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 REPORT RE PLAN OF ACTION**

TABLE OF CONTENTS

Page

I. Introduction . . . 1
II. Purpose of the Plan of Action . . . 2
III. The Plan of Action in Context . . . 2
- A. Introduction . . . 2
- B. Contextual Overview . . . 3

IV. The Administrative Structure Proposed By the Receiver to Achieve Accurate Metric Reporting . . . 6
- A. Introduction . . . 6
- B. The Receiver's Plan for Metrics . . . 7
- C. The Receiver's Plan for Accurate Metric Reporting . . . 8
  - 1. Introduction . . . 8
  - 2. The Receiver's Office of Evaluation, Measurement and Compliance . . . 8

V. Provisions of the Stipulations and Orders; Those Which Should Be Carried Forward and Those Which Should Be Modified or Discontinued Due to Changed Circumstances . . . 9
- A. Introduction . . . 9
- B. Provisions . . . 9
- C. Analysis of the Provisions of Plata Orders . . . 17

VI. Conclusion . . . 19

I.

INTRODUCTION

The Order Appointing Receiver ("Receivership Order") filed February 14, 2006 required the Receiver to develop a "Plan of Action" detailing "the restructuring and development of a constitutionally adequate medical health care delivery system" within the first 180-210 days of assuming office. (Order at 2.) The Court further mandated that the Plan of Action include a "proposed time line for all actions and a set of metrics by which to evaluate the Receiver's progress and success." (Order at 2-3.) The Order also required the Plan of Action to include recommendations to the Court regarding "which provisions of the (1) June 13, 2002 Stipulation for Injunctive Relief, and (2) September 17, 2004 Stipulated Order re Quality of Patient Care and Staffing Order and Injunction (and/or policies or procedures required thereby), should be carried forward and which, if any, should be modified or discontinued due to changed circumstances." (Order at 2.)

On November 13, 2006 the Receiver moved for an extension of time to file his Plan of Action, arguing that it was premature, after a half-year of operation, to affix a formal plan for corrective action because it might gloss over the interconnectedness and severity of the problems concerning both access to and the quality of medical care within the California Department of Corrections and Rehabilitation ("CDCR"). Citing four primary factors: multi-level remedial challenges; state paralysis and trained incapacity; the intensification of overcrowding and its negative impact on the Receiver's remedial efforts; and the need to proceed in a thoughtful and fiscally appropriate manner, the Receiver proposed to submit an initial Plan of Action no later than May 15, 2007 and a revised Plan of Action six months thereafter.

In an Order filed December 19, 2006 the Court found that the initial seven month deadline for creating a Plan of Action was not realistic given the need to create the Receivership from the ground up and the complexity of the remedial tasks. Therefore the Court granted the Receiver's motion, ordering as follows:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

> The Receiver shall develop his first proposed detailed Plan of Action and proposed metrics, designed to effectuate the restructuring and development of a constitutionally adequate medical health system, no later than May 15, 2007. At the same time he shall file a plan to establish the administrative structures to document, accurately track, and report metrics. The Receiver shall thereafter file a revised Plan of Action no later than November 15, 2007.

This report provides an overview of the Plan of Action and the administrative structures that will be created to document, track and report necessary metrics.

II.

PURPOSE OF THE PLAN OF ACTION

The purpose of the Plan of Action is fourfold: to provide a comprehensive report to the Court, State officials, and the public concerning the Receiver's long term plans as well as his specific plans for the next two years; to outline a prison medical delivery system that will encompass a continuum of medical care, ancillary, and support services necessary for optimal outcomes, safety, and cost-effectiveness; to define strategies for achieving and sustaining timely, effective, and efficient clinical services as well as responsible overall medical management and operations; and to serve as a dynamic framework for prioritizing leadership activities and communicating ongoing progress, successes, and challenges.

III.

THE PLAN OF ACTION IN CONTEXT

A. Introduction.

The Receiver has filed *three* Plan of Action related submissions: the Plan of Action, this Report Re Plan of Action, and A Notice of Motion and Receiver's Motion For Order Pursuant to FRCP 60(b)(5) And/Or FRCP 60(b)(6) For Order Modifying Stipulated Injunction And Other Orders Entered Herein ("Motion to Modify Stipulated Orders"). As stated above, the Report re Plan of Action provides an overview of the Plan. The Plan of Action, prepared not in a pleading format but in the appropriate format for a Plan of Action, sets forth the Receiver's plan for restructuring and developing a constitutionally adequate medical health system in California prisons, and his plan to establish the administrative structures to document, accurately track, and

report metrics for that program. The Motion To Modify Stipulated Orders sets forth the Receiver's recommendations regarding those provisions of the stipulations and orders in this case that should be carried forward, and which should be modified or discontinued due to changed circumstances

