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7
8 **UNITED STATES DISTRICT COURT**
9 **NORTHERN DISTRICT OF CALIFORNIA**

10

11 MARCIANO PLATA, et al.,

Case No. C01-1351 TEH

12 *Plaintiffs,*

13 v.

**DECLARATION OF TERRY HILL, M.D.
IN SUPPORT OF (1) RECEIVER'S
REPLY RE PLAN OF ACTION AND (2)
RECEIVER'S MOTION TO MODIFY
STIPULATED INJUNCTION**

14 ARNOLD SCHWARZENEGGER, et al.,

15 *Defendants.*

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

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1 I, Terry Hill, declare as follows:

- 2 1. I am currently the Chief Medical Officer for the California Prison Health Care
3 Receivership and make this declaration in support of the Receiver's Reply regarding the
4 Plan of Action ("POA"), filed by the Receiver on or about May 15, 2007. The facts set
5 forth herein are based on my own personal knowledge and, if called as a witness, I could
6 competently testify thereto.
- 7 2. I received my B.A. in Literature from Reed College in 1974 and an M.D. from the
8 University of California, San Francisco in 1987. From 1987 to 1991, I was first a
9 Resident in Primary Care Internal Medicine and then Chief Resident in Internal Medicine
10 at Highland General Hospital in Oakland, California. From 1991 to 1993, I was a Fellow
11 in Geriatrics at Stanford University and the Palo Alto Veterans Administration Medical
12 Facility. I was a National Institutes of Health Postdoctoral Research Fellow at Stanford
13 University from 1993 to 1994. From 1994 to the present, I have been on medical school
14 faculties, first at Stanford University and then at the University of California, San
15 Francisco, where I am an Assistant Clinical Professor in the Department of Medicine. I
16 also serve on the Advisory Boards of California's three Geriatric Education Centers
17 funded by the U.S. Department of Health and Human Services.
- 18 3. In addition to my academic affiliations discussed above, I was in private practice as a
19 geriatrician from 1994 to 1999. I have been Medical Director for a hospitalist physician
20 group at Summit Medical Center in Oakland, California, for Laguna Honda Hospital and
21 Rehabilitation Center in San Francisco, and for Lumetra, California's Medicare Quality
22 Improvement Organization. I serve on the Board of Directors of the Center for Elders
23 Independence in Oakland, the San Francisco Adult Day Services Network (current
24 President), the California Association of Long-Term Care Medicine (former President),
25 and the California Institute for Health Systems Improvement. I have led or participated in
26 multiple state and national initiatives focused on developing health care standards,
27 measurements, and educational curricula. I have written and spoken about many issues in
28 health care and the improvement of the delivery of health care services. Attached hereto

- 1 as Exhibit 1 is a true and correct copy of my most recent curriculum vitae.
- 2 4. My correctional medicine experience includes serving as a Medical Expert for this Court,
3 first in 2004 in *Madrid v. Schwarzenegger*, then in 2005 in this action. In 2005-2006 I
4 led a Lumetra research and consulting team contracted with the California Department of
5 Corrections and Rehabilitation (CDCR) to (a) describe the subpopulations of older
6 inmates, (b) assess current capacity to meet their needs, (c) project future needs, (d)
7 describe current and future programmatic options, and (e) provide hands-on consultation
8 for a new long-term care unit at California Medical Facility (CMF). At CMF the team
9 addressed policy development, personnel issues, space and equipment planning, and
10 medication management; provided several days of education for clinical and custody
11 staff; and provided case consultations. The final report concluded that the CDCR was
12 unprepared to address its aging inmate crisis and offered 24 recommendations for moving
13 forward. The research methodology used in the report has served as the basis for work
14 now being done by Abt Associates in planning new long-term care facilities for the
15 CDCR. In the past two years I have been invited to national conferences to address the
16 topics of aging inmates, the unique dimensions of bioethics in corrections, and
17 organizational change in correctional health care.
- 18 5. A primary focus of my professional life has been devoted to developing and
19 implementing programs for the improvement of health care delivery in a variety of
20 settings. I have studied the professional literature regarding best practices in health and
21 hospital systems, I have contributed to that literature, and I have successfully
22 implemented programs for organizational transformation in the health care environment.
23 My work at Lumetra, funded by the Medicare program, focused on teaching health care
24 organizations to use measurement in quality improvement initiatives. Especially relevant
25 to the work at hand is my knowledge of quality issues in marginalized and under-
26 resourced health care settings. Several improvements in nursing home care, for instance,
27 have been convincingly demonstrated in recent years, but the preceding two decades were
28 littered with costly initiatives from industry, legislatures, and the courts, most of which

- 1 failed because of an inadequate appreciation of the resistance that can interfere with one-
2 dimensional change initiatives. As a cautionary statement, in one article I wrote,
3 “Improvement efforts in nursing facilities are not likely to succeed without accounting for
4 thin resources, turnover at every level, and lack of a quality management infrastructure.”
- 5 6. One of the primary tasks given me by the Receiver has been to develop the POA. I
6 worked closely with Betsy Chang Ha, the Receiver’s Chief Nursing Executive, as well as
7 with the Receiver and other members of his staff.
- 8 7. I am familiar with the claims made by plaintiffs’ counsel that the POA is a “failure”
9 because it does not currently spell out all of the timelines, details, and metrics that will
10 ultimately be included. These claims reflect profound misunderstandings of the POA
11 itself, of the real challenges that the Receiver faces in attempting to transform medical
12 care delivery in the California prisons, and of the strategies required to overcome those
13 challenges.
- 14 8. In developing the POA, we felt that it was important that its goals and strategies be
15 grounded in accepted health care planning concepts and that these goals and strategies be
16 evidence-based to the greatest extent possible.
- 17 9. We relied heavily on the widely-accepted conceptual framework for health care
18 improvement articulated by the Institute of Medicine (“IOM”), a component of the
19 National Academy of Sciences created in 1970 to provide unbiased evaluations of
20 American health care. The body of work published by the IOM reflects consensus in the
21 mainstream of American health care research and policy about how to achieve
22 transformation of health care organizations. In particular, in 2001 the IOM published
23 *Crossing the Quality Chasm*, which set forth in one place the best practices used by
24 health care organizations that had been most successful in improving care. Evidence of
25 successful strategies came from organizations such as the Veterans Administration
26 hospitals and Kaiser Permanente, both of which had dramatically improved their
27 performance within the previous decade.
- 28 10. As we indicated in the POA, the IOM recommends six organizational changes necessary

