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7

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UNITED STATES DISTRICT COURT

9

NORTHERN DISTRICT OF CALIFORNIA

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11 MARCIANO PLATA, et al.,

Case No. C01-1351 TEH

12 *Plaintiffs,*

13 v.

**DECLARATION OF BETSY CHANG HA,
R.N., M.S., C.H.P.Q., IN SUPPORT OF
RECEIVER'S REPLY RE PLAN OF
ACTION**

14 ARNOLD SCHWARZENEGGER, et al.,

15 *Defendants.*

Date: August 27, 2007
Time: 10:00 a.m.
Courtroom: 12

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1 I, Betsy Chang Ha, declare as follows:

- 2 1. Since March 5, 2007, I have been employed as the Chief Nurse Executive for the
3 California Prison Health Care Receivership. I make this declaration in support of the
4 Receiver's Reply regarding the Plan of Action ("POA"), filed by the Receiver on or about
5 May 15, 2007. The facts set forth herein are based on my own personal knowledge and,
6 if called as a witness, I could competently testify thereto.
- 7 2. I have extensive experience in managing and designing health care delivery systems
8 including, in particular, designing quality improvement programs for such systems. For
9 more than a decade, my professional life has been devoted to applying quality
10 improvement strategies to health care systems for the most at risk and vulnerable patient
11 populations. Attached hereto as Exhibit 1 is a true and correct copy of my resume. I have
12 a Bachelor of Science degree in Nursing from the University of Maryland and a Masters
13 of Science degree in Healthcare Management from California State University of Los
14 Angeles. I am licensed by the State of California as a Registered Nurse and a Certified
15 Professional in Healthcare Quality. I am an active member of Sigma Theta Tau
16 International Honor Society of Nursing. I also served for two years as a member of the
17 Board of Baldrige Examiners for the California Award for Performance Excellence.
- 18 3. I began my nursing career at Johns Hopkins Hospital in 1980. From 1981 to 1996, I was
19 variously employed by Children's Hospital of Los Angeles, a world-renowned academic
20 and pediatric hospital, as a Hematology-Oncology and Bone Marrow Transplant Staff
21 Nurse, Assistant Nurse Manager and Quality Management/Case Management Program
22 Manager. Among other accomplishments during my 15 years at Children's Hospital, I
23 was instrumental in the implementation of a patient/family-centered care model with
24 information system support that integrated discharge planning, care management,
25 utilization and quality review functions into a single clinical care coordinator or advance
26 practice case manager role. The patient was assigned one dedicated care coordinator or
27 case manager based on the complexity of the patient's illness and intensity of services
28 needs. The model is also designed to maximize registered nurses' expertise. The model

1 thereby increases nurse job satisfaction and retention in addition to the benefits it
2 provides to patients.

3 4. From 1996 to 1998, I was employed as the Associate Director of Integrated Health
4 Services for MedPartners, a national practice management company that had grown by
5 acquiring a number of smaller health care delivery organizations. I was responsible for
6 Medicaid program development and management of the day-to-day operations of a
7 number of departments within the Integrated Health Services Division serving the
8 Western Region of the United States. Using Continuous Quality Improvement ("CQI")
9 principles, I directed 16 interdepartmental teams to develop a number of case
10 management hubs within the organization while supporting the conversion of multiple
11 different practice management information systems from acquired companies into a
12 single practice management system.

13 5. From 1998 to 2005, I was employed as Director of Operational and Quality Improvement
14 for CalOptima, a County Organized Health System, located in Orange County, California
15 and authorized by federal law to administer Medi-Cal benefits for approximately 300,000
16 recipients. In that capacity, I oversaw CalOptima's Quality Improvement ("QI") Program
17 which was based upon the standards and regulatory requirements promulgated by the
18 National Committee for Quality Assurance, a leading accreditation organization for
19 health care delivery systems.

20 6. While at CalOptima, I directed all Quality Management/Improvement functions,
21 including credentialing, case review, outcome measurements and reporting systems. I
22 developed and implemented an organizational strategic planning process for the agency
23 based on CQI principles. I also developed and implemented a comprehensive provider
24 network performance management system with an approximately \$8 million quality
25 incentive budget. The program included contract performance measures to ensure
26 minimum performance level and a quality incentive component to reward high
27 performing health provider networks based on HEDIS (Healthcare Effectiveness Data and
28 Information Set) performance measures. I also directed a two-pronged organizational

1 improvement project that included the implementation of a company-wide managed care
2 information system. Developing this managed care information system for the Medicaid
3 product line required fully understanding the company's business processes and
4 regulatory requirements. I succeeded in bringing the project to fruition on time and on
5 budget.

