

TABLE OF CONTENTS

		Page
1		
2		
3	I. Introduction.....	1
4	A. The Receiver’s Reporting Requirements.....	1
5	B. The Order Appointing Receiver.....	1
6	C. <i>Plata, Coleman</i> and <i>Perez</i> Reporting Requirements.....	1
7	D. <i>Plata</i> and <i>Armstrong</i> Coordination Reporting Requirements.....	2
8	E. Integration of Coordination Related Reporting in This Quarterly Report.....	2
9	F. Master Contract Waiver Related Reporting.....	3
10	G. Introduction Summary.....	3
11	II. Particular Successes Achieved by the Receiver.....	4
12	A. Introduction.....	4
13	B. Plan of Action.....	5
14	1. Introduction.....	5
15	2. Plan of Action Update.....	6
16	3. Plan of Action Focus Groups.....	10
17	4. Plan of Action Metrics.....	10
18	C. Receiver’s Requests for Waivers of State Law.....	11
19	1. Receiver’s Supplemental Application No. 1 for Order Waiving State	
20	Contracting Statutes, Regulations and Procedures, Approving	
21	Receiver’s Substitute Procedure for Bidding and Award of Contracts	
22	and Approving Nunc Pro Tunc ACNL Supervisory Nurse Training	
23	Contract.....	11
24	2. Receiver’s Motion for Waiver of State Law Re Physician Clinical	
25	Competency Determinations.....	12
26	3. Receiver’s Motion for Waiver of State Law Re Receiver Career	
27	Executive Assignment Positions.....	13
28	D. Remedial Pilots and Projects.....	14

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

1.	San Quentin State Prison Project.....	14
2.	Construction at San Quentin State Prison During the Reporting Period.....	22
3.	Maxor’s Pharmacy Management Update.....	24
4.	Developments in Recruiting and Hiring.....	34
5.	Credentialing and Privileging of Health Care Providers.....	37
6.	Specialty Care Contracts Pilot.....	41
7.	Health Care Appeals Update.....	45
8.	Medical Transport Vehicles.....	46
9.	Improvements in Nursing Services.....	47
10.	Improvements in Physician Services.....	51
11.	Information Technology Update.....	53
12.	Housing Prisoner/Patients Outside of CDCR’s 33 Institutions: Out of State Prisons, Return-To-Custody Facilities, and Community Correctional Facilities.....	58
13.	Telemedicine Reform.....	65
14.	Health Care Access Units.....	68
15.	Licensure and Operation of Dialysis Clinics.....	72
16.	Cleaning Up Specialty Services in the Wake of Medical Development International’s Failures at California Correctional Institution and California State Prison, Los Angeles County.....	74
17.	Construction Update on the 10,000 Bed Project.....	77
18.	Building Upgrades At All Prisons.....	79
19.	De-licensing of General Acute Care Hospital at California Institute for Men.....	81
E.	Establishing the Office of the Receiver.....	82
1.	New Appointment to the Office of the Receiver.....	82
2.	Determination of Tax Exempt Status by Internal Revenue Service.....	83

1	F.	Coordination with Other Lawsuits.....	83
2	III.	Problems Being Faced by the Receiver, Including Any Specific Obstacles Presented	
3		by Institutions or Individuals.....	84
4	IV.	Accounting of Expenditures for the Reporting Period.....	86
5	A.	Expenses.....	86
6	B.	Revenues.....	86
7	V.	Other Matters Deemed Appropriate for Judicial Review.....	87
8	A.	Communications with the Media and Public.....	87
9		1. Press and Public Information.....	87
10		2. Additional Public Outreach Activities.....	92
11	B.	Prisoner/Patient Complaints and Correspondence Program.....	93
12		1. Growth of the Prisoner/Patient Complaint and Correspondence	
13		Program.....	93
14		2. Quarterly Summary (April – June 2007).....	94
15		3. Prison Specific Distribution of Correspondence.....	95
16		4. Types of Complaints.....	96
17	C.	Evaluation of Prisoner Deaths During 2006.....	99
18	D.	Contracts Entered Into by the Receiver to Assist the Receiver’s Internal	
19		Operations and Contracts Entered Into by the Receiver for the Benefit	
20		of CDCR.....	100
21		1. Receiver’s Contracts with Vendors Providing Services to Assist the	
22		Operation of the Receiver’s Non-Profit Corporation, the California	
23		Prison Health Care Receivership.....	100
24		2. Receiver’s Contracts with Vendors Providing Services to Assist the	
25		Receivership in the Development and Delivery of Constitutional	
26		Medical Care within CDCR and its Prisons.....	103
27	VI.	Conclusion.....	108
28			

1 I.

2 INTRODUCTION

3 A. The Receiver's Reporting Requirements.

4 Given recent coordination efforts by the four Federal Courts responsible for the health
5 Care class actions pending against the California Department of Corrections and Rehabilitation
6 ("CDCR"), the Receiver is now required to submit quarterly reports to four different U.S.
7 District Court Judges. This introduction provides an overview of the Receiver's enhanced
8 reporting responsibilities.

9 B. The Order Appointing Receiver.

10 The Order Appointing Receiver ("Appointing Order") filed February 14, 2006 calls for
11 the Receiver to file status reports with the *Plata* Court concerning the following issues:

- 12 1. All tasks and metrics contained in the Plan and subsequent reports, with degree of
13 completion and date of anticipated completion of each task and metric.
- 14 2. Particular problems being faced by the Receiver, including any specific obstacles
15 presented by institutions or individuals.
- 16 3. Particular success achieved by the Receiver.
- 17 4. An accounting of expenditures for the reporting period.
- 18 5. Other matters deemed appropriate for judicial review.

19 (*See*, Appointing Order at p. 2-3.)

20 C. *Plata*, *Coleman* and *Perez* Coordination Reporting Requirements.

21 Additional reporting requirements were placed on the Receiver following his assumption
22 of the management of certain coordinated functions that involve the delivery of prison mental
23 health and dental services. A Joint Order was issued on June 28, 2007 by Judges in *Coleman v.*
24 *Schwarzenegger* (concerning the mental health care of California prisoner/patients), *Perez v.*
25 *Tilton* (concerning the dental care of California prisoner/patients) and in *Plata v.*
26 *Schwarzenegger*, approving various coordination agreements made between the representatives
27 of the three health care class actions. (*See*, Order Approving Coordination Agreements Attached
28 to Joint May 29, 2007 Order, hereinafter "Joint Coordination Order.") The coordination

1 agreements call for the *Plata* Receiver to assume responsibility for (1) direct oversight of
2 contracting functions for medical, dental, and mental health care; (2) implementation of the long-
3 term information technology (“IT”) system to include the medical, dental and mental health
4 programs; and (3) oversight of pharmacy operations serving the medical, dental, and mental
5 health programs. (*Id.* at 2.)

