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SAN FRANCISCO, CALIFORNIA

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2
3 **IN THE UNITED STATES DISTRICT COURT**
4 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

5 MARCIANO PLATA , et al.,)
6 Plaintiffs)
7)
8 v.)
9)
10 ARNOLD SCHWARZENEGGER,)
11 et al.,)
12 Defendants.)

NO. C01-1351-T.E.H.

**NOTICE OF FILING OF AMENDED
MOTION FOR WAIVER OF STATE LAW
RE RECEIVER CAREER EXECUTIVE
ASSIGNMENTS; EXHIBITS**

13
14 This Motion for Waiver of State Law Re Receiver Career Executive Assignments filed on
15 April 13, 2007, contains an error between page 17, line 23 and page 18, lines 1 and 2. Those
16 lines read: "The single barrier to limited to those who have already attained civil service status,
17 and those who are legislative employees or exempt political employees." It should read, "**The**
18 **single barrier to establishing the RCEA program is that, under California law, competition**
19 **for CEA positions is limited to those who have already attained civil service status, and**
20 **those who are legislative employees or exempt political employees."**

21 An amended motion correcting this problem and other typographical errors is attached
22 herein.

23 Date: April 18, 2007

24
25
26 
27 John Hagar, Chief of Staff
Office of the Receiver
28

1 **PROOF OF SERVICE BY MAIL**

2 I, Kristina Hector, declare:

3 I am a resident of the County of Alameda, California; that I am over the age of eighteen (18)
4 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*.

5 On April 18, 2007 I arranged for the service of a copy of the attached documents described as
6 NOTICE OF FILING OF AMENDED MOTION FOR WAIVER OF STATE LAW RE
7 RECEIVER CAREER EXECUTIVE ASSIGNMENT POSITIONS; EXHIBITS on the parties of
record in said cause by sending a true and correct copy thereof by pdf and by United States Mail
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22 I declare under penalty of perjury under the laws of the State of California that the foregoing
23 is true and correct. Executed on April 18, 2007 at San Francisco, California.

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IN THE UNITED STATES DISTRICT COURT
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MARCIANO PLATA, et al.)
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ARNOLD SCHWARZENEGGER,)
et al.)
) Defendants.)

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**AMENDED MOTION FOR WAIVER OF
STATE LAW RE RECEIVER CAREER
EXECUTIVE ASSIGNMENTS;
EXHIBITS**

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1 I.

2 INTRODUCTION

3 For more than a decade the lack of competent health care leadership has thwarted the
4 ability of the California Department of Corrections and Rehabilitation (“CDCR”) to provide
5 constitutionally adequate health care. To summarize, there has been no adequate management
6 system at almost all of the CDCR’s thirty-three prisons, as well as within the CDCR’s Central
7 Office.

8 A. The Court’s Findings.

9 As found by the Court:

10 The leaders of the CDCR medical system lack the capability and resources
11 necessary to deliver adequate health care, much less fix the abysmal system that
12 now exists ... [and] CDCR lacks an adequate system to manage and supervise
13 medical care, both in the central office and at nearly all of its prisons.

14 *Findings of Fact and Conclusions of Law re Appointment of Receiver (“Findings of Fact”) filed
15 October 3, 2005.*

16 The absence of health care leadership was not the result of mistake, accident, or
17 miscalculation. Rather, the State’s failure to provide even the most basic of management
18 structures for prison health care in California was a matter of policy. For example, prior to the
19 appointment of a Receiver, CDCR officials testified:

20 that medical care simply is not a priority within the CDCR, it is not considered a
21 “core competency” of the Department, and is “not the business of the CDC, and it
22 never will be the business of the Department of Corrections to provide medical
23 care” RT 554: 4-15. Mr. Carruth could not even estimate when significant
24 improvements to the system might be made if the State were left to its own
25 devices. RT 549: 1-4 (Carruth); RT 571:11-22 (Kanan).

26 *Findings of Fact at 6:1-6.*

27 Therefore, and not surprisingly, prior to the Receivership the CDCR’s medical leadership
28 program was all but non-existent. For example:

Of the higher level management positions in the CDCR’s Health Care Services
division, 80% are vacant, making effective supervision impossible. RT 572:6-8;

1 RT 543:10-16 (Carruth). This is akin to having a professional baseball team with only a relief
2 pitcher and no infielders (emphasis in original).

3 *Findings of Fact* at 7:22-25.

4 Furthermore, the CDCR has not hired regional medical directors as ordered ...
5 [and] Court expert Goldenson accurately described the absence of regional
6 management, coupled with incompetent prison staff, as resulting in the “blind
7 leading the blind.”

8 *Findings of Fact* at 7:26 to 8:2.

9 There is also no central leadership in nursing. This makes it difficult to initiate
10 and ensure compliance with nursing policy and practice . . . Moreover, there is a
11 severe shortage of nursing supervisors at the prisons.

12 *Findings of Fact* at 8:3-6.

13 B. The Receiver’s Findings.

14 The CDCR did not institute any significant improvement concerning the medical care
15 leadership crisis following the filing of the Findings and Facts and before the Receiver’s
16 April 17, 2006 appointment date. Indeed, the CDCR’s shortage of clinical personnel *worsened*
17 during this period, requiring the appointment of a Correctional Expert in *Plata*. In response to
18 the Expert’s recommendation, the “Court issued its Order re Interim Remedies Related to
19 Clinical Staffing” filed December 1, 2005.

20 The Receiver has also found a pervasive lack of effective medical management
21 throughout the CDCR system. For example:

22 The medical services provided by the CDCR are without question “broken beyond
23 repair,” as found by the Court in the Findings of Fact and Conclusions of Law.
24 Almost every necessary element of a working medical care system either does not
25 exist, or functions in a state of abject disrepair, including but not limited to the
26 following: medical records, pharmacy, information technology, peer review,
27 training, chronic disease care, and speciality services. Similar to the conditions
28 reported by the Court, the Receiver has observed cases where prisoner/patients did
not receive adequate care because of their inability to access care; also, and
perhaps more disturbing, he has reviewed cases where prisoner/patients did not
receive adequate care even after accessing the CDCR medical care system.

First Bi-Monthly Report at 3:1-9.

1 The prevalence of “trained incapacity” was correctly noted in the Findings;
2 however, it may have been understated. “Trained incapacity” is a major cultural
3 obstacle. Furthermore, it is both a vertical and horizontal issue, i.e., it involves not
4 only the CDCR but all other State Agencies and Departments whose performance
5 significantly affects the CDCR’s ability to perform adequately and appropriately.
6 Thus, the Receiver affirms that the inadequacy of medical care in California’s
7 prisons is not caused by the CDCR alone. As noted in the Findings of Fact and
8 Conclusions of Law, the problems with the CDCR medical care are a product of
9 “[d]ecades of neglecting medical care while vastly expanding the size of the
10 prison system [which] has led to a state of institutional paralysis.”

11 *First Bi-Monthly Report at 4:1-8.*

12 In addition, the lack of qualifications, training and, in some instances, competence
13 of the above personnel has created a culture of incompetence and non-
14 performance which, unfortunately, is more rewarded than not within State
15 employment.¹

16 *First Bi-Monthly Report at 4:1-8.*

17 During the past several months this utter disarray in the management, supervision and
18 delivery of care forced the Receiver to *assume direct management of both the CDCR clinical*
19 *services and health care related administrative programs. See Third Bi-Monthly Report at 7-9;*
20 *Fourth Bi-Monthly Report at 49-52.*

21 At this point in time, no one seriously argues against the proposition that California’s
22 prison medical delivery system does not have adequate numbers of qualified executives and
23 clinical managers in either its prisons or in the Central Office. Without adequate clinical leaders
24 and administrative managers, the remedial actions required by the Court will not be effectuated.
25 Before proposing a solution to this leadership crisis, however, it is important that the underlying
26 causes of this shortfall be explained.
27

28 ¹ As noted by the Court, beyond the obvious problem of condoning malpractice and allowing
incompetent doctors to remain on staff, the leadership vacuum and a lack of disciplinary action for
failure to deliver competent care also fosters a culture of non-accountability and non-professionalism
where the acceptance of degrading and humiliating conditions becomes routine and permissible. *See*
Findings of Fact at 12:22-27.

1 II.

2 THE UNDERLYING CAUSES OF THE
3 PRISON HEALTH CARE LEADERSHIP CRISIS

4 A. Introduction.

5 During a period of eleven months the Receiver and his staff engaged in a number of
6 intensive efforts to understand the root causes for the long-term shortage of competent CDCR
7 clinical leaders. In that regard the Receiver conducted numerous prison inspections; engaged in
8 hundreds of hours of direct face-to-face consultation with CDCR employees of all levels;
9 retained the services of expert consultants; and assembled a team of staff familiar with all aspects
10 of health care delivery and correctional medicine delivery. Following this exhaustive review, the
11 Receiver finds the following factors to be critical elements of the State's failure to provide
12 adequate health care management in its prisons.

13 B. The Underlying Causes of the CDCR Clinical Leadership Crisis.

- 14 1. The State's long-term management philosophy whereby the delivery of
15 medical care was not considered a "core competency" for the CDCR.
16 2. The decades long process whereby the CDCR treated clinical staff as second
17 hand citizens, often placing health care under Wardens' direct control.
18 3. Grossly inadequate salaries for all clinical personnel, including clinical
19 leadership.
20 4. The complete absence of career track programming for the CDCR clinicians.
21 5. Grossly inadequate clinical environments.

