinic space at Avenal.[8]

4. *Challenges to the Receivership.*

The major challenges faced by the Receivership during the reporting period can be summarized into four categories:

a. Challenges involving day to day crisis issues arising because of CDCR operations and

[8] The crisis at Prison served to exemplify why the importance of the Receiver's longer term plans to transform the entire CDCR medical care delivery system. Beyond new positions and new space, Avenal desperately needs additional improvements in laboratory and pharmacy services and in medical record-keeping, as well as in the development of systems of care delivery (including information technology) that can safely manage inmates with serious chronic illness. In other words, while responding to the crisis provides some immediate improvement, the long term change necessary to bring California's prisons up to constitutional minima will not take place without fundamentals such as appropriate salaries, a working pharmacy system, the appropriate numbers of escort personnel, skilled medical delivery management, etc.

mis-management.[9] In the future, these problem will be addressed more effectively by the creation of the Plata Support Division, as described above. However, no one should believe that additional problems created by CDCR operations will not arise on a regular basis in the future.

b. Challenges relating to the coordination of the class actions as described in Section III.B. below. The Receiver and his staff intend to work diligently with the Special Masters, Court experts, and counsel to keep this type of challenge to a minimum.

c. Challenges to the Receivership after the Receiver finds resistence and mis-management on the part of a California control agency. For an example, *see* Section III.A. below.

d. Challenges to the Receivership because certain aspects of California law impedes the development of necessary remedial plans. An example of this final category involves the State Personnel Board ("SPB") which has expressed concern, based on its interpretation of its obligations under California law, concerning the Receiver's plans for (1) hiring LVN's, (2) for implementing a new job position similar to Career Executive Assignments ("CEA"), and (3) for utilizing the modified PPEC procedure to discipline physicians concerning medical malpractice issues.

During the reporting period the Receiver met with the SPB at a public hearing to express the reasons for the proposed programs, and to hear and to consider the SPB's concerns. The Receiver appreciates the efforts expended by the Board to meet and discuss these proposals.

Following that meeting, the Receiver's Chief of Staff and one of his attorneys have met on several occasions with the SPB's Executive Director in an attempt to resolve SPB's concerns, and to implement the remedial plans deemed necessary by the Receiver in a manner that has

[9] An example of this type of problem involves a multi-million dollar "contract" (never signed) for prison speciality services with Medical Development International ("MDI"), a contract negotiated by CDCR officials without informing the Receiver or his staff. This problem, which required many, many hours of investigative work and remedial action calls for complete transparency and a full and accurate report for the Court and the public. The Receiver will, however, hold his reporting until the Inspector General completes an investigation concerning this matter.

minimal adverse impact on SPB operations. As of the date of this report significant progress has been reported concerning all three of the issues mentioned above.

D. Establishing The Receiver's Remedial Team.

The Receiver is close to fully staffing, after months of exhaustive recruitment efforts, the top levels of leadership of his remedial team. Additional staff added to the Office of the Receiver during the reporting period include the following specialists in the areas of nursing, administration, human resources, medical records and information technology:

Betsy Chang Ha, RN, MS, CPHQ is the Chief Nurse Executive for the Receiver. Ms. Ha has over twenty-five years of public and private sector experience in health care delivery systems. Prior to joining the Office of the Receiver, she was the Director of Quality Improvement at the Center for Health Care Strategies (CHCS). At CHCS, Ms. Ha was responsible for quality improvement initiatives and technical assistance for Medicaid managed care organizations, including CHCS's nationally recognized Best Clinical and Administrative Practices (BCAP) workgroups. Prior to CHCS, Ms. Ha was the Director of Operational and Quality Improvement at CalOptima, a county organized health system that provides managed health services to approximately 300,000 members. Prior to joining CalOptima, she was with MedPartners, a national provider managed organization, where she served as the Associate Director of Integrated Health Services, responsible for government programs, health plan compliance, care coordination, and special projects for the western region. Ms. Ha has extensive clinical experience in improving care for the medically complex pediatric population. She developed the integrated continuity care and case management programs at the Children's Hospital Los Angeles and provided consultation for the State of California on the Pediatric Sub-acute Care Task Force and home care services. She also served on the Board of Baldrige Examiners for California Awards for Performance Excellence. Ms. Ha has a master's degree in health care management from California State University of Los Angeles and received her bachelor's degree in nursing from University of Maryland, School of Nursing. She is a Certified Professional in

Healthcare Quality.

Jackie Clark, RN is the Director of Nursing Operations for the Receiver. As Director of Nursing Operations, Ms. Clark is responsible for assisting the Statewide Nursing Officer with providing oversight of the operations and delivery of all nursing services throughout the prison medical system. Ms. Clark has over 20 years of correctional management experience in both prisons and adult and juvenile detention facilities. Most recently she was the clinical director of the San Francisco County Jails system within the Department of Public Health. She previously worked for the Department of Developmental Services, Department of Corrections and U.C. Davis in various managerial roles. She has served as a court monitor and court expert in various cases across the nation related to both correctional and acute care settings. She also has worked as an auditor for the California Medical Association (CMA) and the National Commission on Correctional Healthcare (NCCHC).

Richard Kirkland is the Director of the Plata Support Division, the new division dedicated to supporting the day to day operations of medical care undertaken by the Receiver. Mr. Kirkland worked for over 32 years with the State of California, the last 22 with the CDCR. He retired from the position of Deputy Director for the Office of Fiscal Services, where he was responsible for the oversight and management of all CDCR accounting and support budget functions. In that role he served as the senior level liaison with the Department of Finance and legislative staff with respect to CDCR budget issues. Prior to that, Mr. Kirkland served at Pelican Bay State Prison in a variety of senior management positions for 14 years, including two as Warden and one as Chief Deputy Warden. During that time he participated in and oversaw the implementation of the state's remedial plan in the case of *Madrid v. Tilton*. Mr. Kirkland also has eight years of experience in the management of prison construction projects. He served as Project Director for the construction of Pelican Bay State Prison, Calipatria State Prison, California State Prison–Sacramento, and the maximum security units at the California Correctional Institution (Tehachapi). Prior to that, Mr. Kirkland worked for ten years as an

analyst and supervisor for the California Department of Social Services. During that time he was responsible for the development of rate-setting methodologies, the development of computerized management information systems, and the management of quality control corrective action plans.

Hazel McPherson is a Personnel Policies and Procedures Specialist in the Receiver's Plata Support Division. Ms. McPherson worked for the State of California for over 36 years, most recently as a senior manager in Department of Motor Vehicles' Human Resources Branch. Ms. McPherson has extensive experience in the management of professional, technical and support staff in the field of Human Resources. She has strong expertise in the processing and maintenance of pay and benefits; in the analysis and investigation of requests for, and preparation of, disciplinary actions; in the performance of classification and compensation studies; and in facilitating the return to work of industrially injured employees.

