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NORTHERN DISTRICT OF CALIFORNIA

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

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5 MARCIANO PLATA , et al.,)
6 Plaintiffs)
7)
8 v.)
9)
10 ARNOLD SCHWARZENEGGER,)
11 et al.,)
12 Defendants,)
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NO. C01-1351-T.E.H.

**RECEIVER'S MOTION FOR AN
EXTENSION OF TIME TO FILE
PLAN OF ACTION AND ESTABLISH
ADVISORY BOARD; MOTION TO
MODIFY PROVISION OF JUNE 13, 2002
STIPULATION RE INJUNCTIVE RELIEF**

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I.

INTRODUCTION

The Court's February 14, 2006 Order Appointing Receiver ("Order") requires that the Receiver 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 as Receiver. [Order, p. 2.] The Court ordered 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, pp. 2-3.]

The Court's Order further mandated that the Plan of Action 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, p.2.] Finally, Part VII of the Order called for the creation of an Advisory Board.¹

The Receiver hereby moves the Court for an order: (1) granting an extension of time concerning the filing of a Plan of Action; (2) modifying, on a pilot basis at San Quentin State Prison, that portion of the June 13, 2002 Stipulation for Injunctive Relief which requires that all inmates receive a physical examination from a physician upon reception into the California Department of Corrections and Rehabilitation ("CDCR"); and (3) granting an extension of time concerning the Receiver's obligation to create an Advisory Board.

¹ "The Court, in consultation with the Receiver, shall appoint an Advisory Board of no more than five members to assist and advise the Court and the Receiver with respect to achieving the goals of the Receivership." [Order, p. 9.]

1 II.

2 **DEVELOPING A FINAL CORRECTIVE ACTION PLAN IS PREMATURE AT THIS**
3 **STAGE IN THE REMEDIAL PROCESS AND WOULD HINDER THE RECEIVER'S**
4 **FLEXIBILITY TO RESPOND TO NEWLY DISCOVERED PROBLEMS.**

5 A. Introduction.

6 Affixing a final plan for corrective action at this stage will necessarily gloss over the
7 interconnectedness and severity of the problems concerning both access to and the quality of
8 medical care within the CDCR. As iterated in the Receiver's First and Second Bi-Monthly
9 Reports, the scope of dysfunction in the prison medical care system is far worse than initially
10 envisioned by the Court in its Findings of Fact and Conclusions of Law re Appointment of
11 Receiver. As the Receiver and his staff have commenced their initial projects to reform a very
12 broken medical delivery system, even more abuses have been uncovered. At the same time,
13 additional obstacles to reform are continually being discovered. To effectuate long term
14 sustainable improvement in the medical care delivered in California's prisons, the Receiver must
15 maintain flexibility in devising remedies which respond to the complexity and multiplicity of
16 problems. As explained below, it is simply too soon to establish final, permanent remedial
17 programs.

18 B. Multi-Level Remedial Challenges, Lessons from the San Quentin Project.

19 The San Quentin Project has provided the Receiver and his staff with important lessons
20 concerning the importance of flexibility concerning efforts to remedy problems. Given the inter-
21 connectivity of problems, the unconstitutional medical delivery system in California's prisons
22 must be reviewed from a variety of perspectives. After thorough review, the Receiver will need
23 to adjust strategies and time lines as necessary to encompass both the root cause and the
24 numerous branches and thorns that make up the medical crisis in California's prisons.

25 The San Quentin Project Team has discovered a wealth of inter-related problems that
26 work together to inhibit the remedial process. In turn, weekly meetings have been necessary to
27 re-work strategies for reform, assign new tasks, and adjust project goals and time lines. As

1 explained in the Second Bi-Monthly Report:

2 No one factor is responsible for the utter breakdown of medical services at San
3 Quentin. Every problem which has been encountered, including the untimely and
4 inadequate reception center processes, the use of the OHU as a care center, the
5 inability to obtain and manage supplies, poorly organized and incomplete health
6 records, the failure to provide timely specialty care, the failure to manage
7 laboratory services, the breakdown of diagnostic imaging services, an untimely
8 and ineffective patient appeal process, the lack of adequate clinical and
9 administrative space, the lack of facility maintenance, an absence of information
10 technology, lack of office equipment and even telephones and electrical power,
11 the failure to clean clinical areas, adversarial staff relationships, inappropriate
12 health services organization, and inadequate and poorly trained supervisors stem
13 from a wide variety of long term and entrenched systemic shortfalls which have
14 complicated and in some cases delayed the Team's corrective actions. The
15 Receiver and his staff initially determined that the Project should take place over a
16 ninety day period (with certain elements continuing longer) and followed by
17 continuous monitoring and re-calibration concerning certain corrective actions.
18 The schedule now requires adjustment.