6 7. From 2005 until I joined the Receiver's team earlier this year, I was the Director of
7 Quality Improvement for the Center for Health Care Strategies ("CHCS"), a national non-
8 profit policy research and QI organization dedicated to improving the quality of health
9 care services to those who receive publicly financed care, especially those with chronic
10 illnesses and disabilities. In that capacity, I was responsible for overseeing all CQI
11 initiatives undertaken by CHCS with health care organizations, including state Medicaid
12 agencies, health plans, and providers. I conducted specialized CQI training exercises
13 developed by CHCS for Medicaid stakeholders, supervised QI staff and participated on
14 the CHCS management team.

15 8. In addition to the multiple national projects, I worked on two projects primarily in
16 California during my tenure at CHCS. I developed an innovative Plan/Practice
17 Improvement Project to improve chronic illness care at the Medi-Cal providers' offices,
18 leveraging the support of eight managed care organizations. As a result, the participating
19 organizations saw a 10% decrease in emergency room visits and an 8% decrease in acute
20 hospital admissions related to asthma sufferers. I also designed and facilitated the
21 nation's first county mental health system transformation project based on QI principles
22 in response to increased funding for mental health services in California. The project
23 aimed to improve access to person-centered and recovery-focused mental health services.

24 9. One of the primary tasks given me by the Receiver has been to develop the POA. I
25 worked closely with Terry Hill, the Receiver's Chief Medical Officer, as well as with the
26 Receiver and other members of his staff.

27 10. I understand that plaintiffs' counsel have criticized the POA because it does not currently
28 include the timelines, detail and metrics that will eventually be included. I believe this

1 represents a misunderstanding of both the POA, the theories behind it and the difficulties
2 facing the Receiver as he attempts to transform medical care delivery in the California
3 prisons.

4 11. In developing the POA, we felt that it was important that the methodologies, goals and
5 strategies be grounded in accepted health care planning concepts, and particularly that we
6 utilize evidence-based approaches to design of the POA.

7 12. The principles applied to QI and to organizational transformation in the health care
8 industry are well-established and have been utilized in other industries successfully for
9 many years. The health care industry, in general, has lagged behind in adopting these
10 principles, and both the mental health and correctional health care industries have lagged
11 even further behind. But increasingly, QI principles are being brought to bear in the
12 health care environment. My own work life over the last decade or more is testament to
13 the interest in, and increased reliance upon, these principles to improve the quality of
14 health care in the U.S.

15 13. We relied heavily on the widely-accepted conceptual framework for health care
16 improvement articulated by the Institute of Medicine ("IOM"), a component of the
17 National Academy of Sciences created in 1970, to provide unbiased evaluations of
18 American health care as well as upon the principles for organizational transformation
19 identified by the Malcolm Baldrige National Quality Program ("BNQP"), created by
20 Congress in the 1980s and administered by the federal National Institute for Science and
21 Technology. As noted above, I have particular familiarity with the Baldrige criteria,
22 having served as an examiner for the California Baldrige awards.

23 14. In addition to IOM and Baldrige, principles and concepts articulated by a number of other
24 respected organizations informed our work. In particular, we drew upon available
25 research and resources from the Institute for Healthcare Improvement (www.IHI.org),
26 Improving Chronic Illness Care, a project supported by the Robert Wood Johnson
27 Foundation (www.improvingchroniccare.org), and my former employer, CHCS
28 (www.chcs.org).