B. Contextual Overview.

It is important, when weighing the Plan of Action and the Motion to Modify Stipulated Orders, to place them into context. Therefore, the Receiver requests that the Court consider the following:

1. The Receiver's remedial efforts did not begin on a level playing field. The challenges ahead are extraordinary. No one disputes the fact that the medical delivery system in California's prisons function below Constitutional minima. Likewise, no one disputes the fact that medical delivery is so seriously broken and has remained in a state of terrible disrepair for so long that the remedy of a Receivership was required. To correct this problem, an entirely new and different medical delivery system must be created – from the ground up. Given this, given the massive size and the range of non-health problems which afflict the CDCR, and given the scope of the effort that will be necessary, the Receiver should be afforded strong support from both parties in the case, as well as wide ranging discretion concerning the implementation of his Plan. In other words, the crisis is so serious that the Plan of Action should not be subject to delay because of opinions of counsel or complaints on the part of the State agencies who have allowed the unconstitutional conditions to arise and continue unabated for years.

2. The Receiver's Plan is completely different from the manner in which the State of California attempts to plan, fund, and implement corrective actions. Indeed, if the Plan did not differ significantly from the manner in which the State attempts to manage its prisons, it would not have a chance for success. Therefore, criticism of the Plan in terms of normal State procedures is not helpful.

3. Likewise, the Receiver's Plan is entirely different from the implementation programs that were developed through the stipulation in this case. Following more than a year of

evaluation, the Receiver finds those programs to contain very fundamental flaws.[1] Therefore, to put the Receiver's Plan of Action into context, it is important to spell out some of the major problems of *Plata* itself:

a. The pre-determined, entire-system "roll-out" model of *Plata* implementation was doomed from the start. The State proved entirely incapable of meeting its roll-out mandates. In fact, given the size and complexity of California's sprawling prison system, roll-outs of an entire medical care system will not be successful under any circumstances. To correct this, the Plan of Action calls for a variety of alternative approaches to effective change (*see* Plan of Action at page 40).

b. The original remedial stipulations contained no provisions for the State infrastructure necessary to implement the stipulations themselves. For example, while *Plata* called for the hiring of hundreds of doctors and nurses the salaries, recruitment programs, hiring programs, training programs, and retention programs necessary to bring quality clinicians into the prisons were neither contemplated nor developed. In direct contrast, the Receiver's Plan begins with an essential infrastructure that will support a successful remedial effort.

c. The stipulations called for a cumbersome and expensive physician-based medical delivery system. In direct contrast the Receiver's Plan calls for a more appropriate team-based system utilizing nursing, mid-level, and physician providers.

d. The original plan failed to provide essential elements of an adequate medical delivery system, including information technology ("IT"), clerical support personnel, transportation vehicles, custody access teams, speciality contract support programs, an established network of speciality providers, etc. The Receiver's Plan of Action provides for these essential services.

---

[1] In making this finding the Receiver emphasizes that he realizes that the original Plata "roll-outs" were a product of legal compromises. This finding is not intended as a criticism of the intent of those involved with the initial remedial efforts in this case.

e. The original remedial plan failed to consider and coordinate different aspects of the CDCR's health care delivery program, resulting in failed remedial efforts and increased expenses. For example, until the Receivership was created, there had been no effort by the parties to coordinate the hourly salaries offered to the "contract" doctors and nurses who work inside California's prison with the salaries offered to full-time permanent State doctors and nurses. By allowing contract hourly rates to be increased after State salary increases, the incentives for State employment created by the salary increases were lost. In direct contrast, the Receiver took prompt action to manage this situation, and his Plan of Action calls for the complete restructuring of the CDCR's speciality services, registry and hospital contracting program.

f. In actual practice, the original remedial processes in this case have worked to establish "silos" of health delivery in California's prisons, driving up the overall cost of care and creating unnecessary tensions between the medical, mental health, and dental disciplines. The Receiver's Plan of Action, however, calls for coordination between his remedial efforts in *Plata* with those in the *Coleman*, *Perez*, and *Armstrong* litigation. For example, concerning several system-wide critical programs such as IT system development, pharmacy services, credentialing, medical records, custody access teams, health care bed construction, etc., the Receiver will work closely with the Special Masters and Court experts in the other class actions to effectuate remedial programs that involve all health care disciplines.