19 (Receiver's Second Bi-Monthly Report, pp. 46-47.)

20 One example of the "snow-balling impact" of problems involved the difficulties
21 encountered by the Project Team when trying to improve communication among medical
22 clinicians. Early in the Project, the Team recognized that the inability of clinicians to
23 communicate with each other, exchange necessary schedules, and coordinate in some rational
24 manner with correctional staff about the movement of prisoner/patients was preventing necessary
25 remedial activity. As a result, the Receiver hired contract electricians to install computer lines in
26 clinical offices. However, asbestos and lead were discovered, rendering the initial plan of wiring
27 and remodeling impossible. As a result, the initial plan for hard wiring connectivity had to be
28 abandoned. A second project has been launched to implement either an alternative "hard wiring"
process or a "wireless" connectivity process, an effort which continues to this day.

29 An example of discovering more problems than originally anticipated involves facility
30 maintenance problems so severe that they adversely impact on the health of prisoner/patients as
31 well as staff. For example, the HVAC units in North Block presently function in a manner
32 whereby instead of pulling air from the unit, they circulate in reverse, forcing ambient air down
33 into prisoner housing units along with many years accumulation of filth, pigeon droppings, and
34 other noxious particles. Thus, the Receiver's initial plans for establishing cleaning processes in

1 clinical areas have become more complicated, and now includes consultations with an
2 environmental hygienist firm and a program to establish improved cleaning programs in North
3 Block.

4 An example of a prison specific problem which has, at its core, State wide systemic
5 impacts involves the San Quentin Team's efforts to improve the quality and timeliness of
6 reception center processing. Not only is there inadequate space and facilities for receiving,
7 screening, and examining prisoner/patients in a timely manner (a problem that will necessitate
8 the construction of a new San Quentin reception facility), the unpredictable and at times
9 excessive flow of newly sentenced prisoners who arrive at San Quentin adds another dimension
10 to the reception center problem which must be addressed *before* San Quentin intake processing
11 meets Plata standards. This scheduling problem led to the Receiver's decision to impose a
12 patient cap and reception center intake limit, a determination that must be very carefully
13 formulated and implemented in order to minimize the impact on other reception centers and on
14 the numerous county jails which transport sentenced inmates to San Quentin State Prison.

15 Given the scope, complication, and inter-connectivity of remedial plan challenges
16 encountered by the Receiver during the first six months of Receivership operation, he has
17 concluded that if forced to work according to a prematurely devised Plan and metrics, problems
18 may receive band-aid solutions only, and true, lasting reform may not be achieved. In reaching
19 this conclusion, the Receiver notes that some of the reports filed with the Court prior to the
20 effective date of the Receivership commented upon the problem that resulted because of CDCR
21 attempts to solve the health care crisis in its prisons with short term and superficial solutions.
22 The Receiver is determined to avoid this form of remedial planning mistake.

23 C. State Paralysis and Trained Incapacity.

24 As highlighted in the First and Second Bi-Monthly Reports, and consistent with the
25 Court's findings, dysfunction, paralysis, trained incapacity, broken business practices and
26 political machinations of State government are root causes of the devolution of the prison
27 medical care system to its present unconstitutional level. They remain significant barriers to
28

1 D. The Intensification of Overcrowding and Its Negative Impact on the Receiver's
2 Remedial Efforts.

3 As pointed out in the First Bi-Monthly Report, overcrowding represents a very serious
4 impediment that may, over time, render the Receiver's assignment difficult, if not impossible, to
5 complete:

6 Most California prisons operate at 200% of capacity, with no effective relief in
7 sight. Unless and until the living conditions of some prisons and the
8 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.

9 First Bi-Monthly Report at 3:13 - 19.

10 Unable or unwilling to act concerning this problem, the State has thus far offered no
11 realistic proposals to deal with the growing problem of overcrowding in California's prisons,
12 despite evidence that the CDCR will be out of space by June 2007, except for the beginnings of a
13 program to move approximately 2200 male prisoners out of state. It must be noted that the out-
14 of-state program is not aimed at, and will not result in, a reduction of California's in-state prison
15 population. Rather, the program will lead to an increased overall prison population by adding
16 2200 prisoners confined at privately operated out-of-state institutions. In-state beds freed up by
17 the out-of-state transfers will be filled immediately by new arrivals into the CDCR. In addition,
18 because steps have been taken to evaluate and prohibit from out-of-state transfers those prisoner
19 patients with medical problems, the out-of-state transfer process results in the concentration of
20 prisoners with medical problems within California.