1 to improve health care: (a) redesign of care processes based on best practices developed
2 in the industry; (b) use of information technology for clinical information and support for
3 caregivers; (c) increasing and deepening the knowledge and skills of the clinicians and
4 others; (d) development of a team-based, rather than a physician-centric, delivery system;
5 (e) coordination of care across patient conditions, services and settings over time; and (f)
6 incorporation of performance and outcome measurements for improvement and
7 accountability. *See* POA, p. 11. The goal of the IOM strategies is to ensure that care is
8 safe, effective, patient-centered, timely, efficient, and equitable. Measures reflecting
9 these results must be verifiable. Furthermore, the measurement systems must be able to
10 identify the need for improvement and guide the improvement efforts. Measures are
11 commonly categorized as related to structure, process, or outcome. Structural measures
12 refer to the attributes of the settings of care, including material resources, e.g., medical
13 records; human resources, e.g., adequate staffing and staff expertise; and organizational
14 structure, e.g., hospitals vs. clinics. Process measures reflect what is actually done to the
15 patient in the giving and receiving of care, e.g., prescription of aspirin for a patient at risk
16 of heart attack. Outcome measures reflect direct results on patients' health status, e.g.,
17 the rate of heart attacks. While all have their place, process and outcome measures have
18 proven most useful in guiding improvement initiatives.

19 11. We also drew upon the seven categories identified by the Malcolm Baldrige National
20 Quality Program ("BNQP"), created by Congress in 1987 and administered by the federal
21 National Institute for Science and Technology. The BNQP confers awards upon
22 organizations that achieve demonstrable improvement in organizational efficiency,
23 productivity and service. The seven categories of the BNQP framework are: (a)
24 leadership; (b) strategic planning; (c) focus on patients and other customers; (d)
25 measurement, analysis and knowledge management; (e) human resources development;
26 (f) process management; and (g) results. *See* POA, p. 12.

27 12. The BNQP framework complements the IOM organizational strategies and emphasizes in
28 particular the importance of leadership and human resources development. The IOM

1 strategies presuppose that adequate leadership and human resources processes exist as
2 precursors to organizational transformation. An organization beginning the Baldrige
3 process is presumed to have an enlightened leadership and a modicum of infrastructure
4 support. The CDCR lacks the necessary infrastructure, not just to measure the
5 performance of the organization, but to deliver adequate services in the first instance. The
6 Receiver must begin, therefore, by developing the precursors for positive change in an
7 organization that has suffered from decades of abject neglect. This statewide, complex
8 organization with dozens of sites and multiple levels of care completely lacks elements
9 that even a small community hospital would take for granted, such as a case management
10 program, or a continuing medical education program, or ethics committee, or identifiable
11 leadership in radiology, laboratory services, physical therapy or occupational therapy.
12 The chronic neglect of nursing and pharmacy leadership has been noted elsewhere. The
13 physician leadership has been preoccupied by the time-consuming challenge of weeding
14 out incompetent or irresponsible physicians.

15 13. Much of the POA and the Receiver's activities, therefore, have been devoted to
16 leadership and human resources issues, including recruitment, discipline, the creation of
17 new positions, and the MTA-to-LVN conversion. In important respects, the POA is
18 designed to be a signal to health care professionals that the CDCR is both serious and
19 realistic about organizational transformation. The POA reflects a model of improvement
20 that health care professionals understand and respect. It is, therefore, intended as a
21 recruiting tool for good leadership and, in fact, is already beginning to pay off in this
22 respect. I have recently been contacted by a number of highly qualified individuals who
23 became serious about the possibility of working for the organization after reading the
24 POA. The POA is a signal that the new CDCR will engage the creativity of staff at every
25 level and indeed must do so in order to achieve reliable outcomes. See POA, p. 12
26 ("High Reliability"). If the organization has adequately trained and motivated staff, the
27 other transformational strategies will be much easier to accomplish.

28 14. Other infrastructure, particular information technology and other basic systems, are also

1 critical. Both the information technology and pharmacy systems, among others, are in the
2 process of being developed and implemented at CDCR, but they are not yet fully
3 operational.

4 15. The inescapable reality that CDCR lacks the most basic organizational foundation
5 necessary to perform at an even minimally competent level has direct implications for the
6 development and presentation of timelines, metrics, and detail in the POA. Those
7 elements are necessary, to be sure. We are in the process of developing them, and we will
8 provide the initial timelines in the update of the POA in November; but to provide them
9 at this point would have been premature.

10 16. We could have included timelines in the POA at this point, but they would have been
11 artificial and of doubtful accuracy or validity. The Receiver is still in the start-up phase
12 of the various remedial projects under way. Accomplishing most of the elements in the
13 POA presupposes that recruiting or contracting for the necessary leadership expertise has
14 occurred. The Maxor pharmacy management project can have elaborate timelines
15 precisely because Maxor has brought in a substantial management structure. Had we
16 included gratuitous timelines within the POA, we would have been setting up everyone –
17 the Court, the parties, the Receiver’s staff – for disappointment when those timelines
18 inevitably turned out to be wrong. In the process, the Receiver, Court, and new CDCR
19 leadership would risk losing credibility.