6 The Receiver’s assumption of these responsibilities is coupled with reporting
7 requirements which mandate that the Receiver file quarterly progress reports addressing (a) all
8 tasks and metrics necessary to the contracting functions, implementation of long-term IT, and
9 pharmacy services for mental health care and dental care, with degree of completion and date of
10 anticipated completion for each task and metric; (b) particular problems being faced by the
11 Receiver in accomplishing remedial goals; and (c) particular successes achieved by the Receiver
12 in accomplishing remedial goals. (*See Id.* at 2-3.)

13 D. *Plata and Armstrong Coordination Reporting Requirements.*

14 Additional reporting requirements were also placed on the Receiver following his
15 assumption of the management of certain coordinated functions involving the delivery of
16 American With Disability Act (“ADA”) related services in California prisons.

17 On August 24, 2007, the Court in *Armstrong v. Schwarzenegger* adopted the coordination
18 statements. (*See*, Order Approving Coordination Statements Attached to June 26, 2007 Order
19 hereinafter “*Armstrong* Coordination Order”.) The Court further ordered that the *Plata* Receiver
20 file quarterly progress reports as he had been ordered to do in the other cases. (*Id.* at 2.)

21 E. *Integration of Coordination Related Reporting in This Quarterly Report.*

22 Following the Joint Coordination Order and the *Armstrong* Coordination Orders, the
23 overhaul of contracting functions, the implementation of a long-term IT system, and the
24 oversight of pharmacy operations for medical, mental health, dental and ADA prisoner/patients
25 have been integrated under the Receiver’s remedial umbrella. As such, when this Quarterly
26 Report iterates the progress and challenges facing reform of contracting functions, IT systems,
27 and pharmacy operations, it is referring to mental health, dental, ADA prisoner/patients as well
28 as medical health care prisoner/patients. Specifically, the Receiver’s Coordination related

1 reporting is set forth in the following sections of this Report: Credentialing and Privileging of
2 Health Care Providers (II.D.5); Contracts (II.D.6); Information Technology Update (II.D.11);
3 Telemedicine Reform (II.D.13); Closure of General Acute Care Hospital at California Institute
4 for Men (II.D. 19); and Coordination with Other Lawsuits (II.F).

5 F. Master Contract Waiver Related Reporting.

6 On June 4, 2007, the Court approved the Receiver’s Application for a more streamlined,
7 substitute contracting process in lieu of State laws that normally govern State contracts in six
8 areas: (1) Medical Records and Management of Patient Care, (2) Clinical Space, (3) Recruitment
9 and Staff Accountability, (4) Emergency Response, (5) Fiscal Management, and (6) Pharmacy.
10 (See, Order Re Receiver’s Master Application for Order Waiving State Contracting Statutes,
11 Regulations, and Procedures, and Request for Approval of Substitute Procedures for Bidding and
12 Award of Contracts, hereinafter “Master Contract Waiver Order”.) The Court approved three
13 alternative contracting procedures—depending on the type and amount of contract at issue—that
14 are streamlined when compared to State procedures yet are designed to be transparent and fair
15 and to obtain, in the Receiver’s exercise of reasonable judgment, high quality goods and services
16 at the best price. Part 3 of the Master Contract Waiver Order requires the Receiver include in his
17 quarterly progress reports to the Court, a summary that

18 “(1) specifies each contract the Receiver has awarded during the quarter, (2)
19 provides a brief description of each such contract, (3) identifies to which of the
20 six categories of project discussed herein such contract pertains, and (4) identifies
the method the Receiver utilized to award the contract (*i.e.*, expedited formal bid,
urgent informal bid, sole source.)”

21 (*Id.* at 12.)

22 Section V.C.2 of this report sets forth this required information.

23 G. Introduction Summary.

24 The Receiver’s Sixth Quarterly Report summarizes below the major remedial projects
25 that are underway. To place the particular problems facing specific remedial efforts into context,
26 the discussions required by the Appointing Order of February 14, 2006 will be presented in the
27 following order: 2, 3, 4, 5 and 1.

1 As specified above, Coordination related reporting is discussed in this report as follows:
2 Credentialing and Privileging of Health Care Providers (II.D.5); Contracts (II.D.6); Information
3 Technology Update (II.D.11); Telemedicine Reform (II.D.13); Closure of General Acute Care
4 Hospital at California Institute for Men (II.D. 19); and Coordination with Other Lawsuits (II.F).
5 Master Contract Waiver related reporting will be the subject of the final section of this report,
6 Section V.C.2.

7 II.

8 PARTICULAR SUCCESSES ACHIEVED BY THE RECEIVER

9 A. Introduction.

10 During this reporting period, the Receiver continued to refine and improve his Plan of
11 Action for restructuring and developing a constitutionally adequate health care system in
12 California prisons. This “bigger picture” work of envisioning what a constitutionally adequate
13 correctional health care system looks like progressed as the goals and objectives outlined in the
14 Plan of Action were clarified and prioritized.

15 The Receiver emphasizes that remedial work undertaken in such a dynamic context must
16 have the investment of leadership, as well as line-staff. To this end, the Receiver held several
17 meetings throughout this reporting period with CDCR State and regional leaders concerning the
18 Plan of Action.

19 Concerning the Receiver’s many on-going remedial pilots and projects, there have been
20 numerous significant successes during this reporting period, including the development of
21 additional coordination agreements between representatives from the other health care lawsuits;
22 the joint filing of a stipulation between the Receiver and the State Personnel Board which creates
23 a new civil services classification permitting the broad recruitment of executive and managerial
24 candidates; the hiring of nearly 400 additional clinical staff; the creation of a new
25 multidisciplinary unit to undertake health care reform in Community Correctional Facilities
26 (“CCF”); increase of staffing in the Office of Telemedicine Services; the licensure and operation
27 of dialysis clinics; and the conversion of the General Acute Care Hospital (“GACH”) at
28 California Institute for Men into an unlicensed infirmary.

1 In addition, the Receiver and his staff have spent considerable time during this reporting
2 period working through emergencies which erupted in several remedial areas, including specialty
3 contracts, telemedicine, and pharmacy operations. These emergencies stem from decades of
4 State mismanagement that resulted in the creation of the Receivership, and also from “growing
5 pains” caused by the implementation of the Receiver’s reform measures. As remedial actions are
6 implemented, those operations, procedures and personnel supporting the former systems must
7 rapidly adjust, which at times has resulted in breakdowns in essential functions.