21 Overcrowding has had an adverse impact on all aspects of prison operations, including
22 the delivery of medical care. When developing a Plan of Action, the negative impact of
23 overcrowding, as well as the State's proposed plans to address CDCR overcrowding, must
24 be considered. Given the existing crisis, the Legislature's failure to address the crisis, and the
25 uncertainty of the impact of the Governor's proposed emergency plans, the remedial process will
26 be best served by delaying the development of the Receiver's final plan and metrics.

27 In this regard, the Receiver emphasizes (as will be explained in more detail in his Third
28

1 Bi-Monthly Report) that during the past two months his efforts to assist the Administration to
2 implement the out-of-state prisoner housing program has set-back certain remedial efforts. To
3 effectuate medically safe out-of-state transfers, health care clinicians, under supervision by the
4 Office of the Receiver, commenced the following activities:

- 5 (1) engaged in a series of meetings in San Francisco and Sacramento, working
6 with CDCR correctional officials to develop a broad plan to identify and
7 medically screen prisoners for out-of-state transports;
- 8 (2) worked closely with State attorneys to ensure that contracts with out-of-state
9 private prisons provided adequate provisions for prisoner patient medical care;
- 10 (3) developed a screening instrument, form, and related policies and procedures;
- 11 (4) implemented a screening program at a variety of different CDCR prisons,
12 often utilizing Central Office nurse managers to conduct the screening;
- 13 (5) planned and implemented programs to send qualified experts to each of the
14 private prisons under contract with the State.

15 It is now necessary for the Receiver to plan and implement a program to appropriately
16 monitor those out-of-state private prisons which confines *Plata* patients. Thus, the Receiver's
17 Plan of Action must encompass programs to screen prisoners for out-of-state transfers and to
18 monitor the health care provided to out-of-state class members, projects that were not
19 contemplated by the Order of February 14, 2006. An extension of time to prepare a Plan of
20 Action will allow the Receiver, his staff, and the experts assigned to monitor out-of-state
21 conditions, adequate time to evaluate the staffing, programs, and metrics that will be necessary to
22 provide on-going evaluations of those private prisons which confine *Plata* class members.

23 E. Preventing Waste.

24 As reported in the Bi-Monthly Reports, the Receiver and his staff continue to investigate
25 and uncover duplicative and dysfunctional State practices which waste of millions taxpayer
26 dollars each year. Before finalizing Plan specifics to enhance fiscal management, however, the
27 Receiver needs more time to complete his analysis of existing practices and the benefits of

1 proposed reforms.

2 For example, the State utilizes an outdated practice of using a *paper* based system to
3 manage and track thousands of medical services contracts entered into by the CDCR annually.
4 The cost of these contracts exceeded 408 million dollars in the 2005-2006 budget. Given chronic
5 under staffing, inadequate controls, and the absence of information technology, it is not
6 surprising that in addition to being dysfunctional, the contract system has been the subject of a
7 number of negative audits by the State Auditor and State Controller.

8 Under direction of the Office of the Receiver, the CDCR and other State entities are in
9 the process of developing a new, automated system to manage this staggering number of
10 contracts.² This project may provide a model upon which the Receiver will begin other, similar
11 efforts to reform present State practices in a more cost effective, secure, and business like
12 manner. Significant benefits will be achieved by continuing the due date of the Plan of action to
13 allow the Receiver to evaluate the progress and problems encountered by this pilot effort, as well
14 as the progress and problems which may arise from the Receiver's plan to temporarily allow a
15 consulting firm to manage the CDCR prison pharmacy.

16 Given the scope of waste which exists in the medical delivery system at this point in
17 time,³ the Receiver believes that an extension of time to finalize his Plan of Action will make that

18 ² As described in the Receiver's Second Bi-Monthly Report, at the Receiver's direction, the
19 Project Team began to re-structure the contract process with the assumption that additional
20 information technology resources would not be available prior to the "start date" of the new system.
21 As design went forward, however, the Project Team found that the current and complex *paper* based
22 system contributed to contract process delays and irregularities. The Project Team concluded that
23 improvements to the medical contracting system could not reasonably be accomplished without
replacing the existing paper based system with an electronic system. The Receiver concurred with
this conclusion and thereafter directed the IT subgroup to proceed with recommending a specific IT
system. *Second Bi-Monthly Report* at 19:4 - 9.