22 These long-term systemic shortfalls have been institutionalized into a clumsy, ineffective,
23 and wasteful health care delivery system through manifestations of the following:

- 24 1. The use of civil service classifications with qualifications and corresponding
25 salaries far too low to meet its competency and leadership needs.
26 2. The lack of effective programs to infuse the CDCR leadership structure with
27 experienced personnel from outside the civil service system, accepting instead
28

1 barriers created by the State Personnel Board (“SPB”) bureaucracy that limit
2 the appointment of executives to those from within civil service even when
3 these limitations lead to unconstitutional conditions of confinement.

- 4 3. Utilization of key managers who, instead of being service and performance
5 driven, are assigned civil service classifications which guarantee them
6 continued employment in spite of being indifferent to the Court’s objectives,
7 plans and policies.
- 8 4. The establishment of a dysfunctional organizational structure with two major
9 failings:
- 10 a. An over centralized and geographically remote “Central Office” operation
11 that attempts to function as the state-wide overseer of health care delivery
12 from Sacramento, far away from where medical care is actually being
13 delivered.
- 14 b. The failure to provide local managers with a support structure (e.g., an
15 adequate number of regional administrators) that permits them to carry out
16 their responsibilities.

17 C. The Solution.

18 The primary element of a program to begin to correct decades of management neglect is
19 relatively simple - the infusion of approximately 250 new executives/managers² into California’s
20

21 ²The Receiver’s initial estimate of 250 new executives is largely derived from the “Mercer
22 Model” discussed in section IV(B)(3) of this motion, and depicted in Exhibit 1, Recommended
23 Organizational Structure. For the majority of the thirty-three adult prisons up to four RCEA
24 positions will be necessary. In addition, RCEAs will be needed for Regional and Central Office
25 executive positions. In some instances, this will require supplementing the existing number of
26 positions and in other instances it will involve merely reclassifying existing positions. For example,
27 as discussed in sections IV(C)(2) and (4) there is neither a Health Care Manager classification nor
28 are there positions allocated for purposes of hiring an individual to direct the overall health care
program in each of the prisons. Instead, the Chief Medical Officers (and others) are forced to act
in this capacity, either leaving their originally intended job duties unaccomplished or struggling
unsuccessfully to fulfill both functions at the same time. On the other hand, the Receiver anticipates
reclassifying existing positions such as the institutional Director of Nursing.

1 prison health care delivery system, plus the creation of new and more streamlined and effective
2 managerial controls over both the Central Office and over health care delivery in the thirty-three
3 prisons themselves. This program can be effectuated in a timely manner through the waiver of
4 only one element of the California legal principle pertaining to State executive appointments. In
5 fact, the limited exception proposed by the Receiver is similar to an appointment system used by
6 the Department of Motor Vehicles (“DMV”).

7 **III.**

8 **STANDARD FOR WAIVING STATE LAW**

9 Pursuant to the Order Appointing Receiver (“Order”) filed February 14, 2006, the
10 Receiver must make all reasonable efforts to exercise his powers in a manner consistent with
11 California state laws, regulations and labor contracts. In the event, however:

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

18 *Order at 5:1-11.*

19 **IV.**

20 **FACTS IN SUPPORT OF MOTION**

- 21 A. The CDCR Has A Large and Complex Medical Care System Which Must Be
22 Managed By Appropriately Experienced, Skilled and Well-Qualified Experts in
23 Correctional Medicine.

24 The magnitude of the CDCR’s health care system and the complexities associated with
25 delivering care in a prison setting must be taken into consideration when adopting personnel
26 policies that govern the availability of executives who are qualified and willing to accept the
27 challenge they will face when attempting to change a deeply entrenched culture of non-
28 accountability and substandard care.

1 At present, there are 9,355 authorized positions for California's correctional health
2 services operation. The medical budget alone approximates \$1.5 billion. Prison medical care is
3 far different from the delivery of health care in the community setting because correctional
4 medicine as a specialty is well acknowledged, except in the CDCR. Administering a correctional
5 medicine program presents unique challenges and requires extraordinary skills and abilities. The
6 delivery of care to an incarcerated population includes the added dimension of:

- 7 1. Patients who are generally sicker than the general population because they
8 arrive in prison having had little or no preventative or routine health care. The
9 incidence of communicable and infectious diseases is higher in the
10 correctional patient (HIV, Hepatitis, TB, MRSA and Norovirus). The
11 incarcerated have a high rate of drug abuse, mental illness, chronic liver
12 disease, trauma and degenerative diseases. Overall inmates' biological age is
13 greater than their chronological age, consequently inmates utilize services at a
14 higher rate than the general population.
- 15 2. The incarcerated patient is dependant upon the correctional health care system
16 for all functions (e.g., medications, supplies and appliances).
- 17 3. There is a high incidence among incarcerated populations of mental health
18 conditions which requires that treatment programs must be coordinated
19 between multiple disciplines.
- 20 4. Developing and administering efficient and reliable systems which enable
21 access to care is dependent on understanding and successfully balancing
22 medical needs with custody requirements necessary for safe and secure
23 prisons.
- 24 5. Necessary external support which is vital to the adequate delivery of health
25 care to the incarcerated population is variable and often lacking.
- 26 6. Attitudes and behaviors by both staff and inmates often have a corrosive
27 influence on professionalism.

1 7. Health care providers must possess a wide range of skills and abilities,
2 including primary care and emergency medicine. These skills must be
3 maintained within the isolation typically found within a correctional
4 environment.

5 8. Specialty and in-patient services are difficult to obtain. This is often due to the
6 social stigma of the incarcerated patient, lack of adequate and timely
7 reimbursement for services, liability concerns and fear of alienating a private
8 client base.

9 Therefore, administrators in correctional medicine programs must possess the same skills
10 as those in the private sector *in addition* to being able to successfully navigate almost
11 insurmountable obstacles presented by political and practical restrictions in the corrections
12 environment. If the Receiver is limited to drawing from a very small and perhaps non-existent
13 pool of State civil service employees to effectuate massive restructuring and to change attitudes
14 in order to comply with the Court's directives, his remedial mission will truly become a mission
15 impossible. The change needed in California's prisons must, to a large degree, be effectuated by
16 the infusion of new, skilled, experienced and motivated clinical leaders.

17 B. The CDCR's Organizational Structure Does Not Provide For Effective Leadership
18 and Successful Alterations Depend On Eliminating Obstacles Preventing the
19 Employment of the Most Qualified Candidate.

20 1. *The Overall CDCR Medical Delivery System Has All But Collapsed.*

21 The Receiver's remedial efforts did not begin at ground zero. To the contrary, he
22 inherited a massive medical delivery system which has been broken for decades. The rapid
23 growth of California's correctional system was simply not accompanied by organizational
24 restructuring to meet increasing system demands. Fundamental reforms required in a variety of
25 areas, including its management structure, resulting in the current reality: the lack of an adequate
26 system to manage and supervise medical care exists both in the central office and at nearly all of
27 the prisons. *Findings of Fact* at 4:22-26.

1 desire. The employees are currently supervised by the wardens whose core
2 competencies are aligned with custody rather than medical services.

3 3. Standardize and coordinate care by having one senior physician with ultimate
4 responsibility for all medical decisions.

5 4. Promote teamwork and leveraging of shared resources through paired physician-nurse
6 leadership while maintaining individual reporting relationships.

7 Thus, to effectuate necessary remedial efforts, a new structure is needed within the
8 CDCR. The success of this new management structure, however, is dependent on eliminating
9 the one legal obstacle that clearly prevents the Receiver from recruiting clinical leadership from
10 throughout the public- and private-sector medical community who can be properly compensated
11 and remain employed in a leadership capacity, provided they continue to competently inspire,
12 invigorate and implement change necessary for constitutionally-adequate medical care.

13 The Mercer Model provides for four or five executive positions at each of the thirty-three
14 institutions which are: Chief Executive Officers (which currently do not exist and are filled by
15 diverting individuals from other jobs); Chief Health Care Officers (which exist and are currently
16 under classified as Chief Medical Officers); the institution Directors of Nursing (which exist and
17 are currently under classified as Supervising Registered Nurses II and III); and, a Controller and
18 Chief of Support Operations (which currently do not exist but may be combined into a single
19 new position at each institution, depending on the results of the Receiver's careful, phased-in
20 pilot projects). Additional executive positions will be used in the regional offices and
21 Sacramento's Central Office.

22 C. The CDCR's Health Care Manager Qualifications Differ Substantially From What
23 Exists Outside State Service.

24 1. *Introduction.*

25 In making the recommendation to bring into the CDCR, using careful, time-phased pilot
26 projects, approximately 250 new clinical managers/executives, the Receiver emphasizes he
27 cannot continue to operate within the confines of the CDCR health care operation, if he is to
28

1 bring the massive California medical delivery system up to constitutional minima. The operation
2 is itself the product of decades of neglect and an unwritten CDCR policy of treating health care
3 staff as second hand citizens. As a result, the CDCR utilizes a clinical management structure
4 differing radically from that in the free community. To summarize, the existing health care
5 delivery system is plagued by widespread management deficiencies which serve to undermine the
6 efforts of the Receivership. These deficiencies have been allowed to take root during decades of
7 neglect because the CDCR and the State's control agencies have been content using health care
8 job classifications with minimum qualifications far lower than the complexities of its inmate
9 medical care system demand. A limited but illustrative set of examples are set forth below.