Karen Rea (Williams), PHN, MSN, FNP is the Regional Director of Nursing (Central) for the Receiver. Ms. Rea provides nursing leadership and oversight to state prisons located in Central California. Ms. Rea has 20 years of nursing, education and administrative experience. From 2002 to 2006, Ms. Rea worked as the Quality Assurance Manager and Deputy Director for the Fresno County Department of Children and Family Services where she developed a quality improvement program for social workers and mental health clinicians and managed the only free standing children's emergency psychiatric facility in the Central Valley. From 1993 to 2002, Ms. Rea was the Fresno County Public Health Nurse (PHN) and Supervising PHN of Communicable Disease and Epidemiology program. From 1987 to 1993, Ms. Rea was a Neonatal Intensive Care/ICU Nurse and the Director of the FOCUS substance abuse program for San Joaquin County. Ms. Rea has also worked as a Family Nurse Practitioner, hospice nurse and educator at Pacific Union College and University of Phoenix. Ms. Rea's memberships include: American Association of Legal Nurse Consultants, California Association for Healthcare Quality, California Association of Nurse Practitioners and Academy of Correctional Health

Professionals.

Jane P. Robinson, BSN, RN is the Regional Director of Nursing (Northern) for the Receiver. Ms. Robinson provides nursing leadership and oversight to state prisons located in Northern California. Prior to coming to California, Ms. Robinson worked in correctional health care for the Washington Department of Corrections where she was a Continuous Quality Improvement Nurse and most recently a Health Care Manager. Ms. Robinson has also served as a patient advocate for detainees in jail settings in the capacity of a court expert. And prior to her work in the correctional health care systems, Ms. Robinson was a patient Care Coordinator in an acute care hospital in the Midwest, where her responsibilities included quality management, staff development, and policy and program development.

Waive Sampson, RHIT is a Medical Records Manager for the Receiver. Ms. Sampson is responsible for planning, managing and directing the activities of the medical records unit at San Quentin as part of the Receiver's San Quentin Project. Ms. Sampson has been a health information technology manager and consultant since 1998, working for several organizations, including the San Jose Medical Group, Anderson Health Information Systems, and the Palo Alto Medical Foundation. Ms. Sampson has held the office of Secretary of the Ambulatory Information Management Association, and is a member of the American Health Information Management Association and the California Health Information Management Association.

Randolf Sandoval is an Administrative Aide in the Receiver's San Jose Office. Mr. Sandoval worked most recently as an Office Specialist for the Santa Clara County Public Health Department and Emergency Medical Services Agency, where Mr. Sandoval's duties included computer networking and other information technology support services. Mr. Sandoval is currently studying Management Information Systems at San Jose State.

Susan Scott RN, BSN, PHN, TNCC, MICN is the Regional Director of Nursing (Southern) for the Receiver. Ms. Scott provides nursing leadership and oversight to state prisons located in Southern California. Prior to working in the state prison system, Ms. Scott worked seventeen

years for St. John's Regional Medical Center, Oxnard where she served in multiple roles including Pre-Hospital Care Coordinator, Emergency Department Manager and Director of Emergency Services. Ms. Scott has worked as a clinical nurse in emergency department, operating room, and post anesthesia recovery unit environments. In addition, Ms. Scott has served as a nurse for the Ventura County Search and Rescue Unit, and provided education and consultation for numerous projects related to emergency nursing, pre hospital care and emergency medical services systems. Ms. Scott has a B.S. in Nursing from San Diego State University, and is currently pursuing a Master's Degree in Nursing.

Susan Odegaard Turner, RN, PhD is the Statewide Nursing Officer for the Receiver. Ms. Turner provides oversight of the operations and delivery of all nursing services throughout the prison medical system. Dr. Turner has over twenty-five years experience in the healthcare field, beginning her career as a Critical Care Unit and Emergency Department registered nurse, and ultimately serving in top management roles including Chief Operating Officer and Vice President for various hospitals throughout Southern California. Ms. Turner has a Bachelor's of Science degree in Nursing from Mount St. Mary's College, Los Angeles, a Master's degree in Nursing from the University of California, Los Angeles, a Master's of Business Administration from California Lutheran University, and a Doctorate in Business Administration from Southern California University. Dr. Turner is an Associate Professor for the UCLA Graduate School of Nursing, and is the author of "The Nurse's Guide to Managed Care," and "The Nursing Career Guide," both published by Aspen-Jones Bartlett.

Paul Whittaker is the Program Management Office (PMO) Manager for the Receiver's Chief Information Officer. Mr. Whittaker's previously held positions as Director of PMO for the Clinical Solutions Division of Perot Systems and Senior PMO Manager for Sutter Health IT. Mr. Whittaker has over 25 years of experience in Information Technology, Program Management and Technical Operations including affiliations with private sector organizations such as Hewlett-Packard and Intel, and public sector organizations including the State of

California and the U.S. Department of Defense. In addition to the company positions held by Mr. Whittaker, he also served many years as the owner/operator of his own startup consulting firm.

III.

PARTICULAR PROBLEMS FACED BY THE RECEIVER

A. The Department of General Services' Failure To Cooperate with Maxor.

(1) Introduction.

As reported above, the Maxor team began work in Sacramento on January 1, 2007 with a number of experienced and well qualified correctional pharmaceutical clinicians. As a critical part of Maxor's efforts to improve the CDCR's broken and overly expensive pharmacy system, Maxor requested from DGS, on January 11, 2007, complete copies of the CDCR contracts for pharmaceuticals which had been negotiated by the control agency.

(2) *The Importance of Maxor's Monitoring of DGS Contract Procurement.*

There are three important reasons for Maxor to monitor DGS' procurement of CDCR pharmaceuticals.

1. The prices generally set for the pharmaceuticals utilized by the CDCR are established by a General Purchasing Organization ("GPO") agreement entered into by DGS. These prices can be improved through direct negotiations with individual manufacturer and generic wholesale "house" contracts. As reported earlier by Maxor, however, the State (including DGS) has no functioning system to ensure that the best possible negotiated price is actually obtained in practice. Therefore, while pharmacy items at lower prices than those set by the GPO may in fact be available, no one in DGS bothers to verify that the best price was in fact obtained.

2. Maxor has discovered that DGS operates its Pharmacy and Therapeutics Committee outside the CDCR. While the CDCR comprises the great majority of DGS pharmaceutical purchases, DGS allows representatives from multiple other State agencies to sit on and dominate its Committee. As a result, DGS has failed to achieve the maximum fiscal savings which benefit the CDCR, an outcome it could have realized by negotiating separate contracts based on the

clinical pharmaceutical needs of the CDCR itself. In essence, DGS has entered into purchasing agreements that punish the larger CDCR's budget for the benefit of other, smaller other State agencies, a practice best described as "the tail wagging the dog."

3. Maxor has also discovered that several contracts negotiated by DGS contain unacceptable terms which assure free access on the CDCR Formulary with no restrictions on practitioners, despite documented problems with medication management within the CDCR. As a result, it is probable that clinical practices were influenced by Formulary decisions outside of CDCR review, jeopardizing patient care.

(3) *The DGS Failure To Provide Contracts to Maxor For More Than Two Months.*

Numerous follow-up meetings were held with DGS concerning this issue, including a morning meeting on February 7, 2007 (a meeting which included the Receiver's Chief of Staff), an afternoon meeting that same day, and subsequent meetings on February 22, 2007, March 1, 2007, and March 14, 2007). Nevertheless, it took DGS more than four weeks to provide even a list of its CDCR pharmaceutical contracts to Maxor. When contracts were finally delivered, on February 16, 2007, the DGS submission proved to be incomplete; indeed, concerning a number of vendors DGS failed to provide the real contract at all. DGS continued its dilatory tactics until the Receiver's Chief of Staff again become involved with the problem, at which time he instructed DGS to either deliver the contracts or face the Court. What appears to be a completed set of contracts was finally delivered to Maxor in Sacramento on Friday, March 16, 2007, more than two months after the original request.