8 Even while the CDCR’s medical care system begins to improve, emergencies will
9 continue to erupt. To avoid system breakdowns where possible, the Receiver understands that
10 the overhaul of CDCR’s health care system must not be rushed, but rather occur through careful
11 planning to ensure that the reforms become lasting solutions rather than temporary “band-aids.”

12 B. Plan of Action.

13 1. *Introduction.*

14 On February 14, 2006, the Court directed the Receiver to develop a “detailed Plan of
15 Action designed to effectuate the restructuring and development of a constitutionally adequate
16 medical health care delivery system.” (Appointing Order at 2.) The Court further ordered that
17 “the Plan of Action...include a proposed time line for all actions and a set of metrics by which to
18 evaluate the Receiver’s progress and success.” (*Id.* at 2-3.) Because the Court contemplated that
19 the Plan of Action would require ongoing modifications, the Receiver was also directed to
20 “update and/or modify this Plan as necessary throughout the Receivership.” (*Id.* at 3.)

21 On May 10, 2007, the Receiver filed his first Plan of Action. The Plan presents an
22 “initial roadmap for the change necessary to bring the delivery of medical care in California’s
23 prisons up to Constitutional levels.” (May 2007 Plan of Action, hereinafter, “Plan of Action,” at
24 3.) Drawing upon established conceptual frameworks articulated by the Institute of Medicine
25 and the Malcolm Baldrige National Quality Program, the Plan of Action identifies seven
26 primary goals and roughly 200 corresponding objectives. (Plan of Action at 14-15; 16-43.)

27 Thereafter, the Court directed the Receiver to file a revised Plan of Action and metrics no
28 later than November 15, 2007, including timelines identifying when the specific objectives set

1 forth in the Plan will be achieved. (September 6, 2007 Order re (1) Receiver's May 2007
2 Preliminary Plan of Action, and Motion for Order Modifying Stipulated Injunction and Orders
3 Entered Herein, and (2) Plaintiffs' Motion for Order Directing Receiver to Comply with April 4,
4 2003 Order etc. at 16.) Specifically, Part A of the Court's Order mandated:

5 "The Receiver's November 15, 2007 revised Plan of Action shall identify those
6 objectives, and/or specific portions thereof, that the Receiver plans to achieve
7 within six months, 12 months, 24 months and 36 months from the date of the
8 November 15, 2007 Plan of Action."

8 (*Ibid.*)

9 2. *Plan of Action Update.*

10 Considerable progress has been made relative to the revised Plan of Action to be
11 submitted on November 15, 2007. For example, the Receiver held a series of meetings during
12 the reporting period with Office of the Receiver staff and CDCR State and regional leaders.
13 Through the meetings, the priorities outlined in the May 2007 Preliminary Plan of Action were
14 discussed and refined. (*See*, Plan of Action pages 41-43). Updates on activities currently
15 underway were reported; plans and earlier directives were modified in some cases; and new
16 initiatives were added to the Receiver's 36-month priorities. During the next 36 months, the
17 Receivership will focus on the following projects (this information is intended as a summary,
18 each of the projects listed below will be discussed in detail, including timelines and metrics, in
19 the Receiver's second Plan of Action submission to be filed on November 15, 2007):

20 1. Development of a system to recruit and hire clinical and executive management
21 staff remains the Receiver's highest priority. The initiatives that will be the focus of the next 36
22 months are as follows:

- 23 a. Recruitment and hiring of clinical positions, including physicians, mid-level
24 practitioners, Registered Nurses ("RN"), Licensed Vocational Nurses
25 ("LVN"), and pharmacists. (*See*, Plan of Action Objective A.8).
26 b. Recruitment and hiring of executive and management positions including
27 Receiver's Career Executive Assignment staff; regional and statewide
28 medical and nursing directors; Chief Medical Officers ("CMO"); Regional

1 Directors of Nursing; and institution, regional and statewide Chief Operating
2 Officers. (See, Plan of Action Objective A.7).

3 c. Recruitment and hiring of support staff for the clinical and executive and
4 management positions.

5 d. Orientation and reorientation for existing and new medical employees.

6 2. The construction of approximately 5,000 prison medical beds. (See, Plan of
7 Action Objective F.3.**¹)

8 3. A program to construct necessary clinical space and medical support facilities
9 (e.g. medical records and administrative office space) in existing prisons (approximately 8 to 12
10 prisons per year). (See, Plan of Action Objective F.1.**)

11 4. Implementation of the custody access team program at San Quentin State Prison,
12 and a time-phased roll-out at three additional prisons. (See, Plan of Action Goal E.*)

13 5. Constructing the “foundation” and “walls” of the Receiver’s health care system
14 wide IT program (including telemedicine), and the commencement of user involvement in that
15 process. (See, Plan of Action Goal D.*)

16 6. Continued implementation of the existing system-wide pharmacy restructuring
17 program. (See, Plan of Action Objective B.8.*)

18 7. Continuation of the existing remedial program regarding contract restructuring
19 (specialty care, registries, and hospitals), including an expansion of the program to restructure
20 aspects of contracting that involve negotiations and payments. (See, Plan of Action Objectives
21 A.4 and A.6.*)

22 8. Continued restructuring of the existing State medical care support services
23 functions (both the support services staff at 501 J Street and support service staff at 1515 S
24

25
26 ¹ Those programs followed by a * represent programs where the Receiver will manage health
27 care administrative functions that will serve all disciplines (medical, mental health, and dental).
28 Those programs followed by a ** represent programs where the Receiver may, after further
coordination discussions with the Special Master in Coleman and Court experts in *Perez*, manage
health care administrative functions that will serve all disciplines (medical, mental health, and
dental).

1 Street) into a single appropriately organized and managed Plata Support Services Division. (See,
2 Plan of Action Objectives A.1 and A.2.)

3 9. Restructuring of the health care credentialing process. (See, Plan of Action
4 Objective A.8.5.3.*)

5 10. Continuation of several existing pilot projects, including the San Quentin State
6 Prison Pilot (See, Plan of Action Objective B.2) and the LAC/CCI Specialty Care Pilot; and a
7 pilot project for joint clinical/internal affairs investigations (to be developed cooperatively with
8 the Office of Internal Affairs and the California Office of the Inspector General) (See, Plan of
9 Action Objective C.8). The pilot project to establish the Receiver's Air Force to deliver full-time
10 permanent State physicians from urban locations (e.g. Los Angeles, Sacramento) into rural
11 prisons has been discontinued as a priority at this time. (See, Plan of Action Objective A.8.6.1.)
12 The Receiver determined that efforts and resources would be better served by focusing on other
13 programs to attract clinicians.

14 11. Implementation of an initial model of an appropriate medical care budget. (See,
15 Plan of Action Objectives A.2.4 and A.2.5.)