24 ³ The Receiver has uncovered numerous other examples of waste of taxpayer resources, including
25 but not limited to the purchase of inappropriate medical equipment, the utilization of acute hospital
26 beds for prisoner/patients who require only sub-acute care, and the use of expensive privately owned
27 clinical registries to fill vacant physician and nurse positions within the prisons. As stated in earlier
28 reports, the creation of a constitutional medical care delivery system is entirely consistent with sound
fiscal management. The Receiver, however, needs more time to determine the details of many
specific remedial plan challenges to determine which of many possible options represents the best
long term fiscally responsible approach.

1 plan more cost effective for three reasons:

2 (1) the Office of the Receiver will have a better understanding of the root causes
3 of waste and inefficiency;

4 (2) the Office of the Receiver will be better able, due to the addition of high-level
5 and competent personnel employed by the Receiver, to address waste and
6 inefficiency; and

7 (3) the Receiver will be in a position to begin to measure the impact of the
8 contract project and pharmacy project by the Second Quarter of 2007.

9 F. Structure of Receiver's Remedial Program.

10 The final concern that warrants an extension of time to file the Plan of Action involves
11 the level of disarray, confusion, and mixed priorities that exist in the CDCR Division of
12 Correctional Health Care Services. At present, the Division is woefully short of key management
13 and high ranking clinical personnel. To make matters worse, necessary remedial orders issued by
14 a number of Federal and State courts relative to medical, mental health, dental, Americans with
15 Disability Act, and Correctional Treatment Center licensure issues have overwhelmed the limited
16 human resources of the Division, creating knee jerk and short sighted responses which in turn
17 have led to additional re-work and remedial orders from the courts. All in all, the present state of
18 affairs in the Division is the very opposite of the careful planning and detailed implementation
19 needed to create long term solutions that will effectively eliminate unconstitutional conditions.⁴

20 Whether certain aspects of the current health care system can be fixed by working
21 through existing CDCR structures, or whether remedies must be wholly cut from new cloth by
22 the privatization of some State functions, are issues that have not yet been determined by the
23 Receiver. At this point in time the Receiver and his staff are in the process of determining
24 which, if any, *Plata* remedial functions should remain in the Division of Correctional Health
25 Care Services under State management; which remedial functions should remain in the Division

26 ⁴ In making this finding, the Receiver emphasizes that he is not criticizing the efforts of Peter
27 Farber-Szekrenyi and the few remaining dedicated staff of the Division who continue to attempt in
28 good faith to correct intractable problems with inadequate resources.

1 of Correctional Health Care Services under the direct management of the Office of the Receiver;⁵
2 and which remedial functions should be corrected through direct action by the Office of the
3 Receiver.⁶ Until the determination is complete, development of a Plan of Action is premature.⁷

4 III.

5 OVERVIEW OF RECEIVER'S PLAN OF ACTION

6 A. Introduction.

7 Though he requests an extension of time to prepare a suitably detailed Plan of Action and
8 metrics, the Receiver is prepared to outline the primary objectives of the Receivership.

9 The goals of a constitutionally-adequate prison medical care system are to reduce
10 unnecessary morbidity and mortality, improve inmates' health status and functioning, and protect
11 public health. Therefore, the Receivership must create a sustainable, evidence-based, cost-
12 effective system of care that is continually monitored and revised in order to meet those goals.
13 This requires the right people and systems to be in place to ensure that inmates get the right care
14 in the right place at the right time. Unfortunately, there is nothing simple about achieving this
15 goal within the California prison system. Given the utter disrepair in which the (non)system finds
16 itself today, a total redesign of the existing system will be necessary. The extent of dysfunction
17 has been well documented in reports by the Court's experts, the Court's Findings of Fact and
18 Conclusions of Law leading to the establishment of the Receivership, and the bi-monthly reports
19 of the Receiver. They will not be reiterated here.

20
21 ⁵ For example, the Receiver recently made the decision to form a Plata Compliance Unit within
22 the Division comprised of CDCR employees who report directly to the Office of the Receiver
23 concerning hiring and recruitment of medical personnel, human resource transaction processing for
24 medical personnel, the management of investigations and discipline concerning medical personnel,
25 and the newly created Medical Contracts Unit pilot project.