DGS's failure to deliver the complete contracts for Maxor's review has delayed for two months the Receiver's ability to monitor whether in fact the best price has been obtained for CDCR pharmaceutical purchases. Given that CDCR spends approximately sixteen million dollars each month on pharmaceuticals, the potential savings achieved when Maxor begins the type of monitoring that DGS has failed to implement should be considerable. *See* Exhibit 15, Dr.

Glenn G. Johnson's letter of March 15, 2007.

The pattern of DGS conduct over the past two months presents a classic case of control agency delay and trained incapacity. The hallmarks can be summarized as follows:

1. DGS staff who insist on discussing process at meetings rather than issues of substance.

2. DGS attorneys who cite, as justification for delay, various legal theories (in this case "confidentiality concerns") which they cannot demonstrate apply to the Receivership.

3. DGS attorneys who send e-mails after meetings containing inaccurate "chronologies" about what took place at those meetings.

4. DGS staff who appear at meetings without a DGS attorney, thereafter taking the position that they are unable to take action because they need to ask their attorney for advice.

5. The DGS practice of sending different attorneys to different meetings, with the new attorney taking the position that she has not been involved with the question of contract delivery to a degree where she can advise her client exactly what to do.

(3) *The DGS Failure To Provide Information to Maxor Concerning an Offer by the Heinz Family Philanthropies to Explore 340 B Pricing for California.*

As the Court is aware, one of the elements of the Receiver's contract with Maxor calls for Maxor to attempt to achieve 340B pricing, special discounts available to entities which serve disproportionate populations. Maxor estimates the resulting savings to the State at approximately *sixty-two million dollars annually*. The process, however, of obtaining such pricing discounts is difficult and to begin to explore this option, Maxor requested and the Heinz Family Philanthropies agreed to conduct an analysis concerning 340b pricing for the CDCR at no charge.

The Receiver's Chief of Staff requested that DGS cooperate concerning Maxor's plan to involve the Heinz Family Philanthropies with CDCR pricing at the meeting of February 7, 2007.

Since that date, however, DGS has attempted to erect numerous barriers which prevent this effort, primarily related to compliance with various "confidentiality" agreements which the DGS itself has negotiated.

On March 14, 2007 the Receiver's Chief of Staff instructed DGS to set forth its objections to 340B pricing in writing. A responsive "chronology" letter by Kathleen Yates is attached as Exhibit 16. While the letter contains several factual errors (for example, Dr. Johnson did not concur with DGS' proposal that Maxor and not DGS obtain the pricing information necessary for the Heinz Family Philanthropies appraisal, as Dr. Johnson documented in an e-mail dated March 1, 2007 to Laurie Giberson, one of at least three different DGS attorneys who have been involved with this matter) it's conclusion is stunning. Essentially, DGS takes the position that because of confidentiality provisions that DGS has negotiated, DGS is unable and unwilling to obtain contract information that may save California taxpayers *$160,000.00 per day*. Instead, DGS proposes that Maxor take charge of this effort.

After evaluating what is already known about the quality of DGS contract negotiations and its formulary decisions, and after reviewing what has transpired between DGS and Maxor during the past two months, the Receiver agrees with Ms. Yates. Maxor should not only take over this effort, it should assume effective control over all CDCR pharmaceutical purchases.

(5) *The Receiver's Decision to Begin to Assume Direct Control Over the Negotiation of All CDCR Pharmaceutical Purchases.*

It is apparent to the Receiver and his staff that DGS has neither the skill nor the interest in effectively managing pharmaceutical purchases in a manner consistent with CDCR prisoner/patient's best interest. It is also clear that the CDCR's budget has been adversely impacted by the manner in which DGS approaches contract negotiations and the manner by which DGS has failed to monitor actual purchases. This situation threatens patient care and is fiscally unsound. As such, it cannot continue. Therefore the Receiver has directed that his Chief of Staff begin a carefully planned transition that will enable the Receiver, with the assistance of

the Maxor Corporation, to assume direct control over the negotiation and purchase of all CDCR pharmaceuticals. In the interim, DGS will be instructed not to move forward concerning any pending CDCR related contract negotiation, including the upcoming Roche negotiation.

B. The Failure by Counsel to Coordinate the Integration of Dental Services in the San Quentin Reception Center Pilot Project.

1. *Introduction.*

As explained above, the Receiver's San Quentin pilot includes an extensive upgrading of the prisoner reception process. Although the full implementation of a quality reception process must await the construction of the San Quentin Medical Center, significant improvement in patient screening and care can be achieved in the current limited space available in the relocatable building used for reception. The upgraded reception process, designed by the Receiver's San Quentin team with considerable input from mental health and dental clinicians will provide day-of-arrival one stop shopping whereby all initial medical, mental health and dental screening will take place. Because of very limited space and other facility limitations, it is not possible to put a dentist into the current reception facility. Because of this limitation, the new program calls for dental screening by RNs, something that is not presently provided at San Quentin. With the activation of the Medical Center, the new state-of-the art reception center will have adequate space for dental chairs in the intake areas.

(2) *The Receiver's Efforts to Coordinate an Effective Short Term Screening Process at San Quentin State Prison.*

The Receiver's Chief of Staff and his Acting Health Care Executive Manager at San Quentin, Jayne Russell, arranged numerous meetings and inspections to coordinate this new project with the Court experts for both *Coleman* and *Perez*. For example, concerning the need for dental screening in the new process, Ms. Russell:

1. Formed a Reception Center Committee during October 2006, which has met weekly for the past six months to develop and coordinate the intake process. This pilot has been given

priority status with the Receiver's San Quentin team. Dental was represented by either Dr Morley or Dr. Beasley who have attended weekly since its inception.

2. Numerous policy drafts, flow charts, forms etc. of the various disciplines including custody, medical records, pharmacy, mental health, medical, nursing, lab and dental were regularly reviewed to discuss and decide upon the intake design. Each respective discipline was to coordinate policy drafts with their CDCR managers, regional and statewide.

3. Verified that Dr. Beasley discussed with Dr. Kuykendall this project and obtained his input regarding intake on numerous occasions.

4. Conducted conversations with Dr. Joseph Scalzo, one of the Court experts in Perez, beginning in early November 2006 to address the intake plan and ensure that policy drafts were acceptable with the *Perez* experts' intended practices.

5. Discussed with Dr. Kuykendall the intake plan in November 2006. At that time Dr. Kuykendall stated that he preferred dental screening to be completed by a dentist and not by a nurse. This request was accepted, and the new policies were revised accordingly.

6. Engaged in additional efforts to coordinate and complete the intake proposal, including on-going contact and communication over the past several months with Dr. Scalzo. As a result of these discussions, the decision was made to conduct an inspection of the reception area with counsel, CDCR clinicians, and the Court experts in *Perez*. During this period of time it was also determined that space was not available to put a dentist into the relocatable. Therefore, discussions resumed to use nurses to initiate the dental intake screen.