16 12. Implementation of a clinical peer review-based program to evaluate physician
17 clinical competency. (See, Plan of Action Objective C.8.*)

18 13. Participation in coordinating remedial efforts with the Special Master in *Coleman*,
19 the Court experts in *Perez*, and the Court in *Armstrong*.*

20 14. Development and implementation of a comprehensive inmate appeals pilot
21 program to handle existing health care inmate appeals (CDC 607's); Receiver correspondence
22 received via mail; habeas corpus cases; and health care-related letters submitted to the CDCR
23 and the Receiver by legislators and the Governor. This is a new 36-month priority for the
24 Receivership. It has been added because the four administrative functions are being handled
25 separately at this time, the existing CDCR system is not timely and functions inadequately, and
26 there may be overlap and duplication involving current appeal related efforts.

27 15. Nursing initiatives, including the following:

28 a. Implement a nursing hiring and recruitment executive leadership initiative

1 which will establish a nursing leadership infrastructure, including new job
2 classifications, minimum qualifications and requirements, and performance criteria
3 for the Director of Nursing positions for the headquarters, regional, and local levels.
4 (*See, Plan of Action Objective A.7.*)

5 b. Pilot a nursing orientation and preceptor initiative to include a health care orientation
6 program to be delivered to new employees on day-one of employment. The
7 orientation will be followed by a standardized LVN and RN competency-based
8 preceptor program.

9 The programs will be piloted at four prisons before being implemented statewide.
10 (*See, Plan of Action Objectives A.8.1 and 8.5.*)

11 c. Implement, design and pilot the asthma initiative (a joint nurse and physician
12 program) which will provide care coordination protocols and case management
13 mechanisms to ensure continuity of care at selected Maxor pilot
14 sites to improve asthma care. (*See, Plan of Action Objective B.3.1.*)

15 d. Develop, pilot, and implement emergency response staffing models, protocols and
16 programs to prevent unnecessary patient or staff injury or death. (*See, Plan of Action*
17 *Objective B.1.1.*)

18 e. Continue implementation of the nursing medication process redesign which links the
19 Maxor Guardian System to the redesign of the nursing medication delivery process to
20 ensure timely and accurate delivery of medication to prisoner/patients. This program
21 is currently being piloted at Mule Creek State Prison.

22 (*See, Plan of Action Objective B.8.*)

23 16. Establishment an Office of Evaluation, Measurement and Compliance.

24 Receiver's staff have been assigned to each priority and have been directed to prepare a
25 project "roadmap" for each objective. The Receiver will provide the final roadmaps, summaries,
26 and additional details (including timeframes and metrics) in the November 2007 submission of
27 his revised Plan of Action.

28

1 operational by November 15, 2007. Additional details will be provided in the November
2 iteration of the Plan of Action.

3 C. Receiver's Requests for Waivers of State Law.

4 During this reporting period, the Receiver filed one request for a waiver of State laws
5 which were preventing the Receiver from implementing necessary remedial strategies.² In
6 addition, two previous waiver requests pending at the time of the last report—the April 25, 2007
7 Motion for Waiver of State Law Re Physician Clinical Competency Determinations, and the
8 April 13, 2007 Motion for Waiver of State Law Re Receiver Career Executive Assignment
9 Positions—have progressed further. The status of each waiver is described below.

10 1. *Receiver's Supplemental Application No.1 for Order Waiving State*
11 *Contracting Statutes, Regulations and Procedures, Approving*
12 *Receiver's Substitute Procedure for Bidding and Award of*
13 *Contracts and Approving Nunc Pro Tunc ACNL Supervisory Nurse*
14 *Training Contract.*

15 On June 27, 2007, the Receiver filed his Supplemental Application No.1 for Order
16 Waiving State Contracting Statutes, Regulations and Procedures. This application follows the
17 Court's June 4, 2007 Order Re Receiver's Master Application for Order Waiver Waiving State
18 Contracting Statutes, which waived certain State contracting laws and approving substituted
19 notice, bidding and award procedures with respect to 13 of the Receiver's remedial projects. The
20 Supplemental Application moved the Court for an order waiving the governing State contracting
21 laws and regulations with respect to five *additional* projects: radiology services, clinical
22 laboratory services, nursing leadership development, physician credentialing and medical

24 ² Pursuant to the Order Appointing Receiver filed February 14, 2006, the Receiver must make
25 all reasonable efforts to exercise his powers in a manner consistent with California state laws,
26 regulations and labor contracts. In the event, however:

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

(Appointing Order at 5:1-11.)

1 specialty services. The Supplemental Application also sought an order *nunc pro tunc* approving
2 a November 27, 2006 contract with the Association of California Nurse Leaders concerning
3 nursing leadership training.

4 On July 12, 2007 the Defendants filed a Statement of Non-Opposition to the Application,
5 and the Plaintiffs filed a response, which stated that they “do not oppose any aspect of the
6 Receiver’s motion” but it requested that the Receiver provide them with certain information.
7 (*See*, Pls’ Response at 2, 3.) The Receiver filed a reply on July 17, 2007, in which he agreed to
8 provide the requested information. On August 13, 2007, the Court granted the Receiver’s
9 Supplemental Application, stating:

10 the Court agrees, and the parties do not dispute, that the above projects are
11 “critical to the systemic changes necessary to achieve constitutional medical care in the
12 State’s prisons,” [citation], and without the requested waiver the Receiver
13 would be prevented from achieving this goal in a timely fashion. Further, no
14 party has identified any alternative to the requested waiver that would achieve a
15 constitutional remedy in this instance.

16 (Order Granting Receiver’s Supplemental Application No.1 for Order Waiving State Contracting
17 Statutes, Regulations and Procedures, Approving Receiver’s Substitute Procedure for Bidding
18 and Award of Contracts and Approving Nunc Pro Tunc ACNL Supervisory Nurse Training
19 Contract at 3, 4.)

20 2. *Receiver’s Motion for Waiver of State Law Re Physician Clinical
21 Competency Determinations.*

22 On April 25, 2007, the Receiver moved for a Waiver of State Law Re Physician Clinical
23 Competency Determinations. The motion seeks to establish a meaningful peer review process
24 that results in the revocation of privileges and corresponding termination of employment for
25 clinical misconduct and negligence. The State Personnel Board opposed the motion. The
26 Receiver’s Chief of Staff and Staff Attorney have met and conferred with representatives of the
27 State Personnel Board on several occasions to fashion a process acceptable to both the Receiver
28 and the Board. The Receiver’s representatives proposed a number of alternatives to satisfy the
Board’s concerns, and the Board’s staff have in turn provided counter proposals. The

1 negotiation process continues. Additional information will be provided in the next Quarterly
2 Report.