10 2. *Health Care Managers and Regional Administrative Officers.*

11 a. Prison Health Care Managers.

12 Each prison health care department is run by an individual designated as the Health Care
13 Manager. However, there is no civil service classification for this position. The clinicians who
14 serve in this capacity are not required to possess qualifications commensurate with the
15 responsibility foisted upon them by default, even though health care is a business and -- like
16 every other business -- it needs good management to keep it running appropriately.

17 Outside the CDCR, most medical system managers -- also referred to as *health care*
18 *executives* or *health care administrators* -- plan, direct, coordinate and supervise the delivery of
19 health care. Medical managers include specialists and generalists. Specialists are in charge of
20 specific clinical departments or services, while generalists manage or help manage an entire
21 facility or system. They must be familiar with management principles and practices. *See Exhibit*
22 *2, U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook at 1*
23 *and 3.*

24 A master's degree in health services administration, long-term care administration, health
25 sciences, public health, public administration or business administration is the standard credential
26 for most generalist positions in this field. *See Exhibit 2 at 3.* No parallel health care manager
27 classification exists within the CDCR. In fact, as explained above, the State routinely relies on
28

1 physicians rather than master's degree generalists to act as the health care manager which is the
2 highest level position directing all health care activity in an institution. For example, Chief
3 Medical Officers are called upon to act in this position even though, according to the minimum
4 qualifications established by the SPB, no supervisory or managerial experience is required to
5 become a Chief Medical Officer. *See* Exhibit 3 at 2, SPB Classification Specification.

6 b. Prison Correctional Health Services Administrators.

7 The CDCR also misuses those in the Correctional Health Services Administrator (CHSA)
8 classification by routinely assigning them as Regional Administrators to supervise health care
9 activities in multiple prisons. This is a gross deviation from the standards set forth in the SPB
10 class specification it states CHSA incumbents may supervise support, custodial and security
11 services only. *See* Exhibit 4 at 1, SPB Class Specification.

12 The only education requirement for CHSAs is a bachelor's degree in hospital
13 administration or a related field, or experience that may be substituted for the required education
14 on a year-for-year basis. *See* Exhibit 4 at 2. CHSAs may also avoid the education and
15 experience requirements by laterally transferring without examination from civil service
16 classifications. *See* California Government Code sections 18525.3 and 19050.4. For example,
17 among the currently employed CHSAs, there is a correctional sergeant and a computer
18 information analyst who transferred into the CHSA classification.

19 By way of comparison, a bachelor's degree outside State service is only considered
20 adequate for *some entry-level* generalist positions in smaller facilities, at the departmental level
21 within a health care organization, or in health information management. Graduates with
22 bachelor's degrees in health administration usually begin as administrative assistants or assistant
23 department heads in larger hospitals. They may also begin as department heads or assistant
24 administrators in small hospitals or nursing care facilities, however not in a system of more than
25 9,000 health care employees with a budget of approximately \$1.5 billion. *See* Exhibit 4 at 5.

1
2 4. *CDCR Health Care Management and Executive Positions Are Routinely Filled By*
3 *Lower Level Employees On An "Acting" Basis.*

4 The actual impact of utilizing staff not qualified to manage large components of the
5 CDCR medical delivery system, is far worse than can be determined by a review of job
6 descriptions and qualifications. For years the CDCR attempted to struggle through its day-to-day
7 operation with the widespread use of "acting assignments" where lower level employees perform
8 duties above their classification. Acting assignments may be for extended periods of time. This
9 common practice continues because (1) the State has failed to establish higher level
10 classifications when needed; (2) there has been an inability to recruit candidates with requisite
11 qualifications at the higher level; and, (3) to allow an original incumbent in the position to return
12 from his/her own "acting assignment" causing a domino-like bumping process that proceeds
13 backwards wreaking havoc so that bureaucratic rigors associated with removing managers from
14 actual appointments can be avoided. *See Exhibit 6.*

15 Three serious negative consequences flow from the State's overuse of acting assignments.
16 First, the upper levels of the management structure within the Central Office, regional offices and
17 institutions are composed of professionals who are sorely needed at lower organizational levels,
18 but not trained or qualified for "acting assignments." Second, the individuals themselves acquire
19 *de facto* promotions from within an utterly broken system offering little to prepare its candidates
20 to become executives. Not surprisingly, a significant number of diligent employees who agreed
21 to take "acting" executive assignments in CDCR health care have found themselves under attack
22 by Court experts, counsel and others as a reward for their efforts. Third, there is no continuity in
23 programming because programs are managed by transitional leaders.

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- 1 3. Key executive and managerial appointees must be non-tenured to combat
2 the complacency and indifference grown from the protection against removal
3 except for cause.

4 Unfortunately, portions of a limited number of California statutes prohibit the Receiver
5 from implementing a rational plan to appropriately staff for executive and managerial positions.
6 The following California statutes are:

- 7 1. Government Code section 18546 (defining “career executive” to mean an
8 employee appointed from a list of persons with permanent status in civil service).
9 2. Government Code section 18930 (insofar as it may be interpreted to prevent open
10 examinations for CEA positions).
11 3. Government Code section 18950 (insofar as it may be interpreted as authorizing
12 SPB to forbid open examinations for CEA positions).
13 4. Government Code section 19889 (insofar as it prevents the Department of
14 Personnel Administration (“DPA”) from designating positions as CEA when non-
15 CEA incumbents are presently in the positions³).
16 5. Government Code section 19889.3 (insofar as it limits competitive CEA
17 examinations and appointments to persons with permanent civil service status).

18 These statutes limit the State’s executive candidate pool to political appointees and
19 existing State employees. Because of this, the downward spiral which created the
20 unconstitutional medical care so prevalent in California’s prisons today will be impossible to turn
21 around. The Receiver cannot create constitutional conditions in California’s prisons without the
22 ability to hire highly educated and experienced health care executives and administrators. Under
23 existing California law, however, only State employees are entitled to be considered for the
24 executive and managerial positions deemed necessary by the Receiver. In a very real way, the
25 Receivership has come full circle with the very bureaucratic barriers and legal restrictions which

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27 ³ The Receiver anticipates Defendants proceeding with regard to incumbents as it ordinarily does
28 when it reorganizes.

1 created the need for the Receivership working to thwart the specifics of an essential element of
2 an adequate remedial plan.

3 B. California Law Freezes Executives In Place and Prevents The Employment of the
4 Person Best Qualified for Management Positions.

5 By this motion the Receiver does not seek to remove the CDCR from civil service. Nor
6 does the Receiver request permission to build a contingent of day-to-day clinical leaders outside
7 of State service. The very opposite is intended. By effectuating just one minor change to
8 California law, the best candidates will be recruited, hired, and retained as State employees in
9 leadership positions so desperately needed by the CDCR health care delivery system.

10 By waiving this limited portion of California law, an existing category of non-tenured
11 civil service appointments becomes available to the Receiver, as discussed in detail below.
12 Because these types of appointments are non-tenured it avoids the prospect of top level
13 bureaucrats - promoted from within a system condoning unconstitutional medical care - from
14 being frozen into policy influencing positions where they can afford to be indifferent to the
15 Receiver's objective.

16 C. The Receiver's Career Executive Assignment Non-Tenured Appointments.

17 To both: (1) remedy the lack of leadership which fostered the unconstitutional medical
18 delivery problems in California's prisons; and (2) to engage a remedy in the least intrusive
19 manner possible, the Receiver, through this motion, seeks to utilize broadband Receiver's Career
20 Executive Assignments ("RCEA"). In essence, this position will provide for non-tenured civil
21 service appointments.

22 Under California law, a Career Executive Assignment ("CEA") is an appointment to a
23 high level administrative and policy influencing position within civil service in which the
24 incumbent's primary responsibility is managing a major function or rendering management
25 advice to top-level administrative authority. CEAs are statutorily reserved to top managerial
26 levels and are typified by broad responsibility for policy implementation and extensive
27 participation in policy development. *See* Government Code sections 18546 and 18547. Such
28

1 appointments are the product of competitive examinations among applicants who meet the
2 qualifications for appointment established by the SPB. *See* Government Code section 19889.3.
3 CEA appointees do not, however, have any rights or status in their positions. *See* Government
4 Code sections 18547 and 19889.2. Under California law CEA assignments may therefore be
5 terminated for any reason or no reason provided it is not for an unlawful reason, i.e., age, sex,
6 race, disability, religion, political affiliation or political opinions. *See* Government Code section
7 19889.2; California Code of Regulations., Title 2, section 548.136.

8 The Receiver plans to appoint approximately 250 key executives and high ranking
9 managers using RCEAs. In so doing, he will utilize the critical elements of the California CEA
10 program. For example, the Receiver will mandate competitive examinations and require strict
11 position qualifications as part of his hiring process, as called for by California law. Likewise
12 RCEAs will be subject to termination under the same terms as California CEAs.⁴ The single
13 barrier to establishing the RCEA program is that, under California law, competition for CEA
14 positions is limited to those who have already attained permanent civil service status, and those
15 who are legislative employees or exempt political appointees. These statutes prevent the
16 Receiver from establishing management positions, with appropriately elevated qualifications,
17 which would result in the infusion of extraordinary talent from outside State service.