7. On February 22, 2007 Ms. Russell led a tour of the reception center. Three different State attorneys and one lawyer from the Prison Law office participated in the inspection. After the inspection, and after reviewing a proposed draft of the new policies reviewed, Dr. Kuykendall agreed to allow nursing staff to conduct an oral screening in Reception. It was agreed that nurses would be formally trained by dentists using one of the national curricula available; all dentists present, including the Court experts, were in agreement. Discussions

included the fact that this is an acceptable national practice in compliance with National Commission on Correctional Health Care standards. Given the limitations and reality of limited physical space, combined with cost effective utilization and availability of dentists (doubts had been expressed about being able to hire dentists for the wide range of hours in which San Quentin may receive a bus of new prisoners from local county jails), the parties at the inspection agreed that they reached the best decision.

(3) *The Attorney General's Decision to Delay for an Undetermined Time the Implementation of Dental Screening at San Quentin.*

Despite months of effort, the preparation of policies, the initiation of construction, the agreements following the inspection, and the concurrence of the Court experts, on March 1, 2007 the Deputy Attorney General assigned to *Perez* wrote to Ms. Russell to inform her that while the "CDCR is willing to consider, on a pilot basis, modifications to the dental program's currently existing reception center process[10] at SQSP" that the time line proposed by Ms. Russell was not reasonable and that CDCR will only "provide [Ms. Russell] with its decision after having ample time to review the Court experts' report and the merits of revising the dental programs (sic) existing reception center processes at SQSP" (see Exhibit 17).

(4.) *The Obligation on the Part of Counsel for Both Parties to Work Together to Resolve Coordination Issues.*

While the Receiver will continue to work diligently to effectuate coordination, he cannot allow the State, or the attorneys of either party to attempt to use coordination as a tool to delay the *Plata* remedial efforts. At first glance the substance of this letter, as well as the failure by the attorneys for both parties to have resolved this minor issue (a change in programming that will unquestionably benefit prisoner/patients concerning dental screening in a very cost effective manner) is simply inexcusable.

Upon reflection, however, the Receiver finds that the letter represents a far more serious

[10] The "dental program's currently existing reception center process at SQSP" is to do nothing at all at intake.

problem than problematic conduct by one attorney concerning one issue; it is indicative two serious shortfalls that negatively impact on the remedial process of all the class actions: (1) the failure on the part of the State to decide who, exactly, is in charge concerning its efforts to remedy the findings of the Federal Courts, and (2) the failure of counsel for both parties to work together in a cooperative to coordinate the impact of various class action remedial orders.

Concerning the first issue, it remains unclear who is in charge of CDCR remedial efforts, the Attorney General's lawyers, staff counsel for the CDCR's Office of Legal Services, or CDCR officials. Instead, on occasion, each of these different entities points to the other in an effort to excuse the State's long standing failure to meet the order of the Federal Court. The Receiver also points out that, given the turn-over of CDCR officials and the scope of staffing shortfalls in CDCR headquarters, the lawyers from the California Department of Justice are often placed in very difficult positions when attempting to represent their CDCR client. Unless and until this issue is resolved, Receiverships and Masterships will continue to be necessary in California.

Hopefully, the State is in the process of finally addressing this decades old problem in a direct manner. The Receiver's Chief of Staff was recently informed that the Governor's Legal Secretary and the newly elected Attorney General will soon meet concerning this issue. The Receiver stands willing to assist counsel for defendants with their coordination efforts in any manner that does not delay his *Plata* remedial efforts.

Concerning the second issue, unless and until the attorneys on both sides of this case stop the "monitoring as usual" approach to remedial efforts and begin to meet face-to-face on a regular basis to agree upon priorities and coordination efforts, time consuming and fiscally wasteful problems will continue to arise, harming the remedial efforts of all cases. The Receiver's recently initiated monthly meetings with combined counsel for plaintiffs and defendants will hopefully help pave the way for lawyer reform in this regard.

IV.

ACCOUNTING FOR EXPENDITURES IN THE REPORTING PERIOD

A. Expenses.

The total operating and capital expenses of the Office of the Receiver for the months of November, December and January 2007 were $1,876,165 and $3,733, 609 respectively. A balance sheet and statement of activity is attached as Exhibit 18.

B. Revenues.

On January 29, 2007, the Receiver requested a transfer of $3,168,000 from the State to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of Office of the Receiver for the third quarter of Fiscal Year 2006-2007. All funds were received in a timely manner.

V.

OTHER MATTERS DEEMED APPROPRIATE FOR JUDICIAL REVIEW

A. Waivers of State Law.

(1) *Introduction.*

The Court's February 14, 2006 Order Appointing Receiver establishes a procedure by which the Receiver may request waivers of State laws and contracts when necessary for him to accomplish his duties. As set forth by the Court:

> In the event, however, that the Receiver finds that a state law, regulation, contract, or other state action or inaction is clearly preventing the Receiver from developing or implementing a constitutionally adequate medical health care system, or otherwise clearly preventing the Receiver from carrying out his duties as set forth in this Order, and that other alternatives are inadequate, the Receiver shall request the Court to waive the state or contractual requirement that is causing the impediment.

Order Appointing Receiver at 5:4 - 9.

Increasingly, the Receiver is encountering barriers to necessary remedial efforts based on the bureaucratic impediments which the State claims are created by laws or regulations.[11] In

[11] The Receiver first cautioned the Court about this problem in his First Bi-Monthly Report, stating that "[i]t may, indeed, not be possible to achieve the mission of the Receivership given the

fact, at this point in time, several important remedial plan are now stalled because of claims of State law. Because the Receiver anticipates filing a number of motions to waive State law in the near future, he thought it best to summarize the status of prior, pending, and anticipated motions for waiver in this report.

(2) *Prior Waiver Re Clinical Salaries.*

On September 12, 2006, the Receiver filed with the Court a Motion for Waiver of State Law in order to implement new salary ranges for physicians, mid-level practitioners, registered nurses, licenses vocational nurses, pharmacy employees and other professional and support positions. The waiver of eight State laws was necessary to make way for the Receiver to implement salary increases in a timely manner. On October 17, 2006, the Court granted the motion stating, among other findings, that:

> Defendants have been given the opportunity to address this issue in a timely manner and are unable or unwilling to remedy the chronically high vacancy rates on their own and this inaction is clearly preventing the Receiver from developing or implementing a constitutionally adequate medical health care system and otherwise carrying out his duties as set forth in this Court's February 14, 2006 Order.

Order Re: Receiver's Motion for A Waiver of State Law at 10.

(3) *Pending Nunc Pro Tunc Waiver.*

On February 28, 2006, the Receiver filed an application with this Court for an order *nunc pro tunc* (1) waiving requirements that the Receiver comply with State statutes, rules, regulations and/or procedures governing the notice, bidding, award and protest of contracts with respect to the pharmacy operations contract awarded to Maxor National Pharmacy Services Corporation ("Maxor"); and (2) approving the substituted notice, bidding and award procedure developed by the Receiver with respect to that contract.