3 3. *Receiver's Motion for Waiver of State Law Re Receiver Career*
4 *Executive Assignment Positions.*

5 On April 13, 2007, the Receiver filed a Motion for Waiver of State Law Re Career
6 Executive Assignments because of the health care leadership crisis in the prisons brought about
7 by (1) the use of civil service classifications with qualifications and salaries far too low to meet
8 its competency needs; (2) the lack of an effective program to infuse the CDCR leadership
9 structure with experienced personnel from outside civil service; (3) an employment system that
10 guarantees continued employment in spite of being indifferent to the Court's objectives, plans
11 and policies; and, (4) a dysfunctional organizational structure.

12 To remedy the gross inadequacies in the current management and supervision of the
13 medical care delivery system, the Receiver's motion sought to install a Career Executive
14 Assignment ("RCEA") program enabling him to hire highly qualified administrators who would
15 be classified as civil service employees but (1) could be selected from inside or outside civil
16 service, and (2) would serve "at will". The State Personnel Board opposed this motion.

17 On July 3, 2007, the Court ordered the Receiver and the Board to meet and confer, and to
18 submit a report to the Court within 45 days regarding whether they could agree upon a
19 mechanism for hiring executives. On August 20, 2007, the Receiver and the State Personnel
20 Board filed a Joint Report and Stipulation as the result of extensive discussions and negotiations.
21 On September 11, 2007, the Court issued an order adopting the parties' agreement. (*See, Order*
22 *Adopting August 20, 2007 Stipulation Between Receiver and State Personnel Board.*)

23 The Stipulation and Order provides for the establishment of civil service classifications,
24 consistent with the Board's constitutional authority, which permit broad and inclusive
25 recruitment of executive and managerial candidates with experience, education, knowledge,
26 skills and abilities determined necessary by the Receiver. It provides for examinations open to
27 individuals from both outside and inside civil service who possess the requisite qualifications. It
28 permits non-tenured appointments for up to two years followed by a one-year probationary

1 period before acquiring permanent status. Now that the stipulated RCEA process has been
2 approved by the Court, the Office of the Receiver has begun the process of commencing
3 establishment of specific duty statements, establishing salaries, and recruiting on a pilot project
4 basis as set forth in the pleadings filed with the Court relative to this motion.

5 The Receiver notes that the new State Personnel Board Executive Officer, Suzanne
6 Ambrose, was instrumental in a very positive manner throughout the negotiation process. She
7 has also remained actively involved in the development of a new Nurse Executive classification
8 which the Receiver believes may be formally adopted by the Board as early as October 22, 2007.

9 The Receiver's has met and conferred with the Department of Personnel Administration
10 ("DPA") regarding a broadband salary administration methodology for the new Nurse Executive
11 classification. At this juncture the Receiver believes DPA is prepared to implement the
12 methodology being discussed. The actual salaries for the positions will depend on salary survey
13 results. If necessary, the Receiver will bring the issue of salaries to the Court's attention, but
14 only after meeting and conferring with DPA.

15 D. Remedial Pilots and Projects.

16 1. *San Quentin State Prison Project.*

17 Work at San Quentin State Prison to reform every aspect of health care delivery
18 continues and during this reporting period many successes have been realized including:
19 completion of the construction and remodel of the Reception Center; improving the caliber and
20 stability of the medical staff based on a partnership with University of California, San Francisco
21 ("UCSF") School of Medicine; remodeling of the Medical Records Department. Further details
22 of each of these remedial projects, as well as changes to the nursing program, appeals program,
23 staff education, and many other improvements are described below.

24 a. *Reception Screening Process.*

25 Of particular significance is the completion of the construction and remodel of the
26 Reception Center ("RC") which now provides five intake exam rooms, laboratory area, three
27 mental health rooms, and clerical support office. Long awaited implementation of the revised
28 RC Intake Screening Process began on September 12, 2007. Success of the new intake screening

1 and health assessment program requires the coordination of medical, mental health, dental and
2 custody staff, which will be continually monitored, managed and critiqued. New data tracking
3 provides program evaluation, such as delivery time of essential medications to prisoner/patients,
4 and primary care intake evaluations by an MD or mid-level provider within defined timelines.
5 These are several essential goals in delivering successful intake screening and assessment. The
6 new process also aims to reduce unnecessary and avoidable transfers to the Triage and Treatment
7 Area (“TTA”) or Community Hospitals due to chronic care conditions within the first 30 days of
8 arrival at San Quentin State Prison.

9 Networking efforts with local county jails for intake and release related activities
10 continue; as such, new dedicated facsimile lines in the RC are expected to improve coordination.
11 Physician, nursing, mental health, and psychiatric staffing in the new RC receive on-going
12 review and evaluation as the program’s needs evolve. The prisoner/patient health care
13 orientation handbook is presently being updated.

14 Prisoner/patient health educational materials in English and Spanish were developed and
15 distributed to all clinics and the Inmate Library. Planning and development of an inmate
16 orientation video with Centerforce has begun. Videos on HIV, Hepatitis C, Sexually Transmitted
17 Diseases (“STD”) and Tuberculosis (“TB”) are available for prisoner/patient viewing on the 3
18 television monitors which were installed in the RC holding areas.

19 b. Primary Care Provider Program.

20 A major initiative at San Quentin State Prison has been to establish a medical delivery
21 system with a solid primary care foundation including timely, efficient, and effective services.
22 Over the past year, efforts were focused on developing a professional primary care workforce
23 program that now includes qualified providers, a staffing model, recruitment and retention
24 strategies, orientation, training, continuous professional development and evaluation, and local
25 peer review. During this reporting period, slow but steady progress is becoming apparent.

26 Due to creating an effective primary care workforce program, the caliber and stability of
27 the medical provider staff at San Quentin State Prison continues to improve significantly. For
28 example, since the last Quarterly Report, four additional State physicians have been hired, for a

1 total of eight State physicians, half of whom trained at UCSF. In addition, there are four State
2 mid-level practitioners now on staff.

3 The continued relationship with UCSF supports a primary care workforce pipeline that
4 includes medical students, nurse practitioner students, and primary care residents who rotate
5 through primary care and geriatric clinics at San Quentin State Prison. These clinical rotations
6 provide many benefits including enriched work environments for San Quentin State Prison staff
7 who preceptor the students and residents, enhanced evidence-based practices, and new
8 candidates for medical positions. In addition, pilot projects in North Block such as the diabetes
9 self-management group and the geriatric clinic continue to improve the quality of patient care.

10 San Quentin State Prison also piloted a primary care provider staffing model for
11 consistent coverage of patients by housing unit assignments and clinical service areas. This has
12 helped to develop physician and mid-level practitioner partnerships which are supported by
13 redefined job descriptions, productivity expectations, and continuity care referral guidelines.
14 Providers also received new clinical performance expectations, and timely evaluations and
15 feedback.