4. The Receiver's Plan of Action is not simple. The problems are not simple, ergo the fixes are not simple. Bringing California's prison medical care up to Constitutional levels requires careful planning, establishing priorities, the appropriate timing of specific remedial efforts, and careful coordination, not only within the Plan itself, but also with *Coleman*, *Perez*,

and *Armstrong* remedial efforts.[2] Over time, the Receiver anticipates challenges that will require special efforts by his staff to keep certain elements of his Plan on track. At the same time, changing circumstances or specific failures may require modifying certain elements of the Plan. The Plan of Action is a roadmap, and while there may be detours along the way, the objective will not change: to bring prison medical care up to Constitutional standards.

5. The Receiver has, in the course of his first year of operation, not only established the Office of the Receiver, but also implemented a number of priority remedial programs including raising clinical salaries, establishing expedited clinical hiring processes, restructuring the CDCR pharmacy delivery program through the Maxor Corporation, and restructuring the CDCR specialty provider, registry, and hospital contract units through an IT driven pilot project. The Plan of Action, therefore, incorporates these on-going remedial programs in addition to defining future programs and pilot projects. To summarize, the Plan of Action is not a plan for a plan, it represents a roadmap for change.

IV.

THE ADMINISTRATIVE STRUCTURE PROPOSED BY THE RECEIVER TO ACHIEVE ACCURATE METRIC REPORTING

A. Introduction.

At present no one performs adequate and objective measurements of the systemic performance of California's prison medical delivery system. For example, compliance with *Plata* orders is not measured, nor is clinical quality evaluated on a systemic basis. This fact should surprise no one. While various measurement programs have been announced by CDCR officials, and while various compliance measurements systems have been established, no serious metric process was ever implemented. There are a number of explanations for this, including the following:

---

[2] For this reason, the pending motions for the waiver of State law are especially important in that many crucial elements of the Plan of Action depend on the programs established through the motions.

1. The State has not funded the positions necessary to support a true metrics operation.

2. Adequate IT systems do not exist to compile and provide metrics.

3. The CDCR's prisons have no IT connectivity.

4. Turnover among CDCR officials, and a resulting failure to provide consistent direction re metrics.

5. A lack of clinical competency (including the lack of adequate numbers of trained physicians necessary to perform mortality reviews).

6. An adversarial and increasingly frustrated relationship between counsel for the parties, which (combined with a lack of objective data) has lead to an increasingly expensive and cumbersome practice of conducting prison inspections based not on objective measurements but on the impressions of counsel.

B. The Receiver's Plan for Metrics.

The Plan of Action recognizes that an essential strategy for health care transformation is the incorporation of performance and outcome measurements for improvement and accountability (*see* Plan of Action Goal C, *see also* pages 43- 50). Thus, the Plan proposes four major categories of metrics:

1. *Clinical quality related metrics* (Plan of Action at page 30): The Receiver and his staff recognize the importance of evaluating the quality of care provided to prisoner/patients.

2. *Plata compliance related metrics* (Plan of Action at pages 4 - 9, 47): The accurate and objective measurement of Plata performance standards is essential not only for compliance purposes but also to measure the success of the Receivership itself.

3. *Mortality reviews* (Plan of Action at pages 31, 48 - 49): The Receiver believes that, given the findings of the Court, that accurate and adequate mortality reviews should be a priority metric.

4. *Organization culture and satisfaction reviews* (Plan of Action at pages 31, 49): The effectiveness of any health care delivery system cannot be measured by patient outcomes alone, it is also necessary to evaluate the delivery system, including the attitudes and

performance of health care personnel.

C. The Receiver's Plan for Accurate Metric Reporting.

1. *Introduction.*

Implementing a plan for accurate metrics poses a challenge reminiscent of "what comes first, the cart or the horse?" As of today, accurate metrics are not possible due to a shortage of competent personnel including clinicians, no information technology, no prison connectivity, and no accurate manual systems of control. On the other hand, it is imperative that vital information be provided to the Court, counsel, and the Receivership itself. Therefore, an administrative structure that will provide accurate systemic metrics should be established as soon as possible. It must be understood, however, the some of the resource devoted to metrics (including competent clinicians) will of necessity be diverted from patient care and remedial programs.

2. *The Receiver's Office of Evaluation, Measurement and Compliance.*

To proceed to accurate metric reporting the Plan calls for a three prong intermediate program comprised of the following processes, all of which the Receiver plans to have operational at the time of the filing of his November 15, 2007 modified Plan of Action:

(1) a system to objectively measure the basics of *Plata* remedial plan compliance at no less than six pilot prisons;

(2) an accurate and objective system of mortality reviews;

(3) a pilot program for institutional inspections and *Plata* remedial plan compliance developed with California's Office of the Inspector General.[3]

To effectuate this program, as well as to manage the development of the more sophisticated longer term evaluation, measurement and *Plata* compliance programs set forth in the Plan of Action, the Receiver will establish a new administrative structure within the California Health Care Prison Receivership, an Office of Evaluation, Measurement and

[3] There may be obvious and well founded overlap between metrics objectives one and three.