As explained in prior bi-monthly reports, a key component in the Receiver's efforts to address the failures in the prison health care system is a complete revamping of the pharmacy

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existence of current State laws, regulations, policies and procedures . . ." First Bi-Monthly Report at 4.

operations in the prisons with the assistance of an experienced pharmacy management firm. A limited waiver of State contracting procedures is and was essential to the award of the pharmacy operations contract within a reasonable timeframe. As explained in the application, the State's procedures are cumbersome and overly time-consuming. For example, this Court determined that it can actually take as long as two years from inception of the contracting process to the award of a contract. (*Findings of Fact and Conclusions of Law*, filed October 3, 2005, at 26.) But the need for action to address the problems in the pharmacy operation is and was immediate. Thus, the Receiver adopted a procedure in awarding the Maxor contract, which was faster than the State process, but remained faithful to the fairness and transparency that the State procedures aspire to ensure. Details of the Receiver's process and the necessity for a waiver are provided in the February 28, 2006 application.

(4) *Future Waivers of State Law.*

For reasons similar to those set forth in the Receiver's February 28, 2007 application, the Receiver anticipates filing an additional application for waiver of State law in the next several weeks addressing, on a broader basis, the need for a waiver of State notice, bidding, award and protest requirements related to other contracts necessary for implementing the Receiver's remedial actions. In addition to the waiver of law, the Receiver will seek approval for a reasonable substituted notice, bidding and award procedure with respect those contracts.

In addition the Receiver anticipated filing in April 2007 three personnel related waiver motions concerning: (1) the need to retain for at least two years a number of pharmacy technicians hired on a temporary basis by the CDCR and Department of Finance; (2) a motion to establish approximately 250 CEA equivalent positions in CDCR health care operations; and (3) a motion to connect physician privileging with CDCR medical employment and the establishment of a new PPEC policy.

B. <u>Infectious Disease Outbreaks in California Prisons</u>.

Given the serious levels of crowding in CDCR prisons and the unconstitutional levels of

medical services, the Receiver believes that it is necessary, in this report, to inform the Court about the ever present danger of a serious infectious disease outbreak in California's prisons, a problem that not only jeopardizes inmates and staff, but also has an impact on public health in the community.

Infectious diseases that are spread from person to person occur commonly in correctional settings, with the potential to blossom into outbreaks affecting large numbers of inmates and staff.

Late last year for example, the CDCR narrowly escaped a potentially deadly tuberculosis outbreak. A twenty-year-old man spent three months in three San Diego County jails prior to his November 2, 2006 transfer to the R.J. Donovan Reception Center. As a result of routine testing, RJ Donovan showed that he had florid, highly infectious tuberculosis. Almost immediately thereafter Donovan was closed to inmate movement, creating enormous stress on the already overcrowded prison and jail systems. Because so many inmates were exposed during his San Diego jail stay, and because many of those inmates had transferred to prisons throughout the state, the contact investigation effort was massive and required months of follow-up of potentially infected inmates and staff.

The 2006/2007 California norovirus season has been prolific, with gastroenteritis outbreaks dramatically more numerous than in previous years, according to data from the California Department of Health Services Division of Communicable Disease Control. While most of those outbreaks were in nursing facilities and other senior settings, California prisons experienced an increase as well. Norovirus outbreaks at CSP Solano and Chuckawalla Valley State Prison led CDCR healthcare leaders and wardens to shut down inmate movement at those institutions for extended periods in November.

A norovirus outbreak at San Quentin State Prison beginning in late December affected approximately 900 inmates and 50 staff members. A bus full of inmates from San Quentin was returned mid-trip when inmates began vomiting. The reception center and internal movement

was closed for weeks. Controlling norovirus in prison is vastly more difficult than in nursing homes or on cruise ships, where people can be comfortably confined to their rooms. Inadequate space, plumbing and water supplies in many California prisons interfere with both control and comfort. The gymnasium at San Quentin, with its 380 inmates in double bunks, was hard hit. Vomiting can occur suddenly, without warning, and the virus is thereby spread airborne to surrounding bunks. Again in January, Pleasant Valley State Prison had a norovirus outbreak in a gymnasium that is even more crowded, with triple bunks throughout.

Other prisons have had outbreaks of norovirus and other infectious agents. The Reception Center at the California Institution for Women (CIW) closed in January because of norovirus. Also in December, a case of varicella (chickenpox) occurred at CIW, triggering a large contact investigation and isolation of vulnerable inmates in a special housing wing. In addition, the CDCR's first laboratory-confirmed influenza outbreak in prison began in late January. And lice created a nuisance at San Quentin in January.

In recent months, leaders from the California Department of Health Services, the California Conference of Local Health Officers, CDCR, and the Receiver's Office have been collaborating on a protocol for responding to infectious disease outbreaks in prison. The protocol, still in draft form, clarifies communication and jurisdictional issues toward a goal of preventing transmission of infectious diseases to inmates, staff, and the outside community.

The Receiver will provide additional information concerning the danger of infectious disease outbreaks on his overcrowding related report to be filed in May 2007.

C. Communications with Media and the Public.

1. *Introduction.*

The Receiver continued to ensure that members of the public were informed of his activities and were afforded appropriate background, context and educational materials needed to understand the remedial effort during the reporting period. This outreach included the issuing of press releases and public correspondence from the Receiver, extensive background discussions

and interviews with reporters and producers and meetings with key constituents. To further provide information and answer questions related to the remedial effort, the Receiver continued to expand and update its web site. *See*, www.cprinc.org.

The Receiver's commitment to transparency of the remedial process was demonstrated during this reporting period by his continual availability and responsiveness to the press, members of state government, CDCR inmates and staff, and the general public. The Receiver's office responded to a variety of inquiries about California's prison system. Topics addressed included: medical staff salary increases, the MTA/LVN conversion, the cost and description of San Quentin building projects, proposed locations of 5,000 new prison medical beds, legislators' response to the Receivership, the impact of overcrowding on the prison medical system, out-of-state transfers, the pharmacy contract lawsuit, Norovirus outbreaks at various prisons, Receiver and CPR staff salaries, the cost of Receiver's activities, profiling the Receiver, background on Receivership and plans for future, State Personnel Board issues, specific inmate patients, prison nurses and doctors, mental health bed plan, changes in CDCR management, issues at specific prisons, the Third Bi-Monthly Report and access to the Receiver. In addition, Public Information Officers at individual prisons sought information and guidance from the Receiver's Office about the handling of press interest of local medical issues such as the impact of overcrowding on medical care, Hepatitis-C and nurse staffing and management.