16 Weekly provider meetings provide physicians with continuing medical education and
17 clinical guideline implementation information, emphasizing chronic care management especially
18 for patients with cardiovascular risk factors such as diabetes, hypertension, dyslipidemia,
19 infectious diseases, and asthma. Routine weekly reviews are conducted in several areas,
20 including non-formulary medications, unscheduled transfers to community emergency
21 departments and hospitals, and other significant events that contribute to morbidity and
22 mortality.

23 San Quentin State Prison continues to improve both the quality of care provided by
24 medical staff and the work environment for providers with basic tools such as computers;
25 diagnostic study results and specialty care reports; online and hardcopy reference materials; and
26 clinic space, including two additional primary care offices and two provider offices in the RC.
27 Preliminary patient outcome and provider practice reports indicate these changes have improved
28 the quality of medical care at San Quentin State Prison.

1 c. Nursing Program.

2 Nursing has been recognized as the “glue” that holds the system together. RN Care
3 Managers have prioritized their individual assignments, are given designated work time each
4 week to develop their programs as a team, and are receiving further training. General orientation
5 curriculum for nurses was developed and specific curriculum is being drafted for each clinical
6 area, including Outpatient Housing Unit (“OHU”), TTA, and RC. The Nursing Preceptor
7 Program also ensures that all new RNs and LVN, particularly those new to corrections, receive
8 continued support and individualized training. The Nursing Program has also partnered with the
9 Custody Unit to develop a custody orientation for health care staff. The Nursing Department
10 currently serves on committees to help with building plans, disaster preparedness, compliance
11 with accommodating disabled prisoner/patients, emergency response review, safety, and mental
12 health programs.

13 d. Public Health Nursing.

14 The Public Health Department continues to broaden its scope while expanding patient
15 care on a daily basis. A recent varicella (chicken pox) outbreak, spurred staff to develop a
16 screening project which will commence in October 2007. Community relationships that were
17 formed in June with the State STD Control Branch, have resulted in bi-monthly coordinated
18 meeting and case contact investigation interviews. A monthly meeting is now held with the HIV
19 Surveillance Coordinator from Marin County. Preliminary databases are now utilized to track
20 HIV patients, STD patients and patients who are receiving treatment for latent TB infection.
21 Public Health has also linked with the “Environmental Health and Hygiene” unit to assist in
22 monitoring the cleanliness of all areas of the institution. Under the ambitious efforts of the SQ
23 Public Health Staff, the program continues to grow and address many more issues which are
24 further described below.

25 e. San Quentin State Prison Health Care Appeals.

26 The objective of San Quentin State Prison’s Health Care Appeals pilot program is to
27 reduce prisoner/patient complaints by resolving recurring problems promptly and at the lowest
28

1 level through the utilization of RNs to triage all incoming health care appeals for urgent or
2 emergent health care issues.

3 With the revision of the health care appeals process last quarter, appeal responses have
4 shown considerable improvement, reflective of approximately 50% reduction in overdue appeals
5 over the last two months. In addition, medical staff have reduced the backlog of prisoner/patient
6 appeals based on ADA claims, resulting in an 83% decrease in overdue ADA responses since
7 May 2007.

8 These improvements are due to several recent changes to the Health Care Appeals
9 Program. First, management is holding health care staff accountable for meeting appeal
10 timelines. Also, a Health Care Quality Management Team has been instituted and meets
11 monthly to identify and resolve any pending issues across all disciplines; findings and
12 recommendations are reported to the Quality Management Committee. In addition, the RN Care
13 Managers, who meet on a monthly basis, assist in the answering of appeals and provide
14 continued training and support as needed to the nurses.

15 f. Medical Records.

16 Significant progress has been made this quarter by completion of the remodeling of the
17 Medical Records Department which can now better accommodate current staffing and workload
18 processes. During this reporting period, the Medical Records Department instituted weekly
19 audits and continues to improve the availability and quality of health records, thus providing
20 improved service to clinical services staff and providers. Availability of health records is at
21 approximately 90%, versus approximately 80% six months ago.

22 The Quality Improvement Team continues to meet monthly to identify and resolve any
23 pending issues across disciplines. All findings and recommendations are reported to the Quality
24 Management Committee.

25 Medical Records' use of registry staff has decreased over the last six months, evidenced
26 by approximately an 80% fill rate with a properly trained, permanent, full-time workforce.

27 g. Personnel.

1 Several personnel changes were instituted during this reporting period. For example,
2 management roles have been defined by clinical and operational function and a clinical staffing
3 model was created for the Nursing Program to accommodate an increased need for problem
4 solving and to provide 24/7 management of nursing staff. In addition, a post assignment
5 schedule was developed, incorporating increased relief associated with training and certification
6 requirements.

7 The Receiver's aggressive hiring program continued throughout the reporting period.
8 Position requests are now automatically generated through the Personnel Department and
9 communicated directly to Department Managers to expedite the filling of vacant positions.
10 Hiring fairs were held in July 2007 and September 2007, generating a host of skilled candidates.
11 Currently, there are no Registered Nurse vacancies and only five (9.8%) Licensed Vocational
12 Nurse vacancies.

13 In addition, a Personnel Officer and a Personnel Analyst were recruited in August 2007
14 to provide dedicated medical personnel support. Monthly Human Resources meetings have been
15 instituted to assess the status of current vacancies, pending probationary reports, as well as any
16 recruitment issues.

17 h. Staff Training.

18 1. *Orientation.*

19 A new employee training for health care and custody staff has been developed. This
20 combined training program unifies custody and health care staff in working together with a
21 common goal of delivering patient-centered care. Court mandated and CDCR Department
22 Operations Manual requirements are included in the development of the training program draft.
23 It is expected to be implemented within 30 to 60 days.

24 Several new training programs for nurses have been implemented during this reporting
25 period and are described above in the Nursing Program section.

26 2. *Supervisory Training.*

27 The development of clinical supervisory staff is of utmost importance to carrying out the
28 success of all remedial programs. Supervisors and managers are now afforded supervisory,

1 leadership, probationary and employee disciplinary training upon entry into their leadership role.
2 Managers and front-line supervisors now attend the Basic and Advanced Supervisor & Manager
3 training. Probationary and Annual Performance report training was conducted on August 13,
4 2007 and August 28, 2007 for all health care supervisors, managers, and leads.

5 *3. Policy Training.*

6 In August 2007, weekly trainings began for supervisors on the numerous and newly
7 developed pilot policies and procedures as well as revised local operating procedures. Binders of
8 the new policies and procedures, and local operating procedures were distributed to all
9 supervisors and all service areas. Supervisory staff are, in turn, expected to train their
10 subordinates within 15 days of receiving the training.