Compliance. This Office will be operational prior to the filing of the November 15, 2007 modified Plan of Action.

V.

PROVISIONS OF THE STIPULATIONS AND ORDERS; THOSE WHICH SHOULD BE CARRIED FORWARD AND THOSE WHICH SHOULD BE MODIFIED OR DISCONTINUED DUE TO CHANGED CIRCUMSTANCES

A. Introduction.

The Order of February 14, 2006 referenced two *Plata* Orders, the (1) June 13, 2002 Stipulation for Injunctive Relief ("Stipulated Injunction"), and (2) September 17, 2004 Stipulated Order re Quality of Patient Care and Staffing Order and Injunction ("Patient Care Order"). There is, however, a third relevant *Plata* order, the Order re Interim Remedies Relating to Clinical Staffing, filed December 1, 2005 ("Clinical Staffing Order"). The Receiver has, therefore, included the provision of that order in the summary of provisions set forth below.

B. Provisions.

1. Health screening: A process for screening all patients for communicable disease, such as tuberculosis and sexually transmitted disease, and chronic disease, such as diabetes, renal disease, seizure disorders, cardiovascular disease, and pulmonary disease; screening for cancer; review of vital signs, blood pressure, pulse, and weight; review of current medications; and nurse review and referral for patients with urgent or acute conditions; history and physical examination for all patients within 14 days of arrival at Reception Center; and routine laboratory tests, such as serum pregnancy, cholesterol screening, and optional HIV testing. (Stipulated Injunction ¶ 4)

2. Health transfer: Process to ensure continuity of care when patients transfer to another institution, transfer between levels of care, or are paroled, including continuity of medications, specialty referrals, and other treatment. (Stipulated Injunction ¶¶ 4, 6)

3. Access to Primary Care (Sick Call): System that allows patients to self-refer for medical treatment, including nurse review to identify the need for immediate referral to urgent or emergency treatment, an urgent walk-in procedure, and follow-up services; policies require face-

to-face nurse triage for patients with symptoms within 24 hours, and an appointment with a primary care provider within 5 days for patients classified as urgent and within 14 days for patients classified as routine. (Stipulated Injunction ¶ 4)

4. Priority Ducat System: System for ensuring that custody staff treat health care appointments as high-priority. (Stipulated Injunction ¶¶ 4, 6)

5. Patient Health Care Education: Program to provide patients with instruction in wellness, lifestyle changes, disease prevention, newly diagnosed illness or disease, treatment plans or procedures, pre- and post-operative care, chronic care morbidity reduction. (Stipulated Injunction ¶ 4)

6. Preventive Services: Services to prevent disease and mitigate morbidity and mortality due to existing disease provided to select patient populations based upon risk factors, such as age and chronic conditions, that include cancer screening, immunizations, and health education (education regarding diet, exercise, smoking cessation, etc.). (Stipulated Injunction ¶ 4)

7. Outpatient Specialty Services: Program for providing specialty services, including procedures for urgent and routine referrals and required follow-up; policies require that high-priority consultations or procedures occur within 14 calendar days and routine consultations or referrals within 90 calendar days, with follow-up by a primary care provider within 14 calendars days after the consultation or procedure. (Stipulated Injunction ¶ 4)

8. Physical Therapy: Program to ensure timely access to physical therapy services, including specifications for the follow-up by primary care providers and provisions for transferring to an institution with these services if the home institution does not provide them. (Stipulated Injunction ¶ 4)

9. Diagnostic Services: Program for the appropriate processing of laboratory tests and other diagnostic testing, including procedures for prioritizing the urgency of laboratory orders (STAT, critical, urgent, routine) and required timeframes for review and follow-up of results (routine laboratory tests processed within 14 days of order, x-ray examinations completed within 30 days of order, primary care provider review of lab results within two business days of receipt,

notification of patient of results within 14 days of receipt). (Stipulated Injunction ¶ 4)

10. Medication Management: Services to dispense, administer, and distribute pharmacotherapeutic treatments, including provisions for medication error reporting, medication follow-up counseling, medication renewals and refills, medication for parole, and continuity of medication upon transfer; policies require that prescriptions for formulary medications be filled by the following day and that "stat" medications be issued within 1 hour. (Stipulated Injunction ¶ 4)