- 1 15. As the CQI literature and my own organizational experience demonstrate, there are three
2 basic prerequisites to a successful strategic plan: (1) adequate organizational structure; (2)
3 adequate organizational processes; and, (3) appropriate measurement of outcomes. Each
4 of these elements must be present for a strategic plan to produce the desired results.
5 Therefore, without the first two elements, it is neither feasible nor efficacious to
6 undertake measurement of outcomes. Attempts at measurement of outcomes in an
7 organization with an inadequate structure and/or inadequate processes will produce poor
8 or unreliable results at best, and will reproduce prior failures at worst.
- 9 16. In the abstract, plaintiffs' counsel are correct that a strategic plan requires "timelines,
10 detail and metrics." But the Receiver is not dealing with abstract concepts, he and his
11 team are working to save lives and to bring a dysfunctional medical care system up to
12 constitutional standards.
- 13 17. Transforming CDCR's medical care system will require transforming the culture of the
14 organization. But that culture cannot be transformed without leadership, appropriate
15 human resources development and workable information technology. Because the prison
16 medical system still lacks these ingredients in large measure, it also lacks appropriate
17 organizational processes. CDCR also presents the unique challenge that these necessary
18 elements to a transformation of the organization and its culture must be constructed while
19 the old system is both in operation *and* being deconstructed.
- 20 18. Changing the culture in an organization is not something that can easily be accomplished
21 according to artificial time lines. Indeed, the strategic plan will only be as successful as
22 the people who are responsible for implementing it.
- 23 19. Thus, the single most important factor in achieving such a transformation is having the
24 right people working in the right places in the organization at the right time. *See* POA,
25 p. 12 ("High Reliability"). Good leadership within the organization is particularly
26 critical. That is why so much of the Receiver's activities and the POA itself have been
27 devoted, not just to adding staff, but to adding the right staff throughout the organization.
28 The Receiver must have in place a dedicated and appropriately skilled work force from

1 top to bottom before the remedial process can begin to succeed. We are in the process of
2 building that work force now.

3 20. Other infrastructure, particularly information technology and other basic systems, are also
4 critical. Accurate clinical data are required proactively to identify and stratify patients
5 with various levels of health care needs. A reliable information system is required to
6 support tracking and reporting of outcomes measures. Both the information technology
7 and pharmacy systems, among others, are in the process of being developed and
8 implemented at CDCR. They are not yet fully operational. Until they are, the Receiver's
9 remedial measures will not be fully operational or sustainable.

10 21. The manner in which the Receiver has chosen to attack the multiple and interlocking
11 problems in the system is to undertake a series of pilot projects, at the system wide and
12 local levels. By using this approach, we can test ideas and approaches in narrower, more
13 controlled and more cost-effective settings. This will give us the opportunity to see what
14 works and what does not, and modify our programs through multiple, rapid improvement
15 cycles *before* they are implemented system-wide. In this regard, it is important to
16 underscore that each of the pilot projects underway has its own individual strategic plan
17 with the kind of detail, including task descriptions, timelines, responsible persons, and
18 metrics, that plaintiffs request for the POA generally.

19 22. I believe, however, that it would be inappropriate to attempt to provide complete
20 timelines, details and metrics in the macro strategic plan, *i.e.*, the POA, until adequate
21 infrastructure and business processes have been developed and more fully implemented in
22 the system. Otherwise, we would be risking failure and disappointment if those artificial
23 benchmarks are not achieved. Meanwhile, the infrastructure – in the form of properly
24 trained staff, adequate physical space and equipment, appropriate information technology
25 – is being implemented even as we are piloting the kinds of business processes necessary
26 for a functioning system. In short, the Receiver is still building the building blocks, *i.e.*,
27 the prerequisites, necessary to construct a full and successful strategic plan.

28 23. Organizational transformation in a correctional health care system of the scope we are

1 attempting to implement has not been tried before. The Receiver and his team are
2 breaking new ground. Because the problems in the system are so profound and the stakes
3 are so high, we are moving cautiously by using the pilot project approach, even as we are
4 attempting such a dramatic overhaul of the system. We recognize that improvement will
5 not be sustained unless we concurrently create a fundamental cultural shift by infusing the
6 system with the right leadership and competent staff. The Receiver has talked about
7 moving the remedial processes from “crawling,” to “walking,” and then to “running.” I
8 believe that we are in the process of transitioning from crawling to walking. We are
9 sensitive, therefore, to not wanting to “over promise” when and what results will be
10 achieved at this still relatively early stage.

11 24. We understand, therefore, that the POA is not complete and is at a higher level of
12 abstraction than it will be eventually. But plaintiffs’ counsel are asking for concrete
13 detail when, as the Receiver emphasized, the POA is a “living document.” POA, p. 3.
14 Those were not just words. They were intended to reflect that the remedial process must
15 develop and grow more organically at this juncture. It is premature to impose rigid time
16 lines or metrics onto a system that still lacks so much. As we learn more, then the kinds
17 of time lines and metrics that appropriately belong in a strategic plan can be added to the
18 POA. We intend to submit an updated POA in November that will begin to fill in those
19 details.