18 Consequently, the Receiver seeks the narrowest possible waiver to permit open
19 examinations for RCEA positions so the best qualified individuals from inside and outside State
20 service may be appointed into managerial positions.

21 D. Other Alternatives Are Either Not Adequate Or More Intrusive.

22 As explained above, the State does not have a pool of 250 competent health care
23 executives and managers available to the Receiver through the State's CEA appointment process,
24 nor does the Receiver have authority, under California law, to appoint RCEAs from outside state

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26 ⁴ RCEAs who promote from within civil service will have mandatory return rights to a regular
27 civil service position. (*See* Government Code section 19889.3) RCEAs hired from outside State
28 service will not have this right. They have no prior permanent status as a State employee. RCEAs
hired from outside State service will be terminated in the event they fail to meet job expectations.

1 service. Without question, bringing in talent from outside a system, which created the need for a
2 Receivership, will be needed to implement the remedial process that will, over time, end the
3 Receivership.

4 California law permits contracting for services when administrative or legal goals cannot
5 be accomplished through the utilization of persons selected pursuant to the regular civil service
6 system. *See* Government Code section 19130(b). However, hiring civil service RCEAs rather
7 than contracting out is far less intrusive and establishes a foundation to end the Receivership
8 earlier and more efficiently. The Receiver will leave Defendants with the capacity and leadership
9 to maintain a system that provides constitutionally adequate medical care. Using
10 RCEAs will also protect the ability for qualified civil servants to compete for these positions
11 without being forced to leave State service and sacrificing their benefits in order to become a
12 contractor.

13 E. In Making This Motion, The Receiver Only Seeks the Same for the General
14 Public That Is Already Available to Political Appointees and the DMV.

15 The Receiver notes that permitting those who are not already permanent civil service
16 employees to compete in CEA examinations is not novel to the State of California. For example,
17 legislative employees and exempt political employees who are not civil servants may already
18 compete in CEA examinations. *See* Government Code sections 18990 and 18992. Furthermore,
19 the SPB has promulgated a regulation establishing a demonstration project permitting the DMV
20 to conduct competitive examinations for CEA appointments open to all persons meeting specific
21 qualifications. *See* California Code of Regulations, Title 2, section 549.80. Certainly, the health
22 care delivery crisis in California's prisons warrants a similar exception to California's CEA
23 statutes as the public policy behind allowing exceptions for employees of the California
24 legislature, political employees and the DMV.

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VI.

**THE RECEIVER'S EFFORTS TO IMPLEMENT THE PROPOSED
REMEDY PRIOR TO SEEKING A WAIVER OF STATE LAW**

The Receiver and his staff devoted several months to a series of meetings, discussions and exchange of letters concerning the RCEA issue. For example, the Receiver discussed this program in face-to-face meetings with both the Governor and the SPB. John Hagar, Chief of Staff and Linda Buzzini, Staff Attorney met on numerous occasions with the SPB Executive Officer and SPB Counsel. Ms. Buzzini also conferred with DPA concerning both the salary range and retirement aspects of the RCEA program.

At the conclusion of this process the Receiver reports to the Court as follows:

1. No State official takes the position the leadership crisis, within the CDCR's medical care delivery system can be solved utilizing existing California statutes, regulations, rules and policies.
2. Some State officials expressed private approval of this project. Many noted that proposals, which combine an infusion of "best person qualified" new blood into the State's executive workforce, the recruitment advantages conferred by State benefits, and the increased productivity, loyalty and dedication gained by the ability to terminate RCEAs for any reason, or no reason provided it is not for an unlawful reason, present the opportunity for treating the RCEA as a pilot project to evaluate for additional agency roll-outs.
3. The Receiver believes it appropriate, at least as he begins the process to implement 250 RCEA positions, to work closely with SPB concerning the competitive examination requirements and with DPA concerning the need to establish competitive levels and broadband salary ranges for the RCEAs.⁵ Given the

⁵ For example, the Receiver will conduct salary surveys and present empirical data to DPA in anticipation of DPA adopting and implementing these salaries.

1 cooperation promised by these agencies, the Receiver does not seek additional Court
2 orders concerning these issues at this time.

- 3 4. Two concerns have been raised by State officials concerning the establishment of
4 250 RCEA positions.

5 a. *Pension "Spiking"*: State officials express concern that State employees will seek
6 to promote into Receiver executive assignments for only one year in order to 'spike'
7 their pension, similar to the issue raised by the Department of Finance (DOF) in
8 response to the Receiver's Motion for Waiver of State Law filed September 12,
9 2006. While the "spiking" concern is legitimate in theory, it should not bar the
10 Receiver from going forward with his hiring for three reasons. First, there is little
11 indication that a significant number of State employees are interested in or qualified
12 for the RCEA positions. Second, the State reports it can manage the pension issue
13 administratively, for example, establish criteria that requires three years of service as
14 an RCEA to realize the full salary credit for purposes of calculating retirement
15 benefits.⁶ Third, the Receiver's purpose in establishing 250 RCEA positions is to
16 stop unnecessary death in California's prisons. Given this, the Receiver will make
17 all reasonable efforts to screen such person out during the application and hiring
18 process. As noted by the Court concerning the DOF's prior objections concerning
19 salary increases, if the State is truly concerned, this issue is of sufficient magnitude
20 to justify some type of intervention, it can seek a legislative remedy. *See Order Re*
21 *Receiver's Motion For a Waiver of State Law filed October 17, 2006*, at 13, fn. 7.

22 b. *Executive Migration to The CDCR*: Similar to the objections raised concerning
23 the salary waiver, objections that did not prove to be true in reality, certain State
24 officials express concern that significant numbers of State executives will abandon
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26 ⁶ The Receiver does not oppose this concept provided State officials (1) implement it without
27 delaying his ability to recruit, examine and appoint executives; and, (2) they abide by any relevant
28 requirements, including, e.g. the Dills Act and Excluded Employee Bill of Rights.

1 officials express concern that significant numbers of State executives will abandon
2 their current positions and opt-out for the CDCR RCEA positions. Again, the
3 Receiver believes very few current State employees have the qualifications he seeks.
4 Again, the same issue was raised by the DOF in response to his Motion for Waiver
5 of State Law filed September 12, 2006. In response, the Court held it “can not
6 subjugate its obligations to remedy constitutional violations – violations that involve,
7 in this instance, issues of life and death – because of speculative impacts on other
8 agencies not under court order.” The Court also stated “if this becomes a serious
9 concern the Department of Finance can work with the legislature to address this
10 broader government issue.” *Order Re Receiver’s Motion For Waiver of State Law*
11 *filed October 17, 2006*, at 13 fn. 7.

12 As above, however, the Receiver and his staff are prepared to meet upon request
13 with State officials for purposes of attempting to mitigate or eliminate non-speculative harm to
14 other State agencies and programs.

15 VII.

16 ORDERS REQUESTED

17 Based on all of the above, the Receiver requests that the Court:

18 A. Order the Receiver to commence the design and establish a program to hire and retain
19 250 Receiver Career Executive Assignment appointees no later than May 15, 2007.

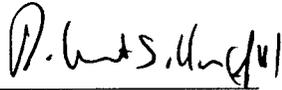
20 B. Issue an Order waiving, for the purpose of establishing a program to hire and retain
21 250 Receiver Career Executive Assignment appointees only, the following California statutes:

- 22 1. Government Code section 18546 (defining “career executive” to mean an
23 employee appointed from a list of persons with permanent status in civil
24 service).
 - 25 2. Government Code section 18930 (insofar as it may be interpreted to prevent
26 open examinations for CEA positions).
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- 1 3. Government Code section 18950 (insofar as it may be interpreted as
2 authorizing SPB to forbid open examinations for CEA positions).
3 4. Government Code section 19889 (insofar as it prevents DPA from designating
4 positions as CEA when non-CEA incumbents are presently in the positions⁷).
5 5. Government Code section 19889.3 (insofar as it limits competitive CEA
6 examinations and appointments to persons with permanent civil service
7 status).

8 Dated: April 17, 2007

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10 Respectfully submitted:

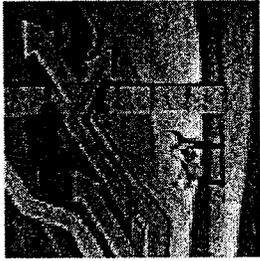
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13 Robert Sillen
14 Receiver