11. Urgent / Emergent Response: Program for the provision of urgent care services and 24-hour emergency medical treatment that includes basic life support, emergency response, and physician on-call services; policies require follow-up within five days for patients whose urgent encounter was due to chronic disease. (Stipulated Injunction ¶¶ 4, 6)

12. Medical Emergency Response Documentation and Review: Process for the review of deaths, suicide attempts, and calls for emergency assistance to determine compliance with existing policies and procedures, adequacy of response time, and appropriateness of custody and medical response and patient treatment, with follow-up actions to address identified deficiencies. (Stipulated Injunction ¶ 4)

13. Outpatient Housing Unit and Licensed Care: Specialized treatment services for varying levels of acuity, including outpatient services requiring specialized housing (Outpatient Housing Unit care), licensed skilled nursing facility care (Correctional Treatment Center care), General Acute Care Hospital care, and palliative care; policies require physician evaluation within 24 hours of admission to a Correctional Treatment Center and an evaluation by a primary care provider within 5 days for all patients returning from an inpatient acute care facility. (Stipulated Injunction ¶ 4)

14. Outpatient Therapeutic Diets: Program for the provision of nourishments and supplements for patients who are pregnant, diabetic, immunocompromised, malnourished, or have oropharyngeal conditions causing difficulty eating regular diets and special diets for patients with renal failure or hepatic failure, or who require a Heart Healthy diet, gluten-free

diet, or diet to preclude food allergies. (Stipulated Injunction ¶¶ 4, 6)

15. Medical Report of Injury or Unusual Occurrence: Process for documentation of patients' on-the-job injuries, physical contact with a staff member during an incident, and any self-reported injury due to self-injury or altercation, Administrative Segregation Unit placement, use of force, or other medical emergency situation. (Stipulated Injunction ¶ 4)

16. OC Contraindications: Process for the evaluation and treatment of patients prior to or after the use OC. (Stipulated Injunction ¶ 4)

17. Medical Evaluation of Patients Involved in Assaults: Process for the evaluation of patients who have been involved in the use of force, including review of the patient's mental health record. (Stipulated Injunction ¶¶ 4, 6)

18. Hygiene Intervention: Process for the identification, evaluation, and referral of patients who demonstrate poor hygiene or whose hygiene compromises the sanitation/hygiene of their personal and immediate housing area. (Stipulated Injunction ¶ 4)

19. Inmate Hunger Strike: Process for the identification, evaluation, and treatment of inmates on hunger strike, including required coordination and reporting between custody and health care staff. (Stipulated Injunction ¶ 4)

20. Comprehensive Accommodation Chrono: Process for the authorization and review of special equipment, housing accommodations, or other accommodations that are medically necessary or are required under the Americans with Disabilities Act. (Stipulated Injunction ¶ 4)

21. Pregnant Patient Care and the Birth of Children: Prenatal care and post-delivery services, including required screenings, frequency of prenatal treatment visits, vitamin and nutritional requirements, referrals for child placement services, and post-partum follow-up; policies require that patients be seen by a obstetrics provider within 7 calendar days of determination of pregnancy that each patient be provided six-weeks post-delivery for follow-up. (Stipulated Injunction ¶ 4)

22. Nursing Services and Protocols: Clinical protocols for nurses in the appropriate evaluation and treatment of patients presenting with specific systemic conditions or complaints.

(Stipulated Injunction ¶¶ 4, 6)

23. Health Record Services: Provisions for the management, content, and archiving of patient health records, including policies for disclosure of information. (Stipulated Injunction ¶ 4)

24. Chronic Care Program: Diagnosis and management of chronic disease (diseases lasting longer than 6 months), including identification and treatment of high-risk patients; policies require an initial intake evaluation within 30 days for patients referred to the Chronic Care Program, and ongoing evaluations every 90 days. (Stipulated Injunction ¶¶ 4, 6; Patient Care Order ¶¶ 13-15)

25. Pharmacy Services: Provisions governing pharmacy operations, including pharmacy licensing, emergency drug supplies, drug storage, consultation with a pharmacist, prescription requirements, and the ordering, stocking, and receiving of medications. (Stipulated Injunction ¶ 4)

26. Public Health and Infection Control: Program for infection control, communicable disease reporting, and bloodborne pathogen control. (Stipulated Injunction ¶ 4)

27. Telemedicine Services: Program for the provision of specialty services through videoconferencing. (Stipulated Injunction ¶ 4)

28. Utilization Management: System to facilitate appropriate use of resources for patients requiring higher levels of care and select specialty services and medications, including reviews to determine placement at appropriate level of care and appropriate utilization of specialty care and pharmacy resources. (Stipulated Injunction ¶ 4)