20 25. Meanwhile, we are also building the organizational structure to permit appropriate
21 measurement of outcomes. Despite ongoing challenges in the system, the Receiver
22 intends to have the first phase of his quality measurement system in place by the
23 November update of the POA. *See* POA, p. 49 (“Office of Evaluation, Measurement and
24 Compliance”); *see also* id., p. 46.

1 I declare under penalty of perjury under the laws of the State of California and the United
2 States that the foregoing is true and correct.

3 Dated: July 30, 2007

/s/
Betsy Chang Ha

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5 I hereby attest that I have on file all holograph
6 signatures for any signatures indicated by a
7 "conformed" signature (/s/) within this efiled
8 document.

/s/
9 Jamie L. Dupree
Attorneys for Receiver Robert Sillen

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EXHIBIT 1

BETSY CHANG HA, RN, MS, CPHQ

PROFESSIONAL OBJECTIVES

To be in a senior leadership position or a strategic partnership to transform the health care delivery system, to positively impact the health and well being of the under-served population, and to promote performance excellence in healthcare organizations.

EDUCATION

California State University of Los Angeles, *Master of Science, Healthcare Management*
University of Maryland, *Bachelor of Science, Nursing*

PROFESSIONAL EXPERIENCE

2005 – 2007 Center for Health Care Strategies Hamilton, New Jersey

The Center for Health Care Strategies (CHCS) is a national non-profit policy research and quality (QI) improvement organization devoted to improving the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities.

Director of Quality Improvement

Oversaw all continuous quality improvement (CQI) initiatives undertaken with health care organizations, including multi-stakeholder collaboratives involving state Medicaid agencies, health plans, and providers. Conducted specialized CQI training exercises developed by CHCS for Medicaid stakeholders. Supervised QI staff and participated on the CHCS management team.

Accomplishments:

- Decreased emergency department usage by 10% and acute hospital admissions related to asthma by 8% among eight managed care organizations in California through an innovative Plan/Practice Improvement Projects to improve chronic illness care at the practices sites while working with the health plans as the leverage points.
- Designed and facilitated the nation's first county mental health system transformation project based on quality improvement principles in response to the Mental Health Service Acts. The project aimed to improve access to person-centered and recovery-focused mental health services.
- Co-authored Best Clinical and Administrative Practices (BCAP) in Medicaid Managed Care- a manuscript submitted for review and acceptance for publication in 2007.

1998 - 2005 CalOptima Orange, California

CalOptima is a County Organized Health System authorized by federal law to administer Medi-Cal benefits for Orange County residents. CalOptima functions as a regional managed care health plan and subcontracts with health networks through full risk contracts to provide health services to approximately 300,000 members.

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Director of Operational & Quality Improvement

Oversaw organization's QI Program developed based on NCQA standards and regulatory requirements. Directed all Quality Management/Improvement functions including credentialing, case review, outcome measurements and reporting such as HEDIS, and Internal Quality Improvement Projects (IQIP). Supervised 12 clinical and analytical staffs. Responsibilities also included provider networks delegation oversight, contract performance measures, and quality incentive program. In addition, designed and implemented a Hospital Quality Program to encourage and reward hospitals for participating in industry quality programs such as the Leapfrog Group.

Accomplishments:

- Developed and implemented an organizational strategic planning process for a public agency based on CQI principles.
- Developed and implemented a comprehensive provider network performance management system with an approximately \$8 million quality incentive budget. The program included contract performance measures to ensure minimum performance level; and a quality incentive component to reward high performing health provider networks.
- Directed a two-pronged organizational improvement project that encompassed a company-wide business process improvement initiative followed by a managed care information system (Facets) implementation project. Met the system go-live date within a \$4.4 million budget by directing a dedicated IS implementation project team of 40 staffs.
- Improved organizational efficiency by consolidating operational and clinical quality departments, implemented integrated business processes, and moved organization from a reactive regulatory compliance only focus to a culture of continuous quality improvement.

1996 – 1998 MedPartners

(Former Friendly Hills Healthcare Network)

La Habra, California

Friendly Hills Healthcare Network (FHHN) was an integrated health care delivery system with 400,000 members. In 1996, FHHN was formally acquired by MedPartner, a national practice management company with a total of 1.3 million members. Subsequent to the merger, MedPartners quickly acquired several other medical groups and hospitals such as the Mullikin Medical Group and Talbert Medical Group.