20 17. The early steps involved in transforming an organization, particularly an organization as
21 complicated and as currently dysfunctional as the CDCR medical care system, cannot be
22 accomplished according to rigid timelines. It is difficult enough to create an organization
23 anew; it is many times more difficult in the situation faced by the Receiver where he not
24 only must create a functioning organization, he must first rip out the dysfunctional
25 components and negotiate renewal within the constraints of the state bureaucracy.

26 18. In its 2001 report, the IOM included a short section on systems thinking and complex
27 adaptive systems. Complex adaptive systems are contrasted to the “scientific
28 management” of Taylorism, introduced into American factories in 1911, a way of

1 thinking derived from the functioning of mechanical systems. The IOM points out that
2 mechanical-systems models can be helpful in organizational situations where “there is a
3 high degree of certainty (as to outcomes from actions) and a high degree of agreement
4 (among the people involved in taking the actions). Here, mechanical thinking with
5 detailed plans and controls is appropriate. An example in health care is a surgical team
6 doing routine gall bladder surgery. Through experience and the accumulation of
7 knowledge, there is a high degree of certainty about the surgical procedures that lead to
8 successful outcomes.” It should be obvious that the Receiver faces a complex adaptive
9 system, defined as “a collection of individual agents that have the freedom to act in ways
10 that are not always predictable and whose actions are interconnected such that one agent’s
11 actions changes the context for other agents.”

12 19. The IOM 2001 report goes on to say: “It is more helpful to think like a farmer than an
13 engineer or architect in designing a health care system. Engineers and architects need to
14 design every detail of a system. This approach is possible because the responses of the
15 component parts are mechanical and, therefore, predictable. In contrast, the farmer
16 knows that he or she can do only so much. The farmer uses knowledge and evidence
17 from past experience, and desires an optimum crop. However, in the end, the farmer
18 simply creates the conditions under which a good crop is possible. The outcome is an
19 emergent property of the natural system and cannot be predicted in detail.”

20 20. Of course, within contingencies such as weather, a farmer tries valiantly to predict and
21 plan. But the Receiver is in the position of having just assumed responsibility for a farm
22 suffering from decades of mismanagement of its soil, power and water supply, buildings,
23 fences, and roads. In addition, his abilities to hire help are seriously constrained. As the
24 Receiver’s team learns more, particularly from the pilot projects now under way, and as
25 we make adjustments to account for the many obstacles anticipated and unanticipated, we
26 will have a much better idea of the *realistic* timeframes in which specific aspects of the
27 remedial process will occur.

28 21. With respect to the development of metrics, the POA explains in some detail the

1 challenges the Receiver faces in establishing a system of verifiable measures of
 2 performance. POA, pp. 43-50. Adequate technology, procedural protocols, and properly
 3 trained staff for data input, retrieval and meaningful analysis do not exist within the
 4 CDCR. All of these are essential for establishing a framework for meaningful metrics. In
 5 fact, in my opinion, one of the most serious problems with the *Plata* standards, audit tool,
 6 and monitoring system was that they required gathering data without adequate systems for
 7 data input, retrieval and verifiable analysis in the first instance, without sufficiently
 8 trained staff with an understanding of the goals of the organization, and without any
 9 coherent articulation of why the data is being gathered or for what the data will be used.
 10 Moreover, the medical care leadership was instructed to gather information without any
 11 well-articulated sense of which information was important or which information should
 12 be gathered first. The prior efforts at measurement

13 suffered from multiple flaws. The electronic tracking system consisted of
 14 unconnected, unsupported Access databases that soon varied from location
 15 to location and contained unreliable data. . . . [T]he individual measures
 16 were unvalidated and yielded results that often flew in the face of direct
 17 observation. The attempt to average all the measures into a composite
 score was wholly uninformed and misguided. Most critically, the findings,
 had they been trustworthy, were not actionable. The available
 management infrastructure could not support development and
 implementation of appropriate interventions. . . .

18 POA, p. 43.

19 22. Without appropriate information technologies for data input, retrieval and analysis, and
 20 without adequately trained and motivated staff, collecting data borders on an exercise in
 21 futility. Moreover, the time and energy that must be expended in collecting data of
 22 questionable validity or utility, particularly in the absence of appropriate information
 23 technology, is an enormous drain on staff members who should otherwise be providing
 24 service to the organization and the inmate-patients. As we noted in the POA, “[i]f it is
 25 already clear that a clinical process is broken, then waiting for an annual audit on the
 26 topic is unnecessary and unwise.” POA, p. 48.

27 23. The Receiver is in the process of attempting to develop a *meaningful* system to begin
 28 measuring quality in the prison medical care system. Clinical quality measures in the

1 medical care industry have only recently been standardized nationwide. In the past
2 several years the National Quality Forum, a multi-stakeholder public-private partnership,
3 has begun to endorse comprehensive performance measure sets for hospitals, ambulatory
4 care, and other settings. The IOM published its measurement volume in 2006. These
5 recently published measurement criteria and protocols for quality care, all of which have
6 been appropriately validated, will assist the Receiver in developing his own metrics.
7 Examples include process and outcome measures for diabetic care and asthma, most of
8 which can be imported as is from the free world into corrections. Measures of access to
9 care in correctional settings, however, are still in their infancy, and they have not been
10 validated or standardized. Together with other members of the Receiver's team, I hope to
11 contribute to national efforts to develop such standardized access-to-care metrics for
12 corrections as we learn from our experience at CDCR. Thus, metrics for this aspect of
13 the system may take somewhat longer to develop.