11 *i. Department Budgets.*

12 The Receiver's Fifth Quarterly Report reported a significant shift in fiscal budgetary
13 responsibility to Health Care Department managers who became responsible for projecting,
14 justifying and maintaining their own budgets. This change in fiscal management responsibility
15 was intended to instill a sense of ownership and accountability in each Department. (*Fifth*
16 *Quarterly Report* at p. 9-10.) CDCR managers are learning the basics of budget management
17 and continue to work with the Chief of Support Operations to track and project expenditure
18 needs in their departments.

19 *j. San Quentin State Prison Specialty Contract Processing.*

20 During this reporting period, a new contract approval and verification process was
21 implemented to ensure that invoices are verified and approved for services rendered and payment
22 is made timely. In addition, Department Managers are held accountable through a weekly
23 review of the *Plata* Contracts Aging Report. This process provides for the immediate
24 identification of questionable, potentially fraudulent claims. Prior to the implementation of this
25 new process, the payment of services that had not actually been rendered may have continued
26 unidentified. The approval and verification of hospital contracts remain an unaddressed issue as
27 there is a critical need to consolidate contracts for in-patient and specialty services.

28 *k. Laboratory.*

1 Laboratory services have continued to improve within the reporting period. Scheduling
2 prisoner/patients for laboratory testing is no longer problematic. Currently, there is no backlog
3 for blood draws and tests. The maintenance of laboratory results in the health records are at
4 approximately 95% compliance rate. New laboratory protocols which bring lab services into the
5 housing units have resulted in timely blood draws and subsequently a reduction in escort
6 coverage. A satellite lab was added to the RC, streamlining RC processing.

7 l. Environmental Health and Hygiene Services.

8 Several improvements to prison janitorial services have been instituted during this
9 reporting period. Audits tools and daily cleaning schedules have been implemented for the
10 clinic, kitchen and housing areas. Weekly audits are conducted of all areas to ensure
11 compliance. Of the three custodian positions established through the Receiver to oversee
12 janitorial services and monitor environmental health and hygiene, one vacancy remains. A
13 vocational program is further progressing to train and certify prisoners and staff in janitorial
14 services.

15 m. Monthly Reports and Metrics.

16 In July 2006, the role of the Quality Management Committee ("QMC") was redefined to
17 ensure effective and efficient local implementation of the Receiver's Plan of Action. Project
18 teams were formed to redesign and integrate various clinical service and support areas. These
19 teams revised or developed pilot policies and procedures and developed metrics for standard
20 monthly reports to the QMC.

21 The monthly report on the RC concluded that primary care intake evaluations, when
22 performed by physicians, are conducted timely 54% of the time and are timely 73% of the time
23 when performed by midlevel providers. The monthly report also found that prisoner/patients
24 received essential medications by day after their initial arrival to San Quentin State Prison
25 approximately 69% of the time. These averages are expected to increase in the next months'
26 reports as the new RC was only fully implemented on September 12, 2007.

27 The monthly report on Specialty Services, including radiology and laboratory services,
28 concluded that the current waiting times for specialty appointments remain acceptable.

1 The medication management and the TTA metrics were just developed and implemented,
2 and reports will be submitted to QMC as scheduled.

3 Currently in development are metrics for the OHU, Scheduling Services, and access to
4 Primary Care Services.

5 2. *Construction at San Quentin State Prison During the Reporting*
6 *Period.*

7 Significant progress continues in the design and construction of the clinical projects at
8 San Quentin State Prison. The highlight of this reporting period is the selection of Hensel-Phelps
9 construction teamed with HOK Architects as the design-build team for construction of the
10 Central Health Services Building. In addition, the overall conceptual budget for completion of
11 the Central Health Services Building is less than initially expected. The challenge now facing
12 completion is to finalize several State funding issues to ensure the funds available to proceed.
13 On other smaller San Quentin State Prison construction projects, minor delays have slowed the
14 progress, but all major projects are proceeding on schedule.

15 A full description of all of the construction projects at San Quentin State Prison are
16 described in the *Receiver's Third Bi-Monthly Report*. The following sections will describe the
17 progress made toward completion during this reporting period.

18 a. *Status of Construction of the Central Health Services*
19 *Building.*

20 The Central Health Services Facility at San Quentin State Prison includes a 50-bed
21 Correctional Treatment Center and a state-of-the-art RC to accommodate the mission of San
22 Quentin State Prison as a CDCR RC. The Receiver's efforts to include representatives of the
23 mental health class action (*Coleman*) and the dental services class action (*Perez*) in the design
24 and planning process have been successful.

25 The selection process for construction of the Central Health Services Facility resulted in
26 proposals from two competent and experienced Design Build Teams. After careful review, the
27 Hensel Phelps/HOK team was granted the contract based on the Team's experience, the superior
28 design proposed, and the proposal cost was under the established budget. Hensel-Phelps/HOK

1 has already begun with the design and abatement of hazardous material in building 22, in
2 preparation for its demolition. They will be authorized to proceed with the demolition and
3 construction of the new facility after the completion of the California Environmental Quality Act
4 (“CEQA”) process. This process has also been progressing on schedule. The Environmental
5 Impact Report was certified by the Secretary of the CDCR on September 7, 2007.

6 b. Funding for the Central Health Services Building.

7 The San Quentin State Prison Central Health Services Building will be funded through an
8 appropriation of the Legislature [Senate Bill 99 (“SB 99”)] which recently passed and is awaiting
9 signature by the Governor. SB 99 authorizes the State Public Works Board to issue up to
10 \$146,160,000 in revenue bonds for the design and construction of the Central Health Services
11 Building. On September 14, 2007 the Public Works Board authorized the sale of the bonds and
12 the use of interim financing contingent on the Governor’s signature of the Bill. Assuming that
13 the Governor signs the Bill, complete funding for the project should be available to the Receiver
14 shortly.

15 c. Status of Interim Medical Construction Including Modular
16 Buildings and Rotunda Sick-Call Rooms.

17 Several construction projects have been completed and are fully operational, including
18 the replacement parking spaces; TTA renovations, including a new inmate holding area; addition
19 of a triple-wide trailer to provide office space for medical care delivery personnel; limited
20 remodeling of the existing medical records unit; and limited remodeling of the existing
21 Receiving and Release modular.

22 In addition, several construction projects are ready for bidding. Request For Bids for the
23 construction of the Personnel Offices Building and the expansion of the West and East Block
24 Rotundas to establish clinical “sick-call” areas will be advertised in September, 2007. The
25 selection of the contractor for the Primary Care and Specialty Medical Services modular will be
26 announced shortly, and the contract is expected to be executed in September, 2007. The contract
27 for the relocation of the exercise yards from upper yard to C yard is ready for execution.
28

1 Progress was also made on the Medical Supply Warehouse Project with completion of
2 the design package for the new Warehouse. In addition, temporary warehouse space was
3 developed to alleviate the crowded conditions of the main warehouse until this project can be
4 completed.