2. *Media and Public Outreach.*

a. Public Information Produced by the Receiver:

Press release December 5, 2006 re: Third Bi-Monthly Report

Press release February 23, 2007 re: physician salary increases

San Quentin Medical Newsletter – January 23, 2007 to institution staff and inmates

Letter from the Receiver – January 23, 2007: fifth in a series of public letters from the Receiver to a broad audience including members of state government

California Progress Report.com – January 25, 2007, "An Open Letter on California Prisons From

Federal Court Receiver Robert Sillen"

b. Receiver's Radio and TV Appearances:

KQED Radio San Francisco – December 5, 2007

KPCC Capitol Public Radio – January 12, 2007

KCBS Radio News San Francisco, Oakland, San Jose – January 27, 2007

c. Receiver's Public Appearances:

Appearance at State Personnel Board meeting – Sacramento, January 23, 2007

Address to Santa Clara County Bench and Bar Association – San Jose, January 24, 2007

Testimony before the California State Senate Budget and Fiscal Review Subcommittee – Sacramento, February 7, 2007

Address to the United African American Ministerial Action Council Community Forum on Health Disparity and Reentry Issues – San Diego, February 28, 2007

d. Editorial Coverage:

Vacaville Reporter Editorial – December 11, 2006, "Prison progress: Receiver's report provides good news"

Contra Costa Times Editorial – December 13, 2006, "Take action on prisons"

Highland Community News Opinion – December 13, 2006, "Piling on the Outrage"

Sacramento Bee Editorial – December 14, 2006, "Finally, a breakthrough: Federal receiver eliminates hybrid job"

San Jose Mercury News Editorial – January 05, 2007, "Governor sees the light on crowded state prisons"

Vacaville Reporter Editorial – January 31, 2007, "Worth the Price: High salaries are investment in reform"

San Jose Mercury News Editorial – February 01, 2007, "Prison crisis cries out for political will: Independent Commission Better than Court Action"

Los Angeles Times Column – February 05, 2007, "Crisis in prison overcrowding cries out for

correction"

Los Angeles Times Editorial – February 26, 2007, "Prison crisis at a boil: Everyone knows the state's corrections system is broken, but no one has the political courage to fix it.

e. Examples of News Coverage:

Los Angeles Times – November 14, 2006, "Inmates sue to limit state prison populations: A federal cap would ease the violence and health issues linked to crowding, lawyers say"

Alameda Times Star – November 14, 2006, "Advocates: Prison too crowded"

Fremont Argus – November 14, 2006, "Lawsuits urge cap on prison crowding"

Sacramento Bee – November 14, 2006, "State inmate limit sought: Prisoner rights lawyers ask U. S. judges to reduce overcrowding"

San Francisco Chronicle – November 16, 2006, "Six California prisons eyed as sited for new health facilities"

Sacramento Bee – November 16, 2006, "Receiver rips prison health system, promises tough fixes"

San Francisco Chronicle – November 17, 2006, "Inmate stuck in van for hours died in desert heat"

Contra Costa Times – November 17, 2006, "Sites targeted for prison health care"

Sacramento Bee – November 17, 2006, "Bold vow on inmate health"

San Luis Obispo Tribune – November 18, 2006, "Effect unclear of possible health facility at CMC"

Whittier Daily News – November 20, 2006, "Nelles considered for medical use: Proposal would house ill inmates at site"

California Healthline – November 20, 2006, "Prison Health Care Reformer Proposes New Medical Facilities"

KTVU Channel 2 – November 29, 2006, "Prison Health Care"

Sacramento Bee – December 2, 2006, "Prison bid challenged: Health czar's contract with

pharmacy service looks like 'cronyism,' U. S. court is told"
Fresno Bee – December 4, 2006, "State lawmakers face tricky issues as session begins"
Hayward Daily Review – December 5, 2006, "Prison health boss cites progress, long road ahead"
CBS 13 Sacramento – December 5, 2006, "Feds Predict Millions in Calif. Prison Savings"
Oakland Tribune/ANG Newspaper – December 6, 2006, "Prison health progress cited: Federal receiver sees long road of reform for shoddy system"
Contra Costa Times – December 6, 2006, "Reforms a start in controlling prison health care costs: Nursing, pharmacy changes a promising beginning, report says"
Monterey County Herald – December 6, 2006, "Inmate care changes could save millions, says official"
San Jose Mercury News – December 6, 2006, "California News in Brief: Report touts savings in prison health system"
Vacaville Reporter – December 6, 2006, "Prison Receiver cites progress"
Sacramento Bee – December 6, 2006, "Receiver rips prison-reform obstructions"
Sacramento Bee – December 9, 2006, "Prison death controversy: System official's letter says federal watchdog accused health worker of killing and inmate"
Sacramento Bee – December 13, 2006, "Bristling on prison control: Assembly's GOP chief opposes 'blank check' for federal overseers"
San Jose Mercury News – December 13, 2006, "California News in Brief: Prisons still unprepared for violent emergencies"
California Healthline – December 13, 2006, "Judge Gives Deadline to Ease Prison Overcrowding"
Sacramento Bee – December 13, 2006, "Crowding adds fuel to the fire"
Associated Press – December 13, 2006, "Prison emergency plans lacking two years after guard's murder"

Sacramento Bee – December 20, 2006, "$10 billion plan for new prison readied: Governor to seek funds to build state, county, health facilities, sources say"

Bakersfield Californian – December 20, 2006, "Judge orders raises for California prison mental health workers"

San Jose Mercury News – December 21, 2006, "Schwarzenegger seeks sentencing review as key to prison reform"

Marin Independent Journal – December 21, 2006, Top Marin stories for 2006: "San Quentin controversies"

California Healthline – December 21, 2006, "Judge Raises Salaries of Prison Mental Health Workers"

California Healthline – December 21, 2006, "Sources: Governor to Propose Prison Expansion Bill"

Marin Independent Journal – December 22, 2006, "Death row price soars"

Sacramento Bee – December 23, 2006, "Steve Wiegand Year End Column: If you ace the quiz...seek help"

Marin Independent Journal - December 29, 2006, "San Quentin gets new warden"

Inland Valley Daily Bulletin – December 31, 2006, "Ideas to ease crowding a mixed bag for Chino"

Los Angeles Times – January 04, 2007, "San Quentin prison closed to new inmates and visitors"

San Francisco Chronicle – January 04, 2007, "San Quentin Flu-like illness hits inmates and employees"

Associated Press – January 18, 2007, "AP Enterprise: Prison-reform offices cost taxpayers millions"

KGET 17 NBC Bakersfield – January 18, 2007, "AP Enterprise: Prison-reform offices cost taxpayers millions"

Contra Costa Times – January 19, 2007, "Prison fixes costly before they begin"

San Jose Mercury News – January 19, 2007, "Cost of federal oversight of state prisons draws fire"

Amarillo Globe-News – January 22, 2007, "Judge set to hear Maxor pharmacy case"

Sacramento Bee – January 24, 2007, "Testy session on prison plan: Federal receiver, state board chief clash over health personnel rights"

Los Angeles Times – January 26, 2007, "Prison pay hikes drain staff at state hospital"

Los Angeles Times – January 26, 2007, "State prison in tail spin panel says"

The Stockton Record – January 28, 2007, "Prison shift from job training to holding center: Shuffle of prisoners leave vocational workshops empty"

Vallejo Time Herald – January 29, 2007, "Prison facilities earn accolades"

Vacaville Reporter – January 29, 2007, "Receiver gives CMF praise in action on virus"

Sacramento Bee – January 31, 2007, "Prison contract challenge denied"

San Francisco Chronicle – February 01, 2007, "Seven California prisons could get new mental health centers"

Sacramento Bee – February 01, 2007, "Housing prices still rising – at state prisons: Labor, medical care drive cost up"

Capitol Weekly – February 01, 2007, "Federal receiver Robert Sillen works to make SPB relevant"

Fremont Argus – February 02, 2007, "Drug firm rebuffed on prison contract"

KGET TV Bakersfield – February 02, 2007, "Seven California prisons could get new mental health centers"

Sacramento Bee – February 04, 2007, "Prison' legal strain: State's cost skyrocket as correctional system struggles to comply with court orders in eight inmate right cases"

Los Angeles Times – February 05, 2007, "Crisis in prison overcrowding cries out for a correction"

Chino Champion – February 05, 2007, "State Resurrects Prison Clinic Plan"

Fresno Bee – February 06, 2007, "Republicans rip spending on prisons: Lawmakers demand a tighter rein on legal cases"

Sacramento Bee – February 07, 2007, "Forty prison medical workers called back from disciplinary leave"

San Diego Union Tribune – February 07, 2007, "Forty prison medical workers called back from disciplinary leave"

KQED Capitol Notes – February 07, 2007, "Prison Medical Cost: A Moving Target?"