14 24. The area of specialty services provides an example of how useful access-to-care measures
15 will emerge in the course of system transformation. The Receiver has used three prisons
16 as pilot sites for redesign of specialty services management. At each site we found
17 varying combinations of broken systems and creative "work-arounds" used by staff to
18 compensate for the broken systems. The challenge of getting reliable, meaningful data
19 regarding referrals and timeliness was met only by putting the Receiver's staff and CDCR
20 leaders at the prisons for significant lengths of time. Standardizing the data and report
21 formats took additional efforts. Even so, interpreting the data alone was not possible
22 until there had been a close examination of the appropriateness of the referrals and the
23 appropriateness of the referral classification as urgent or routine. For example, physicians
24 had learned that designating routine referrals as urgent increased the likelihood of the
25 appointment occurring sooner. But the point of all this effort is to ensure appropriate care
26 to the patient, not to collect and report data. In pursuit of this patient-centered goal, the
27 Receiver's teams in these sites have created access teams, transport teams, and specialty
28 contracting initiatives, working successfully with custody and health care staff. The

1 Receiver has also elected to implement an electronic scheduling system at these pilot sites
2 to replace the CDCR's woefully inadequate IMSATS program. The Receiver has chosen
3 *not* to implement a more elaborate electronic scheduling and tracking system, even
4 though the tracking system would generate desirable data reports, because the latter
5 would take significantly longer to implement, both in these sites and statewide. *Our*
6 *primary focus right now must be on delivering care to the patients, not on extracting*
7 *detailed measures of that care.* Having said that, in the months to come we will plan
8 implementation of an appropriate tracking system. Returning to biological metaphors for
9 improvement truisms, it is said that you can't fatten a cow by weighing it. On the other
10 hand, you can't manage what you don't measure, so in time we'll weigh the cow over and
11 over. Meanwhile, at these three pilot sites we continue to measure access to specialty
12 care "by hand," laboriously, using valuable clinical and administrative personnel, at the
13 same time that they are creating the access and transport teams and new contracts. We
14 have deliberately not asked them to gather data on all the 24 indicators from the *Plata*
15 audit tool pertaining to specialty care. To have done so would not only have led to
16 immense labor of limited benefit, it would have announced that the Receiver's team had
17 misplaced values and deficit know-how in organizational change.

18 25. I have briefly described the work on specialty access as a pilot effort in middle course.
19 This pilot effort will yield written templates and processes, together with a new
20 information technology infrastructure element, all of which can then be disseminated in
21 controlled, step-wise fashion throughout the state. Each domain of interest within the
22 *Plata* standards will require similar painstaking and laborious redesign efforts.

23 26. Unlike measures of access to care in corrections, the free-world quality measures of
24 common chronic diseases are well-established and grounded in medical science. But
25 effective use of these measures in improving care to inmates and transforming the prison
26 medical care system will require us to deploy them with similar attention to context and
27 capacity. We are just now planning an asthma initiative, for instance, in which we will
28 bring clinical transformation teams to pilot sites in order to assist staff in mapping out and

1 redesigning the processes of care. There is no mystery with regard to the need to assess
2 the breathing capacity of asthma patients at each visit, but in the CDCR there is no
3 agreement as to *how* to do so. Who will do the assessments, and how? Who will do the
4 documentation, and how should verbal communication occur between patient and nurse,
5 nurse and physician, physician and patient? What is the role of a respiratory therapist?
6 How can we assure that information flows from the TTA, off-site emergency department,
7 or off-site consultant back to the yard clinic at the next appointment? More specifically,
8 how should we answer these questions now in a system with chaotic medical records,
9 pharmacies and laboratories, in which nurses and physicians have rarely worked together
10 in teams, and in which custody and healthcare staff have often worked at cross purposes?
11 27. The speed with which we can move forward on projects such as these will depend on our
12 ability to recruit additional leadership and front-line staff, retrain or dismiss portions of
13 our current staff, remove barriers and sabotage, bring additional outside resources to bear,
14 and avoid distractions. Returning once again to biological metaphors, you can't make a
15 plant grow faster by yelling at it. But you can profitably attend to the conditions
16 necessary for growth.

17 28. As discussed in the POA, the *en bloc* approach to change—embodied in the June 2002
18 Stipulated Injunction, the 2004 Patient Care Order, the 11-volume Policies and
19 Procedures, and the QMAT audit tool—was a failure for multiple reasons. In fact, the
20 QMAT audits were abandoned in 2005 even before appointment of the Receiver. The
21 QMAT physicians and nurses were redirected to more productive pursuits, and their roles
22 continue to evolve. In retrospect, it is obvious that the QMAT staff, the Medical Experts,
23 the attorneys for both parties, and the Court itself lacked the resources necessary to
24 overcome the abject levels of disrepair and dysfunction in CDCR. It should also be
25 obvious that the situation calls for a new approach to change. Only via competent
26 managers and expert change agents working at ground level will we succeed in
27 redesigning processes and getting reliable, measurable improvements in care.
28 Redesigning care from a distance – the model reflected in the stipulated orders – is not

1 only doomed to fail, it is dangerous. The IOM begins its discussion of evidence-based
2 management by quoting the human factors expert James Reason: “The more removed
3 individuals are from... front-line activities..., the greater is their potential danger to the
4 system.”

5 29. The Receiver’s teams and CDCR staff must redesign processes from the ground up, as
6 illustrated in the examples above. In the process, CDCR medical care policies and
7 procedures will change repeatedly based on pilot projects using rapid-cycle quality
8 improvement. The policy modification steps detailed in the June 2002 Stipulated
9 Injunction would be unacceptably cumbersome even in a stable organization. In the
10 current situation, they are intolerably bureaucratic.