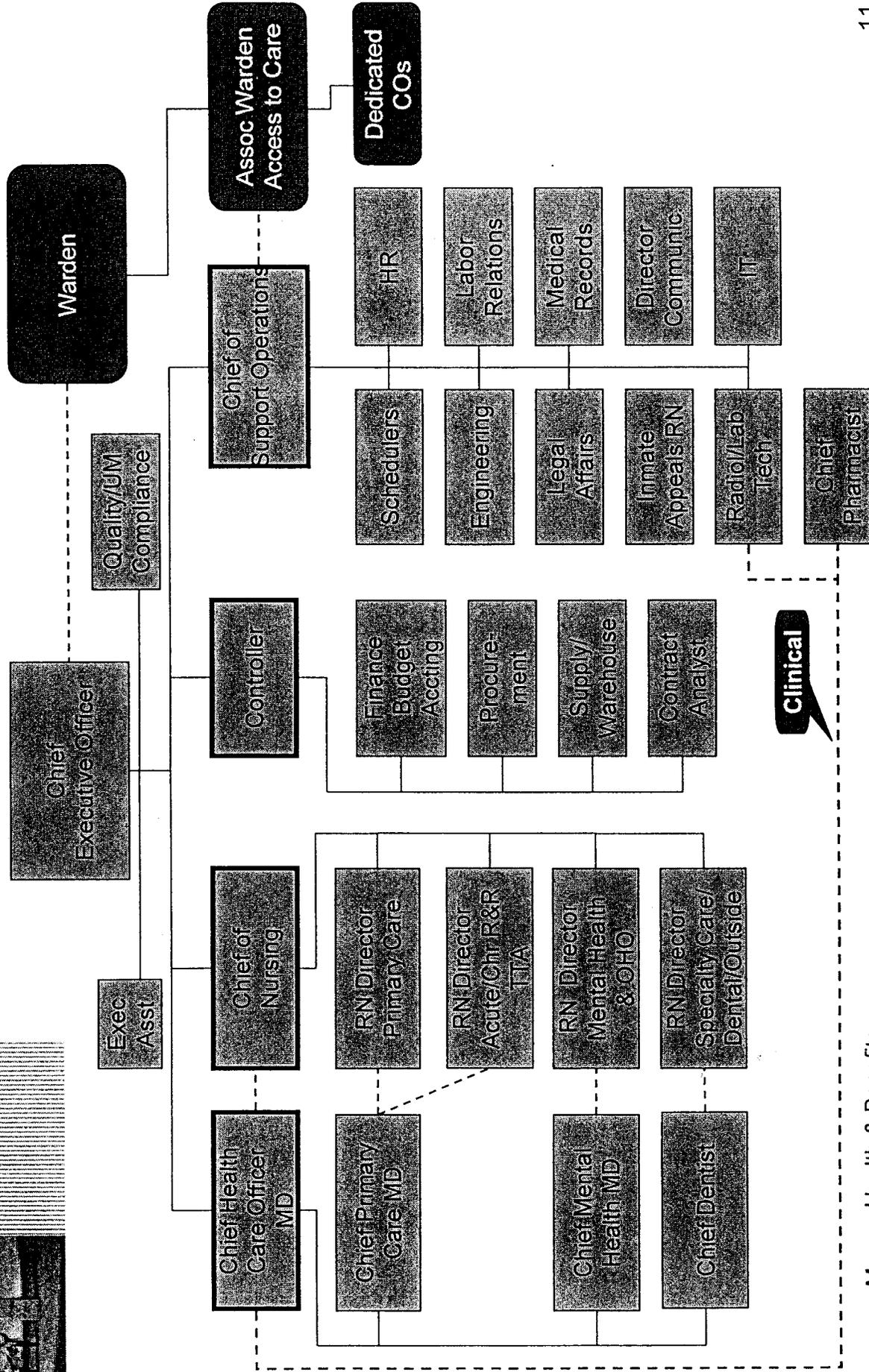
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27 ⁷ The Receiver anticipates Defendants proceeding with regard to incumbents as it ordinarily does
when it reorganizes.

**Motion for Waiver of State Law
Re Receiver Career Executive
Assignment Position**

EXHIBIT 1



Recommended Organizational Structure



Mercer Health & Benefits

**Motion for Waiver of State Law
Re Receiver Career Executive
Assignment Position**

EXHIBIT 2



**U.S. Department
of Labor**
**Bureau of Labor
Statistics**

Occupational Outlook Handbook



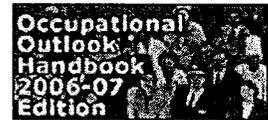
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Medical and Health Services Managers

- [Nature of the Work](#)
- [Working Conditions](#)
- [Training, Other Qualifications, and Advancement](#)
- [Employment](#)
- [Job Outlook](#)
- [Earnings](#)
- [Related Occupations](#)
- [Sources of Additional Information](#)

SIGNIFICANT POINTS

- Rapid employment growth is projected; job opportunities will be especially good in offices of health practitioners, general medical and surgical hospitals, home health care services, and outpatient care centers.
- Applicants with work experience in health care and strong business and management skills likely will have the best opportunities.
- Earnings are high, but long work hours are common.
- A master's degree is the standard credential for most positions, although a bachelor's degree is adequate for some entry-level positions in smaller facilities and in health information management.

NATURE OF THE WORK

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Health care is a business and, like every other business, it needs good management to keep it running smoothly. Medical and health services managers, also referred to as *health care executives* or *health care administrators*, plan, direct, coordinate, and supervise the delivery of health care. Medical and health services managers include specialists and generalists. Specialists are in charge of specific clinical departments or services, while generalists manage or help manage an entire facility or system.

Occupations:

- [Management](#)
- [Professional Service](#)
- [Sales](#)
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- [Farming](#)
- [Construction](#)
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The structure and financing of health care are changing rapidly. Future medical and health services managers must be prepared to deal with evolving integrated health care delivery systems, technological innovations, an increasingly complex regulatory environment, restructuring of work, and an increased focus on preventive care. They will be called on to improve efficiency in health care facilities and the quality of the health care provided. Increasingly, medical and health services managers will work in organizations in which they must optimize efficiency of a variety of related services—for example, those ranging from inpatient care to outpatient followup care.

Large facilities usually have several assistant administrators to aid the top administrator and to handle daily decisions. Assistant administrators may direct activities in clinical areas such as nursing, surgery, therapy, medical records, or health information. (Managers in nonhealth areas, such as **administrative services, computer and information systems, finance, and human resources**, are not included in this statement. For information about them, see the statements on management occupations elsewhere in the *Handbook*.)

In smaller facilities, top administrators handle more of the details of daily operations. For example, many nursing home administrators manage personnel, finances, facility operations, and admissions and also have a larger role in resident care.

Clinical managers have training or experience in a specific clinical area and, accordingly, have more specific responsibilities than do generalists. For example, directors of physical therapy are experienced physical therapists, and most health information and medical record administrators have a bachelor's degree in health information or medical record administration. Clinical managers establish and implement policies, objectives, and procedures for their departments; evaluate personnel and work; develop reports and budgets; and coordinate activities with other managers.

Health information managers are responsible for the maintenance and security of all patient records. Recent regulations enacted by the Federal Government require that all health care providers maintain electronic patient records and that these records be secure. As a result, health information managers must keep up with current computer and software technology and with legislative requirements and developments. In addition, as patient data become more frequently used for quality management and in medical research, health information managers ensure that databases are complete, accurate, and available only to authorized personnel.

In group medical practices, managers work closely with physicians. Whereas an office manager might handle business affairs in small medical groups, leaving policy decisions to the physicians

themselves, larger groups usually employ a full-time administrator to help formulate business strategies and coordinate day-to-day business.

A small group of 10 to 15 physicians might employ 1 administrator to oversee personnel matters, billing and collection, budgeting, planning, equipment outlays, and patient flow. A large practice of 40 to 50 physicians might have a chief administrator and several assistants, each responsible for different areas.

Medical and health services managers in managed care settings perform functions similar to those of their counterparts in large group practices, except that they could have larger staffs to manage. In addition, they might do more community outreach and preventive care than do managers of a group practice.

Some medical and health services managers oversee the activities of a number of facilities in health systems. Such systems might contain both inpatient and outpatient facilities and offer a wide range of patient services.

WORKING CONDITIONS

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Most medical and health services managers work long hours. Facilities such as nursing care facilities and hospitals operate around the clock, and administrators and managers may be called at all hours to deal with problems. They also may travel to attend meetings or inspect satellite facilities.

Some managers work in comfortable, private offices; others share space with other managers or staff. They may spend considerable time walking, to consult with coworkers.

TRAINING, OTHER QUALIFICATIONS, AND ADVANCEMENT

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Medical and health services managers must be familiar with management principles and practices. A master's degree in health services administration, long-term care administration, health sciences, public health, public administration, or business administration is the standard credential for most generalist positions in this field. However, a bachelor's degree is adequate for some entry-level positions in smaller facilities, at the departmental level within health care organizations, and in health information management. Physicians' offices and some other facilities may

substitute on-the-job experience for formal education.

Bachelor's, master's, and doctoral degree programs in health administration are offered by colleges; universities; and schools of public health, medicine, allied health, public administration, and business administration. In 2005, 70 schools had accredited programs leading to the master's degree in health services administration, according to the Commission on Accreditation of Healthcare Management Education.

For persons seeking to become heads of clinical departments, a degree in the appropriate field and work experience may be sufficient early in their career. However, a master's degree in health services administration or a related field might be required to advance. For example, nursing service administrators usually are chosen from among supervisory registered nurses with administrative abilities and graduate degrees in nursing or health services administration.

Health information managers require a bachelor's degree from an accredited program and a Registered Health Information Administrator (RHIA) certification from the American Health Information Management Association. In 2005, there were 45 accredited bachelor's programs in health information management according to the Commission on Accreditation for Health Informatics and Information Management Education.

Some graduate programs seek students with undergraduate degrees in business or health administration; however, many graduate programs prefer students with a liberal arts or health profession background. Candidates with previous work experience in health care also may have an advantage. Competition for entry into these programs is keen, and applicants need above-average grades to gain admission. Graduate programs usually last between 2 and 3 years. They may include up to 1 year of supervised administrative experience and coursework in areas such as hospital organization and management, marketing, accounting and budgeting, human resources administration, strategic planning, law and ethics, biostatistics or epidemiology, health economics, and health information systems. Some programs allow students to specialize in one type of facility—hospitals, nursing care facilities, mental health facilities, or medical groups. Other programs encourage a generalist approach to health administration education.