26 ⁶ The problems which afflict the Division will, unless corrected first, have a direct impact on the
27 Receiver's ability to provide accurate reports to the Court and public. In this regard, there is no rush
28 to establish metrics when the Receiver is unable to ensure that the information gathered and reported
by medical care personnel is relevant, complete, or accurate. The reporting of accurate metrics will
require new organizational structures which have not yet been created.

⁷ One consequence of the lack of resources in the Division that can be dedicated to *Plata*
remedial efforts has been a necessary increase in staffing at the Office of the Receiver.

1 It is important at this point, however, to provide a preliminary statement of the direction
2 being envisioned by the Receiver in attaining Constitutional levels of access to and quality of
3 care for California's inmate patients.

4 A. The Conceptual Basis For a Constitutionally Adequate Prison Medical Delivery
5 System.

6 A strategic plan for meeting constitutional adequacy of the California prison medical
7 system must be founded upon a sound and comprehensive conceptual base. Work by the Institute
8 of Medicine ("IOM") over the past decade, in response to the quality crisis within mainstream
9 American health care, has led to a widely accepted conceptual framework that applies within
10 corrections as well. Just as in the free world, medical care within California prisons should be
11 safe, effective, patient-centered, timely, efficient, and equitable. Of particular importance to the
12 Receiver's challenge, the IOM describes six essential organizational supports for change:

- 13 1. Redesign of care processes based on best practices.
- 14 2. Information technologies for clinical information and decision support.
- 15 3. Knowledge and skills management.
- 16 4. Development of effective teams.
- 17 5. Coordination of care across patient conditions, services and settings over time.
- 18 6. Incorporation of performance and outcome measurements for improvement
19 and accountability.

20 Piecemeal approaches will not work in prison medical care any more than they work in
21 free-world systems. Change must be both top-down and bottom-up. To accomplish the
22 objectives above the Receiver will need transformational leaders who can sustain a focus on the
23 above goals and strategies as well as employee empowerment, incentives, and rewards, with a
24 relentless emphasis on training and on effective communication. Systems are necessary that will
25 support innovation among front-line clinicians, that is open to innovations from the outside, and
26 that effectively disseminate evidence-based practices.

27 Delivering the right form of medical care will require enormous shifts in attitude and
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1 practice in the prison setting just as in the free world. Responses to error and bad outcomes must
2 move from finger-pointing to an honest, comprehensive critique that includes analysis of
3 individual human factors as well as team factors, communication, and organizational
4 effectiveness. In addition, the interdependence of medical care and custody presents
5 opportunities as well as challenges. Reliability - ensuring that the right thing happens every time
6 - is a goal of custody, just as it is within medical care. Some organizations in the military, law
7 enforcement, and emergency services have achieved remarkable improvements in reliability by
8 developing a strong safety culture, utilizing personnel and equipment back-up systems,
9 promoting inter- and intragroup communication, cross-training personnel, and focusing attention
10 on errors and near-misses without wrongfully blaming or absolving individuals. Achieving
11 reliable prison medical care in California will depend upon new levels of collaboration between
12 medical care and custody that result in shared language and practices.

13 B. Conceptual Components of a Constitutionally Adequate Prison Medical Delivery
14 System.

15 The Receiver emphasizes that of many daunting tasks facing him, perhaps the least
16 daunting is outlining the components of a constitutionally-adequate prison medical care system
17 or even the look, feel, and performance of the system. This task pales in comparison to the
18 challenge of implementing such a system, of getting from here to there. A constitutionally-
19 adequate medical care system for California's prisons will have the following characteristics,
20 among others:

- 21 1. Appropriately trained, competent personnel who have incentives for good
22 performance and disincentives for poor performance. This requirement extends
23 from front line clinical and support personnel through all supervisory and
24 management categories, including executive-level managers.
- 25 2. Adequate and appropriate space, supplies, equipment, data and information
26 systems.
- 27 3. Working conditions and environments conducive to good patient care.