KESQ Channel 3 News – February 07, 2007, "Forty prison medical workers called back from disciplinary leave"

Sacramento Bee – February 08, 2007, "Line drawn on prison health fixes: Receiver tells panel he'll cooperate – but no delays will be tolerated"

Daily Trojan USC – February 08, 2007, "State employees summoned from disciplinary leave"

San Jose Mercury News – February 15, 2007, "Agnew's pushed as inmate medical facility"

Daily Journal – February 16, 2007, "Plaintiffs want larger judiciary role in prison fix"

San Jose Mercury News – February 18, 2007, "Herhold: Old, ill inmates at Agnews – worth a look?"

Sacramento Bee – February 20, 2007, "Skepticism on prison plan: Monitor questions a state proposal for mentally ill inmates"

Ventura County Star – February 21, 2007, "Decision is called a 'threat to public safety'"

Sacramento Bee – February 23, 2007, "Inmate releases weighed: Governor faces prison overcrowding"

CBS5 KPIX TV – February 23, 2007, "Calif. Prison Doctors to Get Pay Raise"

Sacramento Bee – February 24, 2007, "Prison health czar slams official: Federal overseer slashes duties and salary of a gubernatorial appointee"

Sacramento Bee – February 25, 2007, "Prison nurses see pay jump: Others aren't so lucky as state rethinks its wage hike system

Sacramento Bee – February 28, 2007, "Prison policy aide resigns: Amid probe, exj-official says medical investment was no conflict of interest.

Sacramento Bee – February 28, 2007, "Computers, prison and health care"

Los Angeles Daily Journal – March 02, 2007, "Receiver's first steps in reforming prison health care"

Sacramento Bee – March 04, 2007, "Health care crisis behind bars: Three deaths in two months focus federal attention on state's most overcrowded facility"

CBS 13 CW 31 Sacramento – March 04, 2007, "Inmate Health Suffers In State's Crowded Prisons"

Orange County Register – March 04, 2007, "Hard time"

San Francisco Chronicle – March 04, 2007, "Inmate health suffers at state's most crowded prison"

San Jose Mercury News – March 04, 2007, "Inmate health suffers at state's most crowded prison"

KABC TV Channel 7 Los Angeles – March 06, 2007, "Governor's Top Prison Health Aide Resigns Under Pressure"

Sacramento Bee – March 06, 2007, "Prison health chief ousted: Governor's office ask for resignation amid trouble with court monitor"

News 8 KFMB San Diego – March 06, 2007, "Schwarzenegger's Top Prison Health aide Resigns Under Pressure"

KCBS Radio News 740 AM – March 06, 2007, "Governor's Top Prison Health Aide Forced to Quit"

Central Valley Business Times – March 06, 2007, " California prison medical chief fired"

San Diego Tribune – March 06, 2007, "Schwarzenegger's top prison health aide resigns under pressure"

ADVANCE for Nurses – March 2007, "Life on the Inside: Demonstrating that compassionate

care can be given anywhere"

Sacramento Bee – March 08, 2007, "It's time for governor, lawmakers to fix prison mess"

Sacramento Bee – March 08, 2007, " Union rips governor's prison plan: Workers say $10.9 billion bid is heavy on building, light on rehab programs.

d. Health Care Industry Press Coverage:

California Association of Physician Assistants News – February 08, 2007, "An Open Letter to Physician Assistants: Opportunities in Correctional Health Care"

3. *Additional Activities.*

In connection with the Receiver's ongoing project to improve medical care at San Quentin, the CDCR and members of the Receiver's Team participated in a public meeting at the Marin County Board of Supervisors chambers on February 8, 2007 that initiated the CEQA (California Environmental Quality Act) process for the construction of San Quentin's new Central Health Services Building. Members of the Receiver's team also joined with San Quentin's warden and staff to host a visit of the Marin County Grand Jury to the institution on February 27, 2007.

The Receiver also participated in a February 13, 2007 interview with the Service Employees International Union (SEIU) Local 1000 for their staff newsletter and web site, regarding the changes to prison medical care and the role of SEIU members in the process. During the reporting period, the Receiver also attended several meetings with members of the California legislature, at their invitation. These included Assembly members Todd Spitzer and Nicole Parra and Senators Michael Machado, Elaine Alquist and Gloria Negrete McLeod.

E. Prisoner Patient Complaints and Correspondence Program.

1. *Introduction.*

As explained in the Third Bi-Monthly Report, the Receiver's Prisoner Patient Complaints and Correspondence Program tracks and response to letters received directly from prisoner patients. Upon initial receipt each letter is read, summarized, logged and acknowledged with a

return letter. All letters regarding medical care are then referred to the Receiver's clinical staff for clinical review. The number of letters clinical staff designate for further investigation remains at approximately twenty percent. (*See* Third Bi-Monthly Report at 41.)

The Receiver's Prisoner Patient Complaints and Correspondence Program has continued to evolve, becoming more streamlined. The addition of administrative staff to the program has allowed for a more timely response to prisoner patient letters received by the Receiver. The addition of clinical staff has resulted in a quicker clinical review process. The senior program staff conducts regular meetings to follow up and track the progress of all letters determined to warrant further investigation.

1. *Analysis of Prisoner/Patient Letters to the Receiver (October – December 2006).*

In the Third Bi-Monthly Report, the Receiver provided a summary of the initial numbers and types of complaints and correspondence received from prisoner patients. The Receiver provides below an update on the prisoner patient complaints and correspondence program, as well as a summary of the numbers and types of complaints and correspondence received for the last quarter of 2006.

The Office of the Receiver currently receives approximately 60 – 70 letters per week regarding prisoner patient medical care. The letters come not only from prisoner patients but also from family members, friends and other advocates, ranging from public interest groups to private citizens. During the last quarter of 2006, the Office of the Receiver processed approximately 454 letters. One hundred twenty-eight of those letters were from people who have written to the Receiver more than once, some several times, regarding either the same or a different issue.

Two primary issues appear to generate the majority of letters written to the Receiver. The first is delay at all levels of the prison health care system including but not limited to seeing a primary care physician, obtaining lab results, scheduling specialty appointments, follow up after

specialty consultations, and delays that result from the broken appeals process. The second is communication, including poor communication between medical personnel and prisoner patients and those who inquire on their behalf. For instance, it is common to hear from patients who are seeking information about the results of a particular test or procedure they had. The Receiver has also been contacted by some who have positive things to report about institution health care, including specific staff performance and the impact of remedial efforts.