29. Implement Inmate Medical Services Program (IMSP) Policies and Procedures in accordance with multi-year roll out schedule. (Stipulated Injunction, ¶¶ 4-5)

30. Institution and patient monitoring by plaintiffs' counsel and institutional information access and reporting to plaintiffs' counsel. (Stipulated Injunction, ¶¶ 7, 9-15)

31. Implement the following requirements regardless of roll out status: 24 hour-coverage by RNs in emergency clinics, intrasystem transfers per policy, treatment protocols

implemented as resources allow, priority ducat system implemented, outpatient special diets available for patients with liver and kidney end-stage failure. (Stipulated Injunction, ¶¶ 6a-6e)

32. Institute Director's level review for inmate appeals. (Stipulated Injunction, ¶ 7)

33. Audit each prison's compliance with IMSP Policies and Procedures consistent with rollout schedule; develop audit instrument and file it with the court; achieve 85% overall compliance with IMSP Policies and Procedures and conduct minimally adequate death reviews and quality management proceedings to reach substantial compliance. (Stipulated Injunction, ¶¶ 19-23)

34. Engage an independent entity to evaluate and train CDCR physicians; complete evaluations for physicians at 2003-2005 rollouts by 12/31/05; ensure providers who are Category 2 are promptly provided remedial training and assigned positions in manner consistent with evaluation results; remove Category 3 physicians from patient care; use evaluators to determine physicians competent to treat high-risk patients; ensure that every physician hired from 1/1/05 through 12/31/08 complete the evaluation process and any remedial training within first four months of employment. (Patient Care Order ¶¶ 1,3,6,7,9,10 (pp. 1-3))

35. Develop a plan to assess and train nurse practitioners and physician assistants. (Patient Care Order ¶ 2)

36. Hire only physician contractors who are board-eligible or board-certified in Internal Medicine or Family Practice. (Clinical Staffing Order ¶ 2(a)(2) (p. 6))

37. Develop criteria and method to identify high-risk patients; identify all patients who meet high-risk criteria, beginning with 2003 rollout institutions, and complete a plan for identifying patients at all other institutions for court review; ensure that high-risk patients are treated by qualified primary care providers; provide nursing and administrative support necessary to assist court-approved independent physicians in evaluating and treating high-risk patients at SAC, COR, CCWF, and SVSP by 11/15/04. (Patient Care Order, ¶¶ 13-16)

38. Submit proposal to control agencies to reclassify all physician categories, including a Regional Medical Director classification, complete a salary survey prior to submission of the

proposal, address the need for salary adjustments in the proposal, and hire additional central office and regional medical directors while the proposal is considered by control agencies; submit a plan to the court to hire and retain central office and regional medical directors; submit a proposal to control agencies for a director of nursing and regional directors of nursing; establish and fill these positions on an interim basis. (Patient Care Order, ¶¶ 17-18) Submit a plan to the court to change the hiring process for local process to central or regional process for physician, NP, and PA positions. (Patient Care Order, ¶ 19)

39. Develop a plan to establish program for on-site clinics through a residency program affiliation to provide care for patients with complex medical conditions. (Patient Care Order, ¶ 20)

40. Complete statewide health care bylaws, credentialing policy, and peer review policy and scheduled plan for implementation. (Patient Care Order, ¶¶ 21-22)

41. Fund, establish, and begin to fill one position at each institution for support of the SATS-LITE system. (Patient Care Order, ¶ 23)

42. Fund, establish, and begin to fill no less than nine additional QMAT positions. (Patient Care Order, ¶ 24)

43. Establish recruitment and retention differentials for physicians, mid-level providers, and registered nurses, in addition to all existing recruitment and retention differentials; modify all written and digital recruitment documents accordingly. (Clinical Staffing Order, ¶¶ 2a-2c (pp. 6-10))

44. Establish a program to process physician, mid-level practitioner, and registered nurse job applicants within 5 business days from receipt of application; establish a monitoring program to ensure standard is met for 90% of all applicants. (Clinical Staffing Order, ¶ 3a (pp. 10-11))

45. Establish a program to interview, evaluate, and render a hiring decision to all physician, mid-level practitioner, and registered nurse job applicants within 10 business days from receipt of application; establish a monitoring program to ensure standard is met for 90% of all applicants. (Clinical Staffing Order, ¶ 3b (p. 11))

46. Establish and implement model statewide primary care NP and PA duty statements. (Clinical Staffing Order, ¶4a, 4b (p. 11))

47. Establish and implement policies and procedures for supervision of NPs and PAs. (Clinical Staffing Order, ¶4c (p. 11))

48. Establish and implement salary scale for PAs commensurate with what is offered to NPs. (Clinical Staffing Order, ¶4d (p. 11))