4. A team approach to patient care that clearly defines roles, responsibilities and expectations, that measures progress and results, that takes appropriate remedial actions and honors change, and that respects the roles and input from all levels of the organization.
5. Effective collaboration between the medical and custody disciplines.
6. Effective integration of medical care and mental health.
7. Leadership that articulates, advances, monitors and maintains the goals and objectives of a constitutionally-adequate system.
8. Redefinition and reconstitution of the “culture” of California’s prison system.
9. Medical care appropriately tailored for the patient groups within California’s prisons such as the chronically ill, women patients, geriatric patients, patients with both medical and mental health problems, and patients in need of long term care.
10. Management of California’s prison population (and, if necessary, imposition of patient limits at specific institutions and reception centers) to ensure adequate access to and provisions for constitutional medical care delivery.
11. Development of standards and metrics which, if adhered to, will produce a reduction in morbidity and mortality both within the prisons and in the communities outside the prison walls.
12. Prudent and effective use of public funds.

Though not all-inclusive, the foregoing are critical elements of a constitutionally-adequate medical care system. At present, none of the above exist, or do not sufficiently exist to meet the goals of reducing morbidity and mortality in a cost-effective manner.

C. Priorities for Remedial Action.

Several issues have emerged that if not resolved will impede meaningful progress. These include, but are not limited to, the following:

1. *System Size and Structure.*

Problem: California’s prison system is too large, too overcrowded, and too

1 geographically dispersed to manage effectively.

2 Approach: Restructure the prison medical system into manageable, accountable regions.

3 Discussion: At present, the CDCR and its medical system is partitioned into three
4 regions. The Receiver will subdivide these regions, at least for the purposes of medical care, into
5 sub-regions which incorporate no more than 3-5 facilities depending on size, medical
6 programming and utilization. The partition will grant responsibility to these sub-regions, hold
7 them appropriately accountable, and establish managerial and fiscal transparency. A pilot project
8 with one sub-region, to test this approach, will begin shortly. The project will involve
9 redefinition of responsibilities for medical, support, and custody personnel; recruitment of
10 qualified managerial, clinical and support staff; implementation of standards, metrics and
11 remedial actions; and provision of adequate resources, including supplies, equipment, space, and
12 personnel.

13 *2. Fragmentation and Erosion of Nursing Infrastructure.*

14 Problem: Fragmentation characterizes every aspect of the medical care system, and the
15 CDCR has neglected and eroded its nursing infrastructure.

16 Approach: Recruit nurse change agents into roles throughout the organization and
17 support them in developing nurse-driven care coordination.

18 Discussion: In functional systems, nurses are the glue that binds the components of
19 patient care on a "24/7" basis. Nurses maintain the focus on patient-centered performance, they
20 assure continuity of care, and they provide system oversight. Change in CDCR medical care will
21 involve redefinition of all provider roles and responsibilities. Each provider classification will
22 work within the appropriate scope of practice, licensure and/or certification. It must be clearly
23 understood, however, that the Receiver is in the process of converting to a nurse-driven system of
24 care. Nurses are, or will be, the care givers in closest and most continual touch with patients and
25 will be charged with lead responsibility for assuring appropriate access to safe care for the inmate
26 population. The Office of the Receiver will provide the nursing infrastructure, environment, and
27 professional development necessary for success in these new responsibilities and roles. It will

1 also provide initial and ongoing training, education and other support as needed by nurses and
2 nurse managers. The “ramp-up” time for this project will be significant.

3 *3. Matching Needs to Prisons.*

4 Problem: Many prisons face a mismatch between the medical needs of their inmate-
5 patients and their capacity to provide the necessary range of services.

6 Approach: Accelerate the process of differentiating facilities by program content and,
7 therefore, by inmate population.

8 Discussion: In recent years the CDCR has begun to differentiate facilities by program
9 content and has begun to cohort inmate-patients accordingly. This specialization has focused on
10 “Centers of Excellence.” Putting aside questions about nomenclature and performance, the core
11 concept is correct. Inmate-patients are languishing in facilities without the staff, expertise, and
12 resources to meet their needs, and attempts to meet these needs are rarely cost-effective.
13 Recognizing these medical and fiscal imperatives, we will clarify and accelerate facility
14 differentiation. Based on such factors as diagnoses, function, behavior, and nursing acuity,
15 inmate-patients must be matched with facilities that have the space, staff, expertise, levels of
16 care, and resources to meet their needs, as well as the security capacity to ensure safety. The
17 Receiver has already initiated the planning process for this “cohorting” and is working with the
18 appropriate State agencies to design, program, and ultimately construct facilities to provide cost-
19 effective specialized care. The new facilities will house several levels of care, not including acute
20 care hospital beds. Well before completion of these facilities, the Office of the Receiver will
21 develop and deploy new methods of assessment and case management that will guide placement
22 of inmate-patients in the best possible locations for care.