New graduates with master's degrees in health services administration may start as department managers or as staff. The level of the starting position varies with the experience of the applicant and the size of the organization. Hospitals and other health facilities offer postgraduate residencies and fellowships, which usually are staff positions. Graduates from master's degree programs also take jobs in large medical group practices, clinics, mental health facilities, nursing care corporations, and consulting

firms.

Graduates with bachelor's degrees in health administration usually begin as administrative assistants or assistant department heads in larger hospitals. They also may begin as department heads or assistant administrators in small hospitals or nursing care facilities.

All States and the District of Columbia require nursing care facility administrators to have a bachelor's degree, pass a licensing examination, complete a State-approved training program, and pursue continuing education. Some States also require licenses for administrators in assisted living facilities. A license is not required in other areas of medical and health services management.

Medical and health services managers often are responsible for millions of dollars' worth of facilities and equipment and hundreds of employees. To make effective decisions, they need to be open to different opinions and good at analyzing contradictory information. They must understand finance and information systems and be able to interpret data. Motivating others to implement their decisions requires strong leadership abilities. Tact, diplomacy, flexibility, and communication skills are essential because medical and health services managers spend most of their time interacting with others.

Medical and health services managers advance by moving into more responsible and higher paying positions, such as assistant or associate administrator, department head, or CEO, or by moving to larger facilities. Some experienced managers also may become consultants or professors of health care management.

EMPLOYMENT

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Medical and health services managers held about 248,000 jobs in 2004. About 30 percent worked in private hospitals, and another 16 percent worked in offices of physicians or in nursing care facilities. The remainder worked mostly in home health care services, Federal Government health care facilities, ambulatory facilities run by State and local governments, outpatient care centers, insurance carriers, and community care facilities for the elderly.

JOB OUTLOOK

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Employment of medical and health services managers is expected to **grow faster than average** for all occupations through 2014, as the health care industry continues to expand and diversify. Job opportunities will be especially good in offices of health

practitioners, general medical and surgical hospitals, home health care services, and outpatient care centers. Applicants with work experience in the health care field and strong business and management skills should have the best opportunities. Competition for jobs at the highest management levels will be keen because of the high pay and prestige.

Managers in all settings will be needed to improve quality and efficiency of health care while controlling costs, as insurance companies and Medicare demand higher levels of accountability. Managers also will be needed to computerize patient records and to ensure their security as required by law. Additional demand for managers will stem from the need to recruit workers and increase employee retention, to comply with changing regulations, to implement new technology, and to help improve the health of their communities by emphasizing preventive care.

Hospitals will continue to employ the most medical and health services managers over the 2004-14 projection period. However, the number of new jobs created is expected to increase at a slower rate in hospitals than in many other industries because of the growing utilization of clinics and other outpatient care sites. Despite relatively slow employment growth, a large number of new jobs will be created because of the industry's large size. Medical and health services managers with experience in large facilities will enjoy the best job opportunities, as hospitals become larger and more complex.

Employment will grow fastest in practitioners' offices and in home health care agencies. Many services previously provided in hospitals will continue to shift to these sectors, especially as medical technologies improve. Demand in medical group practice management will grow as medical group practices become larger and more complex. Managers with specialized experience in a particular field, such as reimbursement, should have good opportunities.

Medical and health services managers also will be employed by health care management companies that provide management services to hospitals and other organizations, as well as to specific departments such as emergency, information management systems, managed care contract negotiations, and physician recruiting.

EARNINGS

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Median annual earnings of medical and health services managers were \$67,430 in May 2004. The middle 50 percent earned between \$52,530 and \$88,210. The lowest 10 percent earned less than \$41,450, and the highest 10 percent earned more than \$117,990. Median annual earnings in the industries employing the largest

numbers of medical and health services managers in May 2004 were as follows:

Federal Government	\$87,200
General medical and surgical hospitals	71,280
Offices of physicians	61,320
Nursing care facilities	60,940
Home health care services	60,320

Earnings of medical and health services managers vary by type and size of the facility, as well as by level of responsibility. For example, the Medical Group Management Association reported that, in 2004, median salaries for administrators were \$72,875 in practices with 6 or fewer physicians, \$95,766 in practices with 7 to 25 physicians, and \$132,955 in practices with 26 or more physicians.

According to a survey by *Modern Healthcare* magazine, median annual compensation in 2004 for hospital administrators of selected clinical departments was \$76,800 in respiratory care, \$81,100 in physical therapy, \$87,700 in home health care, \$88,800 in laboratory services, \$90,200 in long-term care, \$93,500 in medical imaging/diagnostic radiology, \$94,400 in rehabilitation services, \$95,200 in cancer treatment facilities, \$96,200 in cardiology, \$102,800 in nursing services, and \$113,200 in pharmacies. Salaries also varied according to size of facility and geographic region.

According to a survey by the Professional Association of Health Care Office Management, total 2004 median compensation for office managers in specialty physicians' practices was \$72,047 in gastroenterology, \$66,946 in dermatology, \$66,207 in cardiology, \$64,543 in ophthalmology, \$63,801 in obstetrics and gynecology, \$62,545 in orthopedics, \$58,595 in pediatrics, \$52,211 in internal medicine, \$50,924 in psychiatry, and \$50,049 in family practice.

RELATED OCCUPATIONS

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Medical and health services managers have training or experience in both health and management. Other occupations requiring knowledge of both fields are **insurance underwriters** and **social and community service managers**.

SOURCES OF ADDITIONAL INFORMATION

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DISCLAIMER:

Links to non-BLS Internet sites are provided for your convenience and do not constitute an endorsement.

Information about undergraduate and graduate academic programs in this field is available from:

- Association of University Programs in Health Administration, 2000 North 14th St., Suite 780, Arlington, VA 22201. Internet: <http://www.aupha.org>

For a list of accredited graduate programs in medical and health services administration, contact:

- Commission on Accreditation of Healthcare Management Education, 2000 North 14th St., Suite 780, Arlington, VA 22201. Internet: <http://www.cahmeweb.org>

For information about career opportunities in health care management, contact:

- American College of Healthcare Executives, One N. Franklin St., Suite 1700, Chicago, IL 60606-4425. Internet: <http://www.healthmanagementcareers.org>

For information about career opportunities in long-term care administration, contact:

- American College of Health Care Administrators, 300 N. Lee St., Suite 301, Alexandria, VA 22314. Internet: <http://www.achca.org>

For information about career opportunities in medical group practices and ambulatory care management, contact:

- Medical Group Management Association, 104 Inverness Terrace East, Englewood, CO 80112-5306. Internet: <http://www.mgma.org>

For information about medical and health care office managers, contact:

- Professional Association of Health Care Office Management, 461 East Ten Mile Rd., Pensacola, FL 32534-9712.

For information about career opportunities in health information management, contact:

- American Health Information Management Association, 233 N. Michigan Ave., Suite 2150, Chicago, IL 60601-5800. Internet:

<http://www.ahima.org>

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**Motion for Waiver of State Law
Re Receiver Career Executive
Assignment Position**

EXHIBIT 3

SPEC: CHIEF MEDICAL OFFICER, CORRECTIONAL FACILITY
CALIFORNIA STATE PERSONNEL BOARD

SPECIFICATION

Schematic Code: SB10
Class Code: 7547
Established: 2/23/45
Revised: 6/15/93
Title Changed: 6/15/93

CHIEF MEDICAL OFFICER, CORRECTIONAL FACILITY

DEFINITION

Under general direction, in a State correctional facility in the Department of Corrections or the Department of the Youth Authority, to plan, organize, and direct the medical, psychiatric, dental, and clinical services in the care and treatment of individuals housed in a State correctional facility; to perform medical and surgical work; to maintain order and supervise the conduct of inmates or youthful offenders; to protect and maintain the safety of persons and property; and to do other related work.

TYPICAL TASKS

Plans and assigns work, gives instructions, and passes upon difficult medical problems in directing the staff engaged in treating and caring for ward or inmate patients; directs and assists with the medical, psychiatric, and clinical work of the institution; supervises admissions, assigns cases to physicians, checks case histories and progress, and selects patients for discharge from inpatient settings; directs transfer of patients between institutions and outside medical facilities; examines, diagnoses, prescribes, and administers treatment to youthful offenders or inmates; performs major or minor surgery and supervises the postoperative care of patients; makes rounds, checks reports and charts, and diagnoses cases and prescribes medical and surgical treatment; directs the clinical and pathological work and orders examinations and analyses, X-rays, dental work, special diets, and medications; conducts staff conferences and instructs staff in modern techniques and methods; outlines instructions for nurses and attendants in the care of patients; confers with institution administrators on work plans and establishes improved methods, forms, and procedures; requisitions food for hospital diets, drugs, medications, and medical supplies and equipment; supervises the keeping of records and special case histories; prepares reports and dictates correspondence; maintains order and supervises the conduct of persons committed to the California Department of Corrections or the Department of the Youth Authority; prevents escapes and injury by these persons to themselves, others or to property; maintains security of working areas and work materials; inspects premises and searches inmates or youthful offenders for contraband, such as weapons or illegal drugs.