11 30. Rather than using the QMAT physicians and nurses as auditors, we are beginning to
12 empower them as change agents motivated to focus attention on patient-centered care
13 rather than focusing on compliance with the specific requirements of the stipulated
14 orders. The IOM discussion on evidence-based management states, “A leadership
15 approach that aims to achieve a collective goal rather than a multitude of individual goals
16 and aims to transform all workers—both managers and staff—in pursuit of the higher
17 collective purpose can be the most efficient and effective means of achieving widespread
18 and fundamental organizational change.... In health care organizations, where many
19 workers have strong professional identifications, trust of leadership by subordinates often
20 reflects the extent to which leadership is committed to the values inherent in the
21 professions of medicine and nursing.” Attempting to change culture via a nearsighted
22 focus on compliance with particular requirements, a kind of “check the box” mentality,
23 would undercut our credibility as leaders and would merely sustain the unacceptable
24 levels of inmate morbidity and mortality.

25 31. My primary objection to the items that have come to be known as “*Plata standards*,”
26 derived from the 2002 Stipulated Injunction and the 2004 Patient Care Order, lies
27 precisely in this distinction between professional motivation for patient welfare and a
28 “compliance” orientation. A number of the standards, *e.g.*, timeliness regarding primary

1 and specialty care, chronic care, diagnostic services, and medication management, will
2 change as we redesign each of these areas. But what matters is that health care staff trust
3 that standards derive from the best available medical evidence and professional judgment.
4 The sheer oddity of some of the orders, e.g., specific orders and policies regarding
5 physical therapy with no mention of occupational therapy, undermines the credibility of
6 the remedial process.

7 32. The good news is that progress is occurring. The initial information technology and
8 pharmacy initiatives are under way. The Receiver's efforts at recruiting more qualified
9 and more committed staff are beginning to bear fruit. We have already engaged some
10 outstanding outside resources. Bit by bit, the local prison staff are becoming enthusiastic
11 about the realistic possibilities for significant change.

12 33. The Receiver intends to have the first elements of the quality measurement system in
13 place by the November update of the POA. See POA, p. 49 ("Office of Evaluation,
14 Measurement and Compliance"); see also id., p. 46. In the meantime, I believe that it is
15 distracting—indeed, damaging—to devote valuable resources to time-intensive gathering
16 of non-electronic data of doubtful utility, as is occurring under the prior remedial orders,
17 when we are rapidly deploying electronic systems that will yield reliable data and permit
18 the Receiver to obtain meaningful measures of quality, to identify shortcomings and to
19 improve care.

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

22 Dated: July 30, 2007

/s/
Terry Hill

23
24 I hereby attest that I have on file all holograph
25 signatures for any signatures indicated by a
26 "conformed" signature (/s/) within this efiled
document.

27 _____
/s/
28 Jamie L. Dupree
Attorneys for Receiver Robert Sillen

EXHIBIT 1

TERRY HILL, MD
Office of the California Prison Receivership
terry.hill@cprinc.org

POSITIONS

2006-present Chief Medical Officer, California Prison Receivership
2004-2006 Federal Court Medical Expert, *Madrid vs. Schwarzenegger, Plata vs. Schwarzenegger*
2004-2006 Medical Director, then Senior Medical Director for Quality Improvement, Lumetra
1999-2004 Medical Director, Laguna Honda Hospital and Rehabilitation Center, San Francisco
1994-99 Geriatrician in private practice, Oakland
1993-94 Medical Director of hospitalist physician group, Summit Medical Center, Oakland

ACADEMIC AFFILIATIONS

2000-present Assistant Clinical Professor, Department of Medicine, UC San Francisco
2004-present Northern California Geriatric Education Center: Member, Advisory Committee
2002-present California Geriatric Education Center: Member, Advisory Board
1993-present Stanford Geriatric Education Center: Core Faculty
1994-99 Clinical Assistant Professor, Department of Medicine, Stanford University

EDUCATION AND TRAINING

1993-94 NIH Postdoctoral Research Fellow, Stanford University
1991-93 Fellow in Geriatrics, Stanford University, Palo Alto VA Medical Center
1990-91 Chief Resident in Internal Medicine, Highland General Hospital, Oakland
1987-90 Resident in Primary Care Internal Medicine, Highland General Hospital, Oakland
1987 M.D., University of California, San Francisco
1974 B.A. in Literature, Reed College, Portland

CERTIFICATIONS

Certified Medical Director, American Medical Directors Association (1996, recertified 2002)
Certificate of Added Qualifications in Geriatrics (1994, recertified 2004)
Diplomate, American Board of Internal Medicine (1991, recertified 2002)

SELECTED PROFESSIONAL AND COMMUNITY SERVICE

National Quality Forum Palliative and Hospice Care Review Committee, 2005-06
The committee wrote *Framework and Preferred Practices for Palliative and Hospice Care Quality*. See www.qualityforum.org.
California Institute for Health Systems Improvement
Member, Board of Directors
San Francisco Adult Day Services Network
Chair, Board of Directors
Center for Elders Independence (PACE project, Oakland)
Member, Board of Directors
Chair, Professional Advisory Committee

SELECTED PROFESSIONAL AND COMMUNITY SERVICE – continued

- California Coalition for Compassionate Care (www.finalchoices.calhealth.org)
Co-Chair, 1999-2006
- American Medical Directors Association
Member, Public Policy 1999-2001, Membership 2004-06, Communications 2004-06, Ethics Committee 2005-2007
- California Association of Long Term Care Medicine
President, 2002-2005
- California Adult Immunization Coalition
Member, Long-Term Care Advisory Committee, 2003-2006
- California Medical Association
Consultant to Committee on Quality Care, 2006
Member, Long Term Care and Aging Technical Advisory Committee, 1997-99
Member, Committee on Long Term Care, 1992-4
Member, Council on Quality Care, 1989-92
- American College of Physicians/American Society for Internal Medicine
Founding Member, 1990-94, Northern California Council of Associates