49. Modify, within 10 business days of date of order, every vacant Physician and Surgeon position to allow for the hiring of a PA, NP, or physician to fill the vacant position (Clinical Staffing Order, ¶4e (p. 12))

50. Commence advertising and begin hiring mid-level practitioners. (Clinical Staffing Order, ¶4f (p. 12))

51. Establish and implement a policy requiring that recently hired physicians be supervised by the regional medical Director when the physician is hired at an institution where the CMO and Chief Physician and Surgeon positions are vacant. (Clinical Staffing Order, ¶4a (p. 12))

52. Establish and implement an adequate orientation program for new civil service and contract physicians, mid-level practitioners, and registered nurses. (Clinical Staffing Order, ¶4b (p. 12))

53. Establish and implement a program to hire physicians, mid-level practitioners, and registered nurses on a regional basis to allow for placement at prisons with the most need. (Clinical Staffing Order, ¶ 5c (p. 12))

54. Modify existing contracts with CMG and NOAH to provide an hourly rate adequate to attract physicians and mid-level providers who meet CDCR standards. (Clinical Staffing Order, ¶ 6a (p. 13))

55. Ensure that CMG and NOAH are reimbursed appropriately for all billed services within 30 days of receipt of billing. (Clinical Staffing Order, ¶ 6c (p. 13))

56. Verify credentials, licensure, and security clearance of all contract providers on a provisional basis within 2 business days of presentation by CMG and NOAH; complete final verification within 5 business days. (Clinical Staffing Order, ¶ 6d (p. 13))

57. Complete hiring interview and make provisional decision to hire or reject CMG or NOAH contract providers within 4 days of submission for 90% of applicants. (Clinical Staffing Order, ¶ 6e (p. 13))

58. Establish and implement an orientation program for contract physicians and mid-level providers (Clinical Staffing Order, ¶ 6f (p. 14))

59. Establish an adequate program to monitor prisoner health services provided by CMG/MHA/Staff Care (Clinical Staffing Order, ¶ 6g (p. 14))

60. Designate an individual who has the authority to implement the recommendation in the court order and is accountable for such implementation. Ensure that designated individual meets with the Correctional Expert, the Medical Experts, and counsel and soon as is practicable to develop a plan to monitor compliance with the order and the designated individual shall file no later thatn December 15, 2005 an initial status report describing the status of each item in this Order. (Clinical Staffing Order, ¶ 7 (p. 14))

61. Court medical experts to conduct on-site inspections during January and February 2006 of those prisons which parties agree are in greatest need with respect to staffing. (Clinical Staffing Order, ¶ 8 (p. 15))

C. Analysis of the Provisions of Plata Orders.

For discussion's sake, the 63 provisions summarized above can be divided into three general categories: (1) substantive provisions that set forth standards of care; (2) implementation or procedural provisions which instruct the CDCR how to achieve specific elements of the standards of care;[4] and (3) monitoring related provisions.

[4] Not surprisingly, after the State failed to comply with many provisions of the 2002 stipulations and orders, the parties began to approach the Court to request additional implementation related orders. Unfortunately, as explained in the Motion to Modify Stipulated Orders many of the orders were not implemented in a timely or successful manner.

1. *Substantive Provisions.*

The Receiver does not propose amending those provisions which set forth standards of care for prisoner/patients. While at some time in the future, following the implementation of his Plan, changes may be proposed, at this point in time the Receiver regards these standards to establish what the parties believe are appropriate standards for prison medical delivery. The Plan of Action is geared to implement these standards. Thus, the Receiver does *not* propose to modify or eliminate the following provisions: 1 - 28

2. *Implementation Provisions.*

The Receiver moves to eliminate certain, although not all, of the implementation provisions. Certain implementation orders have been complied with. In most cases the implementation provision which the Receiver seeks to eliminate has (1) never in fact been implemented, or; (2) has not proven to be an effective remedial action; or; (3) conflicts with the Receiver's Plan of Action, or (4) all three of the above. Provision by provision justification for the elimination of specific orders is set forth in the Motion to Modify Stipulated Orders. To summarize, the Receiver moves to eliminate the following provisions only: 29, 31, 32, 33, 37, 38, 39, 41, 42, 43, 44, 45, 51, 53, 56, 57, 59.

3. *Monitoring Provisions.*

The Receiver moves to modify aspects of the provisions of *Plata* which provide for monitoring. As explained in the Motion to Modify Stipulated Orders, given the change of circumstance of the Receivership itself, existing monitoring provisions are not conducive to effective and objective measurement of Plata remedial requirements. To the contrary, some provisions have become unduly burdensome to CDCR staff working under the direction of the Receiver and have proven to be unnecessarily expensive and not adequately objective.