23 D. Conclusion.

24 Dysfunction pervades every aspect of the CDCR medical care system. It would be folly to
25 impose a purportedly reasonable structure on this dysfunction without recognizing that every
26 aspect of the system must be transformed. In addition, the Receiver believes it imperative that all
27 interested parties understand, in broad terms, the critical elements and characteristics of the

1 proposal was evaluated by Court experts Madeleine LaMarre and Dr. Joe Goldenson. The
2 experts raised questions about certain aspects of the proposal. Dr. Terry Hill is coordinating
3 meetings between the experts and the San Quentin Team to address the experts' concerns. In
4 addition, counsel for the parties have been provided with copies of the proposal as well as the
5 experts' report.

6 The overall goal of the proposal is to provide comprehensive screening and evaluation to
7 optimize the intake process for efficient service delivery. It will:

- 8 1. Identify significant medical concerns at reception and facilitate a continuum of
9 quality health care.
- 10 2. Allow for completion of medical intake screening and assessment and mental
11 health evaluation on all inmates as they arrive each day.
- 12 3. Support a process to eliminate backlog and the need to schedule inmates for
13 initial intake activities.
- 14 4. Reduce custody escort and inmate movement, resulting in more timely
15 completion for classification and permanent assignment.
- 16 5. Provide health information, wellness materials, and access to care instructions
17 to inmates during reception at San Quentin.
- 18 6. Encourage inmates to take personal responsibility and make informed medical
19 choices.

20 B. Summary of the Proposed Pilot Modification of *Plata* Requirements.

21 The proposed intake policies and procedures will meet compliance with all *Plata*
22 requirements with one exception, set forth below. The proposed policy modification is also in
23 accordance with the National Commission on Correctional Health Care (NCCHC) national
24 standards, 2003. Routine laboratory screening tests are in accordance with the U.S. Preventive
25 Service Task Force (USPSTF) guidelines.

26 At present, *Plata* Policy "Health Screening – CH 2 C, History and Physical Examination"
27 requires a somewhat limited medical/mental health screening (performed by a Medical Technical
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1 Assistant and subject to possible referral to a Registered Nurse [“R.N.”]) immediately upon
2 intake and thereafter, “..within 14 days of arrival at the RC each inmate will receive a complete
3 history and physical examination performed by a nurse practitioner, physician assistant, physician
4 or surgeon.”

5 The proposed process calls for a three stage reception process. First, incoming prisoner
6 patients are screened on arrival by a Licensed Vocational Nurse. Second, all incoming prisoner
7 patients are provided with a comprehensive medical history and physical assessment to be
8 performed by an R.N. and reviewed and co-signed by a primary care provider or designee. Any
9 abnormal findings shall be immediately referred, and the routine assignment of a Nurse
10 Practitioner in the reception area will provide immediate access and referral when identified.
11 This RN assessment will be completed for all incoming inmates (without exception) *on the first*
12 *day of arrival*, including laboratory testing and a mental health screening/evaluation. The
13 proposed second stage same-day RN screening will improve timely access to care and continuity
14 of care for prisoner patients at higher health risk because of age or significant medical conditions.

15 Following this assessment, primary care physicians will then be required to see those
16 inmates within seven days who are referred due to significant acute or chronic medical
17 conditions, strictly defined by criteria and guidelines.⁸ Patients requiring referral and follow up
18 will be scheduled with their primary care team to ensure primary and secondary treatment and
19 prevention of disease with timely response for patient care. The Receiver emphasizes that this
20 process is multi-disciplinary and inclusive of all departments which impact care for the inmate at
21 inception including medical records, medical, nursing, mental health laboratory, dental, as well
22 as custody and transportation staff.

23 The changes in circumstance which warrant adoption of the pilot proposal include the
24 following:

25 A. The revolving door into and out of the California prison system appears to be

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27 ⁸ In addition, prisoner patients who are healthy but at least forty years of age will be evaluated
28 by a mid-level practitioner within thirty days.

1 swinging at rate whereby, at present, approximately sixty-two percent of the prisoners who arrive
2 at San Quentin's reception unit are parole violators. On average, a prisoner's re-entry into the
3 prison system occurs within one year of release. For a significant portion of these patients, a full
4 blown physical is not medically necessary.

5 B. The CDCR's population, however, continues to have significant medical and mental
6 health problems. Given the patient demographics, the San Quentin team determined that an
7 MTA screening followed only by a physician review fourteen days thereafter, may not be timely.
8 Given this, the Team made the decision to provide a full, formalized RN assessment the same
9 day the prisoner patient arrives at the prison.