JOURNAL ARTICLES AND LETTERS, BOOK CONTRIBUTIONS

- “Death Certification in Long Term Care”
Terry Hill, Cheryl Phillips, John Franklin Randolph. *Journal of the American Medical Directors Association*, September 2005.
- “Improving End-of-Life Care in Nursing Facilities: Reflections from the California Coalition for Compassionate Care”
Terry Hill, Mary Cadogan, Marjorie Ginsburg, Judy Citko. *Journal of Palliative Medicine*, 2005 April; 8: 300-312.
- “Influenza Deaths in Spite of Immunization and Prophylaxis”
Terry Hill, Angela Platzer, Cristina Reyes. Letter to editor: *Clinical Infectious Diseases*, 2005 February 1; 40: 492-493.
- “Mommy dearest: a medical director’s analysis” and “Professional promises in the ‘real’ world: a medical director’s analysis.” In *Moral Dilemmas in Community Health Care: Cases and Commentaries*. Becky Cox White and Joel Zimbelman, eds. Old Tappan, NJ: Longman, 2004: 58-60 and 249-252.
- “The Last Transfer”
Terry Hill, Mathy Mezey, Ethel Mitty. Letter to the editor: *Hastings Center Report*, March 2003.
- “Guidelines for End-of-Life Care in Nursing Homes: Principles and Recommendations”
Linda Farber Post, Ethel Mitty, Melissa Botrell, Nancy Dubler, Terry Hill, Mathy Mezey, and Gloria Ramsey. *NAELA Quarterly (National Association of Elder Law Attorneys Quarterly)*, 2001 Spring; 14(2):24-30. Also published as monograph by New York Univ. and Montefiore.
- “Aging and Mental Health”
Terry Hill and Cynthia L. Henderson. “Aging and Mental Health” (journal review). *JAMA*. 1998; 280:100-101.
- “Barriers to Effective Communication in Skilled Nursing Facilities: Differences in Perception Between Nurses and Physicians”
Mary Cadogan, Cheryl Franzi, Dan Osterweil, and Terry Hill. *Journal of the American Geriatrics Society*. 1998; 47:71-75.

JOURNAL ARTICLES AND LETTERS, BOOK CONTRIBUTIONS – continued

"The ER Incident"

Annals of Internal Medicine. 1992; 116: 867-868. Regarding race, class, and cynicism in an inner-city public hospital. Republished in *On Being a Doctor*, Philadelphia: ACP, 1995.

OTHER WRITING AND RESEARCH

"Aging Inmates: Challenges for Healthcare and Custody: A Report for the California Department of Corrections and Rehabilitation"

Terry Hill, Brie Williams, Gail Cobe, Karla Lindquist, under CDCR-Lumetra contract. May 2006.

"Physician Notification of Laboratory Results"

John Franklin Randolph and Terry Hill. California HealthCare Foundation *FastFacts* for nursing home professionals, May 2006 (see www.chcf.org).

"Lighting the Way to Quality Improvement"

Southern California Physician, July 2005 (see www.socalphys.com/jul05).

"Elder Mistreatment Feeds Liability Crisis"

San Francisco Medicine. March 2004 (see www.sfms.org/sfm).

"Surrogate Decision-Making, Public Guardianship, and Advance Care Planning in Long-Term Care"

Jonathan Evans, Lisa Boulton, Terry Hill, Ladislav Volicer, writing for the Ethics Committee of the American Medical Directors Association. Published as white paper (see www.amda.com).

"Laguna Honda Hospital, Past Into Future"

San Francisco Medicine. April 2002 (see www.sfms.org/sfm).

"Life and Death Choices"

San Francisco Chronicle, December 21, 2001.

"Providing Quality Care to Chronically Ill Ethnic Elders"

Terry Hill and Levanne Hendrix. *San Francisco Medicine*. November/December 2000).

"Recommendations for Improving End-of-life Care for Persons Residing in California Skilled Nursing and Intermediate Care Facilities"

Published as monograph in January 2000 (see www.sachealthdecisions.org) by statewide task force called ECHO (Extreme Care, Humane Options).

"Health Care for Ethnic Elders: Health Status, Communication, and Ethics. A Curriculum in

"Ethnogeriatrics for Physicians in Training"

Published as monograph by the Stanford Geriatric Education Center, 1996.

"What Difference Does a Life Make? Life Histories and Personhood in Nursing Homes"

Research project as Hartford Scholar, Hartford Center of Excellence in Geriatrics at Stanford, 1992-94. Presented as poster, American Geriatrics Society, May 1994.

"What Does the American College of Physicians Really Want?"

Winner of health policy essay contest, California chapter of ACP, March 1992.

"Trends in Birth Outcomes at San Francisco General Hospital, 1980-83"

Found adverse changes after implementation of 1982 Medi-Cal reforms, using analysis of covariance to control for eight maternal risk factors in 5000 births.

PRESENTATIONS AND CONFERENCES

"Bioethical Discussion Sounds Different Behind Bars"

Annual Ethics Symposium, Kaiser Permanente Northern California, San Ramon, March 2007

"The California Plan: From Backwater to Mainstream"

National Conference on Correctional Health Care, Atlanta, October 2006

PRESENTATIONS AND CONFERENCES – continued

“Quality Vision, Relationships, and Reliability”

National Hospice and Palliative Care Association, Clinical Team Conference and Scientific Symposium, San Diego, April 2006.

“Quality 2006: Reliability Depends on Relationships”

VHA West Coast conference, Entering a New Quality Era, March 2006

“Medication Safety in Older Patients”

California Medical Facility, January 2006.

“Depression Matters: Screening and Assessment”

Lumetra teleconference, November 2005, and Nursing Home Collaboratives, January 2006.