MINIMUM QUALIFICATIONS

Possession of the legal requirements for the practice of medicine in California as determined by the Medical Board of California or the California Board of Osteopathic Examiners. (Applicants who are in the process of securing approval of their qualifications by the Medical Board of California or the Board of Osteopathic Examiners will be admitted to the examination, but the Board to which application is made must determine that all legal requirements have been met before candidates will be eligible for appointment.)

and

Either I

Two years of experience performing the duties of a Physician and Surgeon or Staff Psychiatrist in a California state correctional facility.

Or II

Four years of experience in the practice of medicine, including one year's practice in a hospital or correctional institution.

KNOWLEDGE AND ABILITIES

Knowledge of: Modern principles and practices of general medicine and surgery and skill in their application; modern hospital administration and management; principles and techniques used in the diagnosis and treatment of mental diseases; principles and practices of personnel management and effective supervision; Department's Affirmative Action Program objectives; a manager's role in the Affirmative Action Program and the processes available to meet affirmative action objectives.

Ability to: Plan and direct the medical, surgical, dental, and psychiatric activities in an institution and instruct nurses in routine procedures; diagnose and treat a wide variety of diseases and injuries; prepare and supervise the preparation of case histories and the keeping of hospital records; prepare comprehensive medical reports; analyze situations accurately and adopt an effective course of action; communicate effectively; effectively contribute to the Department's affirmative action objectives.

SPECIAL PERSONAL CHARACTERISTICS

Empathetic understanding of patients of a State correctional facility; willingness to work in a State correctional facility; emotional stability; patience; tact; alertness; and keenness of observation.

SPECIAL PHYSICAL CHARACTERISTICS

Persons appointed to this position must be reasonably expected to have and maintain sufficient strength, agility and endurance to perform during stressful (physical, mental and emotional) situations encountered on the job without compromising their health and well-being or that of their fellow employees or that of inmates or youthful offenders.

Assignments may include sole responsibility for the supervision of

inmates or youthful offenders and/or the protection of personal and real property.

**Motion for Waiver of State Law
Re Receiver Career Executive
Assignment Position**

EXHIBIT 4

SPEC: CORRECTIONAL HEALTH SERVICES ADMINISTRATOR, CORRECTIONAL FACILITY
CALIFORNIA STATE PERSONNEL BOARD

SPECIFICATION

CORRECTIONAL HEALTH SERVICES ADMINISTRATOR,
CORRECTIONAL FACILITY
Series Specification
(Established November 4, 1982)

SCOPE

Classes in this series are used in the Department of Corrections to plan, organize, and direct the health services support, custodial and security services of a health care program in a State correctional facility to include a hospital operation and related health services; in conjunction with the medical administrators to formulate overall policy for health care operations at the facility; to supervise and independently perform administrative duties for the health care program; to maintain order and supervise the conduct of inmates; to protect and maintain the safety of persons and property; and to do other related work.

Schem Code	Class Code	Class
KE55	4910	Correctional Health Services Administrator I, Correctional Facility
KE50	4912	Correctional Health Services Administrator II, Correctional Facility

FACTORS AFFECTING POSITION ALLOCATION

Scope of administrative responsibility, complexity of work, independence of action and decision making, degree of supervision received and exercised, and the scope, size, and complexity of the various hospital and health services programs in a State correctional facility.

DEFINITION OF SERIES

A Correctional Health Services Administrator, under administrative direction of a top medical administrator or nonmedical Correctional Chief Deputy or Warden, plans, organizes, and directs all health services support, custodial and security services and administrative activities of the hospital, psychiatric and dental program which typically include nursing, pharmacy, X-ray, clinical laboratory, dietary, supply, housekeeping, rehabilitation services and medical records and such administrative responsibilities as fiscal and contract management, recruitment and administrative assistance; plans, implements, and directs the health services, inmate custody and security program; reviews, evaluates, and develops policies and procedures which will provide effective and expeditious delivery of clinical care and health-related services to promote optimum achievement of program goals and objectives; consults with medical

treatment specialists on long-range and short-range program alternatives in order to improve efficiency and anticipate program support needs while taking into consideration security needs; works closely with the institution's Business Manager in preparing the hospital and health services budget; evaluates the budgetary needs of the various hospital program services, exercises expenditure controls, and initiates budget transfer requests to assure full utilization of resources in developing building and constructing plans to meet long-range hospital program needs; coordinates community self-help programs with the institution's Community Resources Manager; promotes favorable public relations; assures efficient management; participates in the recruiting, selecting and training of health services support staff and evaluates their performance; conducts studies, gathers data, and prepares reports; maintains order and supervises the conduct of persons committed to the Department of Corrections; prevents escapes and injury by these persons to themselves or others on the property; maintains security of working areas and working materials; inspects premises and searches inmates for contraband, such as weapons or illegal drugs.

DEFINITION OF LEVELS

CORRECTIONAL HEALTH SERVICES ADMINISTRATOR I, CORRECTIONAL FACILITY

This level, under general administrative direction, has overall medical support services and administrative responsibility for a medium-sized health care program to include hospital, psychiatric, and dental services in a State correctional facility, such as the California Institution for Men and the California Men's Colony.

CORRECTIONAL HEALTH SERVICES ADMINISTRATOR II, CORRECTIONAL FACILITY

This level, under general administrative direction, has overall medical support services and administrative responsibility for a large and complex health care program to include hospital, psychiatric, and dental services in a State correctional facility, such as the California Medical Facility.

MINIMUM QUALIFICATIONS

CORRECTIONAL HEALTH SERVICES ADMINISTRATOR I, CORRECTIONAL FACILITY

Either I

One year of experience in the California state service in a major hospital administrative or management function, performing medical support services duties at least comparable in level of responsibility to those of Hospital General Services Administrator II, Supervising Nurse III, Pharmacist II, or Hospital Administrative Resident III.

Or II

Experience: Three years of progressively responsible experience in medical health care administration which must have included at least two years with responsibility for directing two or more administrative management and support services comparable to those found in a large hospital such as nursing, pharmacy, dietary, rehabilitation, laboratory, or administrative studies. (A post-Baccalaureate Degree in Hospital Administration or in a closely related field may be

substituted for one year of experience.)

(Experience in the California state service applied to this requirement must be of at least the level, duration, and type specified in Pattern I above.)

and

Education: Equivalent to graduation from college with a major in hospital administration or in a related field. (Additional qualifying experience may be substituted for the required education on a year-for-year basis.)

CORRECTIONAL HEALTH SERVICES ADMINISTRATOR II, CORRECTIONAL FACILITY

Either I

One year of experience in the California state service in a major hospital administrative or management function performing medical support services duties of a class at least comparable in level of responsibility to those of Hospital Administrative Resident IV.

Or II

Two years of experience in the California state service performing duties in a major hospital administrative or management function performing medical support services duties at least comparable in level of responsibility to those of Hospital General Services Administrator II, Supervising Nurse III, Pharmacist II, or Hospital Administrative Resident III.

Or III

Experience: Four years of progressively responsible experience in medical health care administration which must have included at least three years of experience with responsibility for directing two or more administrative management and support services comparable to those found in a large hospital such as nursing, pharmacy, dietary, rehabilitation, laboratory, or administrative studies. (A post-Baccalaureate Degree in Hospital Administration or in a closely related field may be substituted for one year of experience.)

(Experience in the California state service applied toward this requirement must be at least the level, duration, and type specified in Patterns I and II above.) and

Education: Equivalent to graduation from college with a major in hospital administration or in a related field. (Additional qualifying experience maybe substituted for the required education on a year-for-year basis.)

KNOWLEDGE AND ABILITIES

ALL LEVELS:

Knowledge of: Principles and practices of organization, supervision and management; problems involved in administrative health services support programs of a hospital; program development and evaluation techniques; objectives of the treatment programs of a hospital; the Department's Affirmative Action Program objectives; a manager's role in the Affirmative Action Program and the processes available to meet affirmative action objectives.

Ability to: Plan, organize, direct, and evaluate health services

support and programs to meet treatment needs of the hospital, psychiatric, and dental program in a correctional facility; establish and maintain effective working relationships with medical and psychiatric professional staff and with others; collect and analyze data and make administrative studies and prepare clear, concise and comprehensive reports; analyze situations accurately and take effective action; supervise, train and motivate staff to achieve maximum effectiveness; communicate effectively; and effectively contribute to the Department's affirmative action objectives.

SPECIAL PERSONAL CHARACTERISTICS

ALL LEVELS:

Demonstrated leadership ability and objective understanding of the problems of the California Department of Corrections; empathetic understanding of patients of a State correctional facility; willingness to work in a State correctional facility; alertness; keenness of observation; tact, patience, and emotional stability; willingness to accept and effectively carry out administrative responsibility.

SPECIAL PHYSICAL CHARACTERISTICS

ALL LEVELS:

Persons appointed to positions in this class must be reasonably expected to have and maintain sufficient strength, agility, and endurance to perform during stressful (physical, mental, and emotional) situations encountered on the job without compromising their health and well-being or that of their fellow employees or that of inmates.

Assignments may include sole responsibility for the supervision of inmates and/or the protection of personal and real property.