Associate Director of Integrated Health Services

Responsibilities encompassed program development and day-to-day operation of the Government Programs, Specialty Case Management, Ancillary Services, Extended Care Services, and Health Plan Compliance departments serving the Western Region membership. In addition to new program development and systems consolidation, responsibilities also included concurrent 20% reduction in work force as the result of mergers and acquisitions.

Accomplishments:

- Developed and implemented a Medi-Cal Managed Care Program serving over 100,000 Medi-Cal members within 22 staff model healthcare centers using an integrated health care model.
- Achieved bed-days benchmarks within first quarter of 1998 by concurrently directed 16 interdepartmental project teams, created case management hubs, and supported the conversion of multiple legacy systems into one practice management system using CQI principles and strong project management skills.

1981 – 1996 Children's Hospital Los Angeles Los Angeles, California

Children's Hospital Los Angeles (CHLA) is a world-renowned academic and research pediatric hospital serving the greater Los Angeles area.

Hematology-Oncology and Bone Marrow Transplant Staff Nurse, Assistant Nurse Manager and Quality Management/Case Management Program Manager

Advanced through the clinical ladders and served in various staff, training, management, and specialist roles at CHLA. While under the full-time employment at CHCS, attended graduate schools part-time and completed course work for MS degree in Health Care Management.

Accomplishments:

- Instrumental in the implementation of a patient/family-centered care model with information system support by integrating discharge planning, care management, utilization and quality review functions into a new clinical care coordinator role.
- Created a How-to Manual to train physicians and clinical staffs how to developed clinical pathways to include psychosocial components as well as discharge planning.
- Functioned as the case manager and pediatric hospice home care coordinator for children with catastrophic and terminal conditions.
- Developed the first pediatric hospice home care program through a demonstration model project funded by U.S. Department of Health and Human Services in 1989.
- Co-authored Home Care for Children with Catastrophic Disease: Implementation of a Hospital Based Hospice Care program.

1980 – 1981 Johns Hopkins Hospital Baltimore, Maryland

Johns Hopkins Hospital is a part of the Johns Hopkins Health System Corporation, a non-profit organization. The hospital is a world-renowned academic medical center that provides a comprehensive range of state-of-the-art tertiary and quaternary care.

Hematology-Oncology and Bone Marrow Transplant Staff Nurse – (first nursing position post graduation)

- Participated in the clinical trials of adults and pediatric bone marrow transplant protocols.

PROFESSIONAL MEMBERSHIPS, CERTIFICATIONS, AND CONSULTANCY

- California Board of Registered Nursing, RN License: 340884 – Active
- Certified Professional in Healthcare Quality - Active
- Certified California Award for Performance Excellence Board of Baldrige Examiners 2000 – 2002
- Served as a member of the Orange County HIV/AIDS Planning Council 2004-2005
- Served on a sub-taskforce of the California state's pediatric Subacute Care Task Force 1993 – 1995

COMPUTER PROFICIENCY

MS Office including MS Word, Project, VISIO, Power Point and Excel

CERTIFICATE OF SERVICE

The undersigned hereby certifies as follows:

I am an employee of the law firm of Futterman & Dupree LLP, 160 Sansome Street, 17th Floor, San Francisco, CA 94104. I am over the age of 18 and not a party to the within action.

I am readily familiar with the business practice of Futterman & Dupree, LLP for the collection and processing of correspondence.

On July 30, 2007, I served a copy of the following document(s):

DECLARATION OF BETSY CHANG HA, R.N., M.S., C.H.P.Q., IN SUPPORT OF RECEIVER'S REPLY RE PLAN OF ACTION

by placing true copies thereof enclosed in sealed envelopes, for collection and service pursuant to the ordinary business practice of this office in the manner and/or manners described below to each of the parties herein and addressed as follows:

___ BY HAND DELIVERY: I caused such envelope(s) to be served by hand to the address(es) designated below.

X BY MAIL: I caused such envelope(s) to be deposited in the mail at my business address, addressed to the addressee(s) designated. I am readily familiar with Futterman & Dupree's practice for collection and processing of correspondence and pleadings for mailing. It is deposited with the United States Postal Service on that same day in the ordinary course of business.

___ BY OVERNIGHT COURIER SERVICE: I caused such envelope(s) to be delivered via overnight courier service to the addressee(s) designated.

___ BY FACSIMILE: I caused said document(s) to be transmitted to the telephone number(s) of the addressee(s) designated.

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25

26 Dated: July 30, 2007


Lori Dotson

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