“The Space Between Knowledge and Practice Change”

NorCal Geriatric Education Center Geriatrics Faculty Scholars course, UCSF, June 2005 and April 2006.

“Palliative Care Cases, Practice, Policy: Deciding What We’re Doing Right and We’re Not Doing”

Kaiser Permanente Oakland Medical Center conference, May 2005.

“Culture Change in the Nursing Home”

California Association of Long Term Care Medicine annual seminar, Anaheim, May 2005.

“Reducing the Threat of Influenza and Other Seasonal Viruses”

Geriatric grand rounds, UCSF, November 2004. Also at American Medical Directors Association annual seminar, New Orleans, March 2005.

“Finding the Ethical Moment: Ethical Issues in Skilled Nursing Facilities”

With Joan King-Angell and Neal Snyder, case-based workshop at 2005 Ethics Symposium, Kaiser Permanente Northern California, Berkeley, March 2005.

“Promising Practices in End-of-Life Care”

At California Association of Health Facilities Director of Nurses Conference, Reno, January 2005.

“The Nursing Home Quality Initiative Update” and “Reducing Influenza’s Threat in Nursing Facilities”

At California Association of Health Facilities Institute, Lake Tahoe, August 2004.

“Influenza Prevention and Treatment in Nursing Facilities”

At California Adult Immunization Summit, Sacramento, May 2004.

“Minimizing the Threat of Influenza and Other Winter Viruses”

California Association of Long Term Care Medicine annual seminar, Anaheim, May 2004.

“Pain Management and the Lumetra Nursing Home Quality Initiative: Essential Physician Roles”

An evening program of the California Association of Long Term Care Medicine and Lumetra, presented several times throughout California, 2003-2004.

“Maintaining Dignity Towards the End of Life”

For residents and staff in long-term care facilities at annual meeting of the California Association of Homes and Services for the Aging, Pasadena, May 2004; San Jose, May 2005.

Lumetra Nursing Home Collaboratives.

Chaired Bay Area and Sacramento year-long collaboratives to improve pain and pressure sore prevention and management. Multiple presentations on these topics and organizational change, 2003-2004. Modified into one-day Quality in Action workshops, multiple locations, 2004.

Commitment to Compassionate Care: Addressing End-of-Life Issues

Course director for this two-day curriculum for nursing facilities, sponsored by California Coalition for Compassionate Care, given March 2000, June 2001, June 2002. Modified for broader audience at day-long workshops for American Society on Aging Summer Series, San Francisco, June 2003, June 2004 and September 2005.

PRESENTATIONS AND CONFERENCES – continued

“End-of-Life Care: Making Decisions, Managing Symptoms”

California Department of Health Services Physicians Educational Meeting, Sacramento, November 2003.

“Symptom Management at End of Life” and “Creating Institutional Change”

At symposium sponsored by California Association of Long Term Care Medicine, San Diego, November 2003.

“Symptom Management at End of Life”

Cypress Foundation Conference sponsored by Monterey and Santa Cruz County Medical Societies, Seaside, October 2003.

“Influenza and Pneumonia Prevention in Nursing Facilities”

At California Adult Immunization Summit, Pasadena, May 2003.

“Artificial Nutrition and Hydration: Assessment, Evidence, and Ethical Issues”

Kaiser Oakland Medical Center, October 2002.

“Improving End-of-Life Care in Nursing Facilities”

Association of Health Facility Survey Agencies annual seminar, Williamsburg, October 2002.

“Who Has the Capacity to Decide What, When? Legal and Practical Considerations”

California Association of Long Term Care Medicine annual seminar, Anaheim, May 2002 and April 2005.

Achieving Excellent End-of-Life Care in Nursing Facilities: Advanced Topics

Organized this conference with sponsorship by the California Geriatric Education Center, the California Association of Long Term Care Medicine, and the California Coalition for Compassionate Care, Anaheim, May 2002, repeated Napa, November 2002. Gave presentation on practical quality improvement strategies in end-of-life care.

“Beyond Cultural Chaos to Successful Communication in Long Term Care”

American Medical Directors Association annual seminar, San Diego, March 2002.

“What It Takes to Change Practice in Nursing Facilities: Expertise, Consensus, Persistence”

California Association of Long Term Care Medicine annual seminar, Anaheim, May 2001.

“Chronic Pain, Aging, and the Processes of Care”

At Practical Geriatrics conference, Stanford, November 2000.

“Community-Based Elder Care: Assessment and Referral”

Organized conference on the role of the physician in community-based long-term care co-sponsored by seven local and state organizations, San Francisco, October 2000. Also gave above presentation. Repeated presentation at California Academy of Family Physicians annual seminar, February 2001.

“Surveyor Drug Review: New Guidelines and Investigative Protocols”

Presentation at conference on HCFA’s Quality Indicators and Survey Process sponsored by California Department of Health Services, California Association of Homes and Services for the Aging, and California Healthcare Association, August 1999.

“Negotiating Dying: Communication is the First Great Divide”

Kaiser Oakland, 1998; Long Term Care Bioethics Consortium of the East Bay, 1999; Kaiser Permanente statewide videoconference, 1999; California Association of Adult Day Services, Long Beach, 1999; Practical Geriatrics conference, Stanford, 1999; Alta Bates Hospital, 2000; Cypress Foundation Conference, Seaside, 2000; Laguna Honda Hospital, 2000; Santa Teresa Hospital, 2000; American Society on Aging Summer Series, San Francisco, 2000; Kaiser/UCSF End-of-Life Care Conference, 2002; and multiple sessions with medical and nurse practitioner trainees.