10 V.

11 **CREATION OF AN ADVISORY BOARD SHOULD OCCUR AFTER THE RECEIVER**
12 **HAS DEVELOPED A FINAL PLAN OF ACTION**

13 The Order mandating the creation of an Advisory Board to assist and advise the Receiver
14 and the Court, is premature at this time. Therefore, the Receiver requests the Court continue this
15 aspect of its Order until the Receiver has developed Corrective Action Plan specifics.

16 An Advisory Board which is removed from the day-to-day decision making process of the
17 Receivership is not at this time an effective use of Advisory Board member's expertise. Rather,
18 at this stage, when the Receiver is still adopting and revising his Plan, intensive and detailed
19 expertise is needed at every stage of problem analysis and remedial Plan development. The
20 Receiver has addressed this need by hiring expert staff, including clinicians and corrections
21 experts familiar with all aspects of prison medical delivery. These staff members, supported in
22 some cases by retained consultants, provide the Receiver with everyday hands-on analysis and
23 advice.

24 While the eventual creation of an Advisory Board is critical to assisting the Receiver in
25 achieving the goals of the Receivership, the multitude of interconnected problems facing the
26 creation of a constitutionally adequate medical health care delivery system demands that the
27 Receiver utilize experts in a more hands-on, day-to-day capacity to devise a comprehensive,
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1 sound Plan for corrective action. Once the Receiver has completed his analysis and developed a
2 Plan, an Advisory Board's guidance will be an essential element in ensuring the goals of the Plan
3 are met. Furthermore, the specific composition of the Advisory Board may well depend on the
4 type of long term challenges faced by the Receivership, the scope of which will be better
5 understood at the conclusion of the extension period.

6 VI.

7 CONCLUSIONS AND RECOMMENDATIONS

8 The Receiver's request for an extension of time must be placed in context. The Office of
9 the Receiver has accomplished much during the first six months of operation: significant
10 progress toward a new IT supported system to procure, manage and pay for medical contracts;
11 establishment of appropriate salary ranges for clinical personnel; planning and initial
12 implementation of streamlined hiring procedures for clinical personnel; completion of an
13 investigation of the pharmacy system, preparation of a request for proposals, and the selection of
14 a vendor to manage the CDCR's pharmacy system; the inspections of numerous prisons;
15 implementation of the San Quentin Project; and the formation of the Office of the Receiver itself,
16 accompanied by an effective recruitment program which has attracted a wide range of
17 correctional and health care experts to assist the Receiver.

18 The Receiver's initial remedial programs have been directed toward those elements of a
19 broken medical delivery system that have been identified, by the parties and court experts, as the
20 most critical problems facing the Receivership. At the same time, however, the Receiver cannot
21 and will not allow the Receivership to be tossed about by the "crisis mentality" which afflicts the
22 CDCR. *In addition* to addressing pressing concerns, it is essential that the Receiver engage in
23 thoughtful and competent long term planning.

24 Therefore, the Receiver requests that the Court modify that portion of the Order of
25 February 14, 2006 which requires a formal Plan of Action and metrics as follows:

26 1. Beginning with the Bi-Monthly Report of January 2007, the Receiver shall report to
27 the Court concerning progress toward establishing a Plan of Action and the necessary metrics to
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1 measure the success of the Plan.

2 2. The Receiver shall file his first proposed Plan of Action and proposed metrics no later
3 than May 15, 2007. At the same time, he shall file a plan to establish the administrative
4 structures to document, accurately track, and report metrics.

5 3. The Receiver shall file a revised Plan of Action and metrics six months thereafter, no
6 later than November 15, 2007. He shall submit to the Court modifications to the Plan of Action
7 and metrics as necessary thereafter.

8 The Receiver believes he will be in a position to begin evaluation of candidates for the
9 Advisory Board when he files his initial Plan of Action, May 15, 2007.

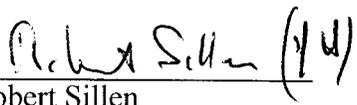
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11 Dated: November 13, 2006

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Robert Sillen
Receiver

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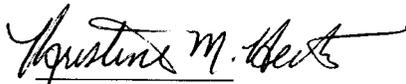
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23 I declare under penalty of perjury under the laws of the State of California that the foregoing
24 is true and correct. Executed on November 13, 2006 at San Francisco, California.

25 
26 Kristina Hector