As set forth in the Motion to Modify Stipulated Orders, the Receiver proposed to proceed carefully in this regard. In essence, he moves to establish a pilot project in cooperation with California's Office of the Inspector General to commence a more objective, clinically appropriate, and metric-oriented monitoring program which will provide monitoring information

relevant to the Receiver, the Court, and counsel for the parties. To effectuate this, the Receiver moves to modify provision 30 only.

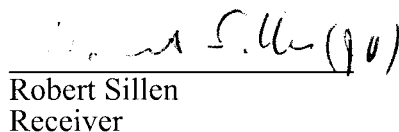
VI.

CONCLUSION

The process of raising the delivery of medical care in California's prisons to constitutional levels, as described in this Plan of Action, will be a daunting challenge, requiring thoughtful planning, careful coordination, and a number of time-phased inter-related remedial programs. As the Receiver has repeatedly emphasized, there are no quick fixes. The Plan of Action is a living document, subject to revision and additional detail as it is developed. At this point in time it is not possible to set forth a proposed time line for all future remedial actions, nor is it possible to describe all future budgetary impacts of the Plan. This information, however, will be presented in future iterations of the Plan as various elements of the Plan are put into action.

Based on the above, and based on the Plan filed concurrently with this Report, the Receiver requests that the Court approve his Plan of Action. The Receiver will submit for the Court's review an updated Plan of Action no later than November 15, 2007.

Dated: May 10, 2007.



Robert Sillen
Receiver

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 10, 2007 I arranged for the service of a copy of the attached documents described as RECEIVER'S REPORT RE PLAN OF ACTION 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:

ANDREA LYNN HOCH
Legal Affairs Secretary
Office of the Governor
Capitol Building
Sacramento, CA 95814

ELISE ROSE
Counsel
State Personnel Board
801 Capitol Mall
Sacramento, CA 95814

BRIGID HANSON
Director (A)
Division of Correctional Health Care Services
CDCR
P.O. Box 942883
Sacramento, CA 94283-0001

J. MICHAEL KEATING, JR.
285 Terrace Avenue
Riverside, Rhode Island 02915

ROCHELLE EAST
Deputy Attorney General
455 Golden Gate Ave., Suite 11000
San Francisco, CA 94102

STEVEN FAMA
DON SPECTER
ALLISON HARDY
Prison Law Office
General Delivery
San Quentin, CA 94964-0001

PAUL MELLO
Hanson Bridgett
425 Market Street, 26th Floor
San Francisco, CA 94105

BRUCE SLAVIN
General Counsel
CDCR-Office of the Secretary
P.O. Box 942883
Sacramento, CA 94283-0001

KATHLEEN KEESHEN
Legal Affairs Division
California Department of Corrections
P.O. Box 942883
Sacramento, CA 94283

RICHARD J. CHIVARO
JOHN CHEN
State Controller
300 Capitol Mall, Suite 518
Sacramento, CA 95814

MOLLY ARNOLD
Chief Counsel, Department of Finance
State Capitol, Room 1145
Sacramento, CA 95814

LAURIE GIBERSON
Staff Counsel
Department of General Services
707 Third Street, 7th floor, Suite 7-330
West Sacramento, CA 95605

MATTHEW CATE
Inspector General
Office of the Inspector General
P.O. Box 348780
Sacramento, CA 95834-8780

DONNA NEVILLE
Senior Staff Counsel
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

WARREN C. (CURT) STRACENER
PAUL M. STARKEY
Labor Relations Counsel
Department of Personnel Administration
Legal Division
1515 "S" Street, North Building, Suite 400
Sacramento, CA 95814-7243

GARY ROBINSON
Executive Director
UAPD
1330 Broadway Blvd., Suite 730
Oakland, CA 94612

YVONNE WALKER
Vice President for Bargaining
SEIU
1108 "O" Street
Sacramento, CA 95814

PAM MANWILLER
Director of State Programs
AFSME
555 Capitol Mall, Suite 1225
Sacramento, CA 95814

RICHARD TATUM
CSSO State President
CSSO
1461 Ullrey Avenue
Escalon, CA 95320

TIM BEHRENS
President
Association of California State Supervisors
1108 O Street
Sacramento, CA 95814

STUART DROWN
Executive Director
Little Hoover Commission
925 L Street, Suite 805
Sacramento, California 95814

MICHAEL BIEN
Rosen, Bien & Asaro
155 Montgomery Street, 8th Floor
San Francisco, CA 94104

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 10, 2007 at San Francisco, California.

Kristina Hector