PRESENTATIONS AND CONFERENCES - continued

- "Advance Care Planning in Nursing Facilities: New California Breakthroughs"
At California Association of Medical Directors annual seminar, May 1999, and at annual meeting of California Association of Homes and Services for the Aging, May 1999.
- "Geriatrics: Beyond Team Sport to Organizational Sport"
Presentation to UCSF Division of Geriatrics, March 1999.
- "Processes for Decision-Making at the End of Life: A California Update"
Presentation at New York University conference, April 1998, and at Gerontological Society of America preconference, November 1998.
- "Death, Decisions, and Documentation: What's at Stake, Who's at Risk in End-of-Life Care"
Summit Medical Center, July 1998.
- "Urinary Incontinence: Primary Care Responsibilities"
Medical Staff conference, Summit Medical Center, May 1998.
- "Collaboration to Improve Care: Trust is a Two-Way Street"
American Medical Directors Association annual seminar, San Antonio, March 1998.
- "Clinical Issues in Caring for Ethnic Elders: Culture, Communication, and Ethics"
Workshop at Ethnogeriatrics and Managed Care conference, Stanford, January 1998.
- "Adverse Drug Reactions in the Elderly: How to Steer Clear of Mishaps and Disasters"
San Ramon Regional Medical Center, June 1996, and Summit Medical Center, October 1997.
- "End-of-life Decision-making" and "Nursing Homes, Moral Spaces: Encouraging Everyday Ethics"
Keynote addresses, Stanislaus Long Term Care Bioethics Forum, October 1997, and at American Baptist Homes of the West Annual Meeting, January 1998.
- "Ethics, Power, and Data Management in Managed Care"
Workshop at Institute '97, sponsored by California Association of Health Facilities and Quality Care Health Foundation, August 1997.
- "Psychotropic Medication and Behavior Management in Long Term Care: Dementia, Delirium, Depression, Anxiety, Psychosis, Distress"
Presentations at series of statewide conferences on restraint reduction, September 1996.
- "Psychotropic Medication and Behavior Management" and "Interdisciplinary Team Building"
California Healthcare Association conferences, Irvine and Oakland, May 1997.
- "Getting to Teamwork: Improving Communication in Long Term Care."
California Association of Medical Directors annual seminar, May 1997. Repeated to UCSF Division of Geriatrics, August 2002.
- "Risk and Control of Cooties in Long Term Care: Scabies and Herpes Zoster"
San Ramon, May 1997.
- "The Ethnic Elderly, Families, and Health Care Teams: Pathways to Effective Partnerships."
Course leader and presenter within this 40-hour training program of the Stanford Geriatric Education Center, Summit Medical Center, and Samuel Merritt College. Feb-April 1997.
- "Growing Concerns in Gerontology"
Medical Staff conference, San Ramon Regional Medical Center, April 1997.
- "Who's Fit to Be Tied? Fall Prevention and Restraint Reduction"
Medical Staff conference, San Ramon Regional Medical Center, March 1997.
- "Psychotropic Medications for Agitated Behaviors in Dementia"
Presentations at a series of statewide conferences on restraint reduction sponsored by six organizations, September 1996.

PRESENTATIONS AND CONFERENCES - continued

- "Improving Care for the Frail Elderly: A Team Approach to Common Problems"
Presented sessions on team-building, cognitive impairments, falls, restraints, and communication, San Ramon Regional Medical Center, August 1996.
- "Phone Calls and Protocols: Trust Is a Two-way Street"
Presentation on nursing standardized procedures at conferences sponsored by the Long Term Care Communication Coalition; September 1995 and May 1996.
- "Medical Treatment of Stroke"
San Ramon Regional Medical Center, May 1996.
- "Chronic Cardiac Conditions and Revolving Door Admissions: Proactive Case Management"
Golden State Rehabilitation Hospital, May 1996.
- "Outreach to Ethnically Diverse Older Adults"
TriCities Elder Coalition, Union City, May 1996.
- "'Agitation' in Subacute and Long Term Care"
Organized, moderated, and wrote syllabus for this conference at Summit Medical Center, July 1995, co-sponsored by eight organizations; gave presentation on team-building.
- "Physician-Patient Communication Amidst Cultural Chaos: Muddling Toward Excellence"
Brookside Hospital, April 1995.
- "Cultural Competence as a Quality Improvement Project in Health Care Institutions"
Presentation to American Baptist Homes of the West corporate leadership, April 1995.
- "Are Hospitals Really Necessary? How to Provide Good Care for Sick Patients in Nursing Homes"
Lectures at Highland Hospital and Stanford Medical School, February 1995.
- "Midlife: A Life Course Perspective"
At conference, "Crossing the Middle Years," Summit Medical Center, December 1994.
- "Communications among Nursing Home, Physician, and Acute Hospital"
Panel discussion at Western Scientific Assembly of CMA, March 1994.
- "Improving Nurse-Physician Communication in Long-Term Care"
Panel discussion at annual session of American Society on Aging, March 1994.
- "Physician-Patient Communication"
Workshop, Stanford Medical School, multiple dates 1993-95.
- "Racism in Medicine"
Presentation at symposium of California Physicians' Alliance, July 1992.
- "Death"
Highland General Hospital, May 1991. Alta Bates Hospital, January 2000.

CERTIFICATE OF SERVICE

The undersigned hereby certifies as follows:

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

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

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

DECLARATION OF TERRY HILL, M.D. IN SUPPORT OF (1) RECEIVER'S REPLY RE PLAN OF ACTION AND (2) RECEIVER'S MOTION TO MODIFY STIPULATED INJUNCTION

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

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

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

Andrea Lynn Hoch
Legal Affairs Secretary
Office of the Governor
Capitol Building
Sacramento, CA 95814

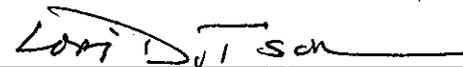
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26 Dated: July 30, 2007



Lori Dotson