2. *Prison Specific Distribution of Correspondence.*

The 454 letters received by the Office of the Receiver were mailed from 31 of the 33 adult prisons. California State Prison – Solano is still the source of most correspondence, with 55 letters. The next-highest number of complaints came from: California Medical Facility (46), Avenal State Prison (41), San Quentin State Prison (33), Pleasant Valley State Prison (31) and California Training Facility (29).

The number of letters by institution is set forth below:

Avenal State Prison 41
Calipatria State Prison 7
California Correctional Center 1
California Correctional Institution 3
Centinela State Prison 6
Central California Women's Facility 9
California Institution for Men 2
California Institution for Women 9
California Men's Colony 12
California Medical Facility 46
Corcoran State Prison 12
California Rehabilitation Center 2
Correctional Training Facility 29

Chuckawalla Valley State Prison 8

Folsom State Prison 6

High Desert State Prison 5

Ironwood State Prison 8

Kern Valley State Prison 6

California State Prison, Los Angeles County 13

Mule Creek State Prison 21

North Kern State Prison 1

Pelican Bay State Prison 15

Pleasant Valley State Prison 31

R.J. Donovan Correctional Facility 10

California State Prison, Sacramento 6

California Substance Abuse Treatment Facility 28

Sierra Conservation Center 2

California State Prison, Solano 55

San Quentin State Prison 33

Salinas Valley State Prison 22

Valley State Prison for Women 5

3. *Types of Complaints.*

The majority of letters (233) concern the prisoner patient's disagreement with the medical care provided. Other types of complaints include lack of access to care, problems with the medical appeals process and complaints against medical staff. Some specific examples of medical care issues brought to the Receiver's attention included an prisoner patient with lupus who requested specialty care, a patient with end stage liver disease who requested assistance to get on the transplant list, a patient experiencing more than one year's delay in obtaining a prosthesis, and a patient who suffered lengthy delays in treatment of known lymphoma cancer.

Another example involved an prisoner patient who has suffered from persistent abdominal pain for years without receiving a diagnosis. Upon further investigation, Receiver staff determined that the patient had been receiving adequate medical care that meets the community standard. Institution medical staff have seen to it that the patient received a series of diagnostic tests and specialty consultations. Unfortunately, though many illnesses and conditions have been ruled out, the source of the pain has yet to be determined. The patient continues to be monitored. Another prisoner patient had been diagnosed with cancer in 1999 and has a recurring brain tumor. Before incarceration, the patient was under doctor's orders to receive an MRI every six months to monitor the tumor. Upon arrival in state prison, the patient did not receive his first MRI for 18 months. This patient's complaint was designated for further investigation and ultimately resulted in a visit by Receiver staff. The patient is currently being treated by institution medical staff and Receiver staff is continuing to monitor the situation.

Complaints are summarized by category and set forth below:

Issue Category	Statewide Total
Access to Care	22
Medical Appeals Problems	10
Complaint v. Staff	42
Disagree with Care	233
Miscellaneous*	147
Suspicious Death	0
Custody Interference w/ Medical Care	0

*Miscellaneous Category	Statewide Total
Mental Health	11
Dental	13

Legal	2
Pharmacy	29
Other	92

4. *Conclusions.*

The value of the program is felt not only by the prisoner patients when their letters prompt intervention by Receivership staff, but also provide the Office of the Receiver with a useful perspective concerning the development of proposed systemic intervention. Although prisoner/patients who choose to write to the Receiver are a self-selected, non-representative sample of the prison population, prisoner/patient correspondence assists in the establishment of clinical priorities by describing the impact of systemic issues on individual prisoners.

VI.

CONCLUSION

The accomplishments during the initial eleven months of the Receivership, as reported in this and prior bi-monthly reports, has been considerable. On April 17, 2006, the first day of the Receivership, it consisted of four employees, including the Receiver, operating out of a hotel room as its office. During the first year it was of critical importance to build the Office of the Receiver's capability through the recruitment of the best possible health care and correctional professionals, and establish space and other components of an infrastructure which would enable the Receivership to conduct its business, accomplish its mission, and learn as much as possible about the CDCR's medical delivery system so that initial efforts could be made to increase access to and the quality of medical care for prisoner/patients.

As we enter the second year of the Receivership, our progress may be likened to coming out of the "crawl" phase of the "crawl/walk/run continuum" and entering a more advanced but still significantly limited and more time consuming "walk" phase. The motions for waivers of State law that will be filed in April 2007, if approved, will enable the Receivership to move into

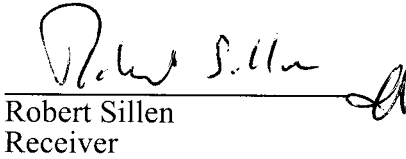
this next phase and thereby, to advance forward. Our Plan of Action, to be produced in an initial version in May 2007 and a more finalized version in November 2007, should provide the Court with a more complete and definitive framework for the Receiver's remedial actions over the course of the next three to five years. To summarize, the Plan of Action will set forth those activities necessary to develop, implement, monitor, evaluate and revise our "road map" to achieving constitutional minima in the provision for medical care in California's prisons.

The challenge is as immense as the CDCR system itself, and the Receiver's efforts will be thwarted and impeded, along the way, by those who have vested interests in maintaining the status quo. In many ways the Receivership has been through whatever "honeymoon phase" ever existed and our going forward will encounter increased resistance as, more and more, CDCR "traditions" and the State's "conventional wisdom" are increasingly challenged. There remains no quick fixes and no panaceas. Trial and error, albeit based on solid health care management principles will continue.

The Receiver anticipates that his implementation of new operating and support systems, including personnel policies and procedures, union contracts, business practices and the like will be challenged. The ability and/or willingness of the State to cooperate with and participate in meaningful change will be severely tested. The resources needed, financial, human, and political will be significant. The crisis in California's prisons was created over the past several decades as a result of political expediency, incompetence, and the creation of a wasteful custody and health care operation devoid of accountability. Some of the changes that need to occur in the future will be costly, controversial and a challenge for the State and the Court. The Receiver's mission is entirely doable. How long it will take, how much it will cost, and when the State can anticipate the return of its medical system is, most assuredly, a function of how appropriately the

primary stakeholders in this process, the CDCR, the State, and counsel, participate in the Receivers' remedial process.

Dated: March 19, 2007



Robert Sillen
Receiver

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PROOF OF SERVICE BY MAIL

I, Kristina Hector, declare:

I am a resident of the County of Alameda, California; that I am over the age of eighteen (18) years of age and not a party to the within titled cause of action. I am employed as the Inmate Patient Relations Manager to the Receiver in *Plata v. Schwarzenegger*.

On March 20, 2007 I arranged for the service of a copy of the attached documents described as RECEIVER'S FOURTH BI-MONTHLY REPORT on the parties of record in said cause by sending a true and correct copy thereof by pdf and by United States Mail and addressed as follows:

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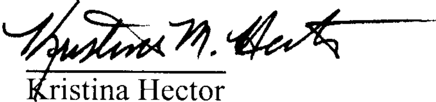
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on March 20, 2007 at San Francisco, California.



Kristina Hector