CLASS HISTORY

Class	Date Established	Date Revised	Title Changed
Correctional Health Services Administrator I, Correctional Facility	6/15/93	--	--
Correctional Health Services Administrator II, Correctional Facility	6/15/93	--	--

**Motion for Waiver of State Law
Re Receiver Career Executive
Assignment Position**

EXHIBIT 5

SPEC: SUPERVISING REGISTERED NURSE, CORRECTIONAL FACILITY, SERIES
CALIFORNIA STATE PERSONNEL BOARD

SPECIFICATION

SUPERVISING REGISTERED NURSE, CORRECTIONAL FACILITY
Series Specification
(Established June 15, 1993)

SCOPE

This series specification describes three professional Supervising Registered Nurse classes in the Department of Corrections and the Department of the Youth Authority that supervise nursing services in State correctional facilities and do other related work. All classes in this series are responsible to maintain order and supervise the conduct of inmates or youthful offenders and maintain the safety of persons and property; to prevent escapes of and injury by persons committed to the Department of Corrections and the Youth Authority to themselves or others or to property; to maintain security of working areas and work materials; and to inspect premises and search inmates or youthful offenders for contraband, such as weapons or illegal drugs.

Schem Code	Class Code	Class
TI74	9317	Supervising Registered Nurse I, Correctional Facility
TI76	9318	Supervising Registered Nurse II, Correctional Facility
TI77	9319	Supervising Registered Nurse III, Correctional Facility

DEFINITION OF SERIES

The Supervising Registered Nurse series describes three classes that supervise the professional nursing services in a State correctional facility. The incumbent at each level plans, organizes, and directs the overall nursing services operations for a State correctional facility; plans, assigns, and directs the work of nursing staff; ensures nursing duties are assigned within the scope of the Nurse Practice Act; ensures the qualifications and current licensure of nursing staff on an on-going basis; ensures sufficient number of qualified nursing staff are on duty to provide adequate patient care; ensures the provision of quality nursing care including audits and quality reviews; develops and implements nursing services policies and procedures; participates in the recruitment of nursing staff; coordinates the nursing services with the work of other departments within the institution; assesses training needs and plans and conducts in-service training programs for nursing staff; collaborates with physicians and other health care providers; conducts hiring interviews, makes hiring selections, and evaluates the performance of nursing staff; prepares performance evaluations and takes or recommends appropriate actions; is responsible for infection control, safety, and cleanliness in Nursing Services area; reviews records and reports prepared by nursing staff for accuracy, timeliness, and

completeness; serves on appropriate health care committees and other institutional committees; participates in the development of the health services' and institution's budget; maintains and prepares other records and reports; inventories and procures medical supplies and equipment; and plans and conducts nursing staff committees.

DEFINITION OF LEVELS

SUPERVISING REGISTERED NURSE I, CORRECTIONAL FACILITY

This is the working supervisory level in the series. Incumbent, in a correctional facility, either (1) directs nursing services in out-patient programs; or (2) directs nursing services as a shift supervisor in a licensed inpatient care facility other than a general acute care hospital; or (3) directs nursing services as a unit nursing supervisor in a licensed general acute care hospital.

SUPERVISING REGISTERED NURSE II, CORRECTIONAL FACILITY

This is the second supervisory level in the series. Incumbent, in a correctional facility, either (1) directs nursing services in a licensed inpatient care facility other than a general acute care hospital; or (2) directs nursing services as a shift supervisor in a licensed general acute care hospital; or (3) directs nursing services as an assistant to the director of nursing at a licensed general acute care hospital; or (4) directs nursing services in a Medical Outpatient Housing Unit (OHU) plus clinic and/or camp.

SUPERVISING REGISTERED NURSE III, CORRECTIONAL FACILITY

This is the full supervisory level in the series. Incumbent, in a correctional facility, directs nursing services in a licensed general acute care hospital and out-patient program areas.

MINIMUM QUALIFICATIONS

ALL LEVELS:

Possession of a current license as a registered nurse in California. (Applicants who do not meet this requirement will be admitted to the examination, but they must secure the required license before they will be considered eligible for appointment.)

SUPERVISING REGISTERED NURSE I, CORRECTIONAL FACILITY

Either I

Experience: Two years of experience in the California state service performing the duties of a Registered Nurse, Correctional Facility.

Or II

Experience: Two years of experience (within the last five years) as a registered nurse in a general acute care hospital. (Possession of a Bachelor of Science Degree in Nursing or a Master's Degree in Nursing may be substituted for one year of the required experience.)

Candidates who are within six months of completing the experience

requirements will be admitted to the examination, but they must complete all requirements before they will be considered eligible for appointment.

SUPERVISING REGISTERED NURSE II, CORRECTIONAL FACILITY

Either I

Experience: One year of experience in the California state service performing the duties of a Supervising Registered Nurse I, Correctional Facility.

Or II

Experience: Three years of experience in the California state service performing the duties of a Registered Nurse, Correctional Facility.

Or III

Experience: Three years of registered nursing experience within the last five years, one year of which must have been in a supervisory capacity, and two years of which must have been in a general acute care hospital. (Possession of a Bachelor of Science Degree in Nursing or a Master's Degree in Nursing may be substituted for one year of general acute care hospital experience.)

Candidates who are within six months of completing the experience requirements will be admitted to the examination, but they must complete all requirements before they will be considered eligible for appointment.

SUPERVISING REGISTERED NURSE III, CORRECTIONAL FACILITY

Either I

Experience: One year of experience in the California state service performing the duties of a Supervising Registered Nurse II, Correctional Facility.

Or II

Experience: Three years of experience in the California state service performing the duties of a Supervising Registered Nurse I, Correctional Facility.

Or III

Experience: Four years of registered nursing experience (within the last ten years) in a licensed general acute care hospital, two years of which must have been in an administrative or supervisory capacity. (Possession of a Bachelor of Science Degree in Nursing or a Master's Degree in Nursing may be substituted for one year of general acute care hospital experience.)

Candidates who are within six months of completing the experience requirements will be admitted to the examination, but they must complete all requirements before they will be considered eligible for appointment.

KNOWLEDGE AND ABILITIES

ALL LEVELS:

Knowledge of: Professional nursing principles and techniques; disease process and treatment modalities; appropriate administration of medications; principles and procedures of infection control; principles of effective verbal, written, and group communications;

principles of personnel management; laws and regulations governing nursing practice; principles of effective supervision; a manager's/supervisor's responsibility for promoting equal opportunity in hiring and employee development and promotion, and for maintaining a work environment that is free of discrimination and harassment.

Ability to: Plan, organize, direct, and supervise the work of a staff of nurses and other health care staff; apply nursing principles; assess, evaluate, and document patient's symptoms and behavior; analyze situations accurately and take effective action; maintain effective working relationships with health care professionals and others; effectively promote equal opportunity in employment and maintain a work environment that is free of discrimination and harassment; and communicate effectively.

SUPERVISING REGISTERED NURSE II, CORRECTIONAL FACILITY
SUPERVISING REGISTERED NURSE III, CORRECTIONAL FACILITY

Knowledge of: All of the above and programs in a State correctional facility of the Department of Corrections.

Ability to: All of the above.

SPECIAL PERSONAL CHARACTERISTICS

ALL LEVELS:

Empathetic understanding of patients of a State correctional facility; willingness to work in a State correctional facility; emotional stability; patience; tact; alertness; and keenness of observation.

SPECIAL PHYSICAL CHARACTERISTICS

ALL LEVELS:

Persons appointed to this position must be reasonably expected to have and maintain sufficient strength, agility, and endurance to perform during stressful (physical, mental, and emotional) situations encountered on the job without compromising their health and well-being or that of their fellow employees or that of inmates or youthful offenders.

Assignments may include sole responsibility for the supervision of inmates or youthful offenders and/or the protection of personal and real property.

CLASS HISTORY

Class	Date Established	Date Revised	Title Changed
Supervising Registered Nurse I, Correctional Facility	6/15/93	11/3/04	--
Supervising Registered Nurse II, Correctional Facility	6/15/93	11/3/04	--

Supervising Registered Nurse III, 6/15/93 11/3/04 --
Correctional Facility

**Motion for Waiver of State Law
Re Receiver Career Executive
Assignment Position**

EXHIBIT 6

1 I, YULANDA MYHNIER, declare that if called I could and would competently testify as
2 follows:

3 1. I am a Correctional Administrator, acting in the capacity of Deputy Director, Health Care
4 Administrative Operations Branch. Since July 2006, I have been responsible for providing fiscal
5 oversight for Health Care Services in the field and served as the Division's liaison with the
6 Department's Budget Management Branch.

7 2. The CDCR statewide nursing budget tops \$203 million annually just for its personnel.
8 There is an average of 77 nurses in varying classifications supervised by each institution's Director
9 of Nursing.

10 3. Additionally, last fiscal year 1.163 million additional hours of registry nursing services
11 were provided under the supervision of the 33 institution Directors of Nursing.

12 4. For years the CDCR has engaged in widespread use of "acting assignments," where lower
13 level employees perform duties above their classification. Acting assignments may be for extended
14 periods of time. This common practice continues because (1) the State has failed to establish higher
15 level classifications when needed; (2) there has been an inability to recruit candidates with requisite
16 qualifications at the higher level; and, (3) to allow an original incumbent in the position to return
17 from his/her own "acting assignment," causing a domino-like bumping process that proceeds
18 backwards.

19 I declare under penalty of perjury that the foregoing is true and correct to the best of my
20 knowledge. Executed this 16 day of April 2007, in Sacramento, California.

21
22 
23 Yulanda Mynhier, Deputy Director (A)
24 Health Care Administrative Operations Branch
25
26
27
28