5 A decision was made to not proceed with the ventilation upgrades and cleaning of the
6 North Block due to its high cost and limited medical benefit.

7 d. Conclusion.

8 The continued successful completion of the smaller projects and the significant
9 milestones accomplished on the Central Health Services Building has only been possible by the
10 significant cooperation of San Quentin State Prison clinical personnel, custody personnel and
11 staff from the Office of the Receiver.

12 3. *Maxor's Pharmacy Management Update.*

13 a. Introduction.

14 Continued progress was made this reporting period towards achievement of the *Roadmap*
15 goals and objectives, although not without a few obstacles or delays. (An Analysis of the Crisis
16 in the California Prison Pharmacy System Including a Road Map from Despair to Excellence,
17 hereinafter "Roadmap", Exhibit 1.) Significant progress in achieving target goals continued in
18 seven main areas during the past three months: pharmaceutical contracting and purchasing,
19 hiring pharmacy administration and staff, education of pharmaceutical staff, organization and
20 management of pharmacy staff, implementation of pharmacy software, development of a central
21 pharmacy, and centralization of clinical initiatives. (See Pharmacy Management Consulting
22 Services Monthly Progress Reports to the California Prison Health Care Receivership
23 Corporation June, July & August 2007, Exhibits 2, 3 & 4, respectively.)

24 Particular successes achieved by the Receiver in accomplishing remedial goals:

25 b. Pharmaceutical Contracting and Purchasing.

26 Maxor is working closely with the Pharmacy & Therapeutics ("P&T") Committee to
27 identify favorable contracting opportunities. Utilizing P&T category review recommendations,
28 Maxor has negotiated with manufacturers on five therapeutic categories, preferred agents for

1 three categories have been selected and two more are pending. All are predicted to result in
2 improved continuity of patient care and significant cost savings. As a result of efforts to
3 communicate with the pharmacists-in-charge ("PIC") to improve purchasing, approximately
4 \$138,643 was saved on average per month for June, July and August 2007. Maxor continues to
5 work with the wholesaler to meet CDCR's volume demands. Over the past three months, as a
6 result of stock requests to AmerisourceBergen, Maxor has been able to capture approximately
7 \$405,669 in savings. In August 2007, Maxor aided CDCR in achieving an additional cost
8 savings of \$125,525 by locating an alternate supplier for albuterol inhalers.

9 c. Hiring Pharmacy Administration and Staff.

10 Maxor is now actively involved in the recruitment and hiring of facility-based staff. As a
11 result of Maxor's staffing evaluation and recommendations, ten new pharmacist and three new
12 technician positions were approved by the Office of the Receiver. Efforts to replace registry PIC
13 with State employees are progressing well. In January 2007, there were nine registry PICs and
14 one facility with no PIC. In August 2007, there were a total of six registry PICs and no facility
15 without a PIC. Recruitment activities continue for hiring clinical pharmacy specialists ("CPS").
16 One additional CPS started in August 2007 and two more will start in September 2007 to bring
17 the total to four of eight budgeted positions and extends CPS positions to seventeen CDCR
18 facilities. An additional Drop-In team technologist has also been hired this reporting period.
19 Maxor, in conjunction with Receivership personnel, distributed a recruiting letter to over 32,000
20 licensed pharmacists in California in August 2007. In addition, clarification in hiring and
21 disciplinary authority has been provided to Maxor, thereby ensuring consistency in personnel
22 matters.

23 d. Education of Pharmaceutical Staff.

24 The third PIC meeting was held August 15, 2007 in Sacramento and included training in
25 targeted areas of clinical and operational change related to the *Roadmap*. *Pharmacy Horizons*,
26 the pharmacy newsletter, continues to be published monthly and is in its fifth edition. In June
27 2007, MC Strategies (the pharmacy personnel tracking and educational software tool) was
28 launched to all pharmacists. Asthma and hypertension education modules as well as a module on

1 the new therapeutic interchange policy have been added to MC Strategies along with the seven
2 other policy and procedure modules. MC Strategies allows for tracking of employees who have,
3 as well as have not, completed the training modules.

4 e. Organization and Management of Pharmacy Staff.

5 The facility pharmacy inspection process has been accepted as a beneficial quality
6 improvement tool by facility level staff. The number of pharmacies passing inspection (or with
7 only minor unresolved procedural problems) has increased from 3% to 39% from March to July
8 2007. Maxor will soon begin the process of re-evaluating facilities that claim to have resolved
9 problems identified by Maxor to validate resolution. Review of the facility inspection grid has
10 become a standing agenda item for the P&T Committee. In addition, the pharmacy Drop-In
11 team has been assisting several facilities with operational issues and concerns. The team is
12 currently working with California Correctional Center, High Desert State Prison, California
13 Medical Facility, Salinas Valley State Prison, California Institution for Women, Folsom State
14 Prison and California State Prison, Solano regarding facility management and operational needs.

15 f. Implementation of Pharmacy Software at Folsom State Prison and
16 Mule Creek State Prison.

17 1. *Folsom State Prison.*

18 The Maxor's GuardianRx pharmacy software implemented on May 14, 2007, did not go
19 as smoothly as anticipated. The original project scope was to implement GuardianRx within the
20 pharmacy only; however, problems occurred which had repercussions beyond the pharmacy
21 walls, impacting the nursing medication delivery process to patients.

22 A host of problems occurred, beginning at the planning and training phases. The local
23 leadership did not have the capacity or the "know how" to anticipate the impact of GuardianRx
24 on operations and plan accordingly. For example, Folsom State Prison staff were not trained in
25 advance to operate under the new system. The facility's space constraints also limited the
26 nurses' ability to deliver medications safely to the patients. The CDCR computer network could
27 not support reliable user access to the new GuardianRx system. The nurses and prisoner/patient
28

1 were not prepared ahead of time for the disruption to the medication delivery process, as a result
2 of the automation in the pharmacy.

3 Additional problems stemmed from a lack of coordination between pharmacy and
4 nursing staff in connecting the medication delivery process to the new pharmacy system. For
5 example, the LVN and Psychiatric Technicians (“PT”) are responsible for medication delivery to
6 the prisoner/patients and to initiate the medications refill process. To do their jobs, LVNs and
7 PTs need accurate Medication Administration Reports (“MAR”) in order to administer the right
8 medication to the right patient at the right time through the right route. By June 7, 2007 some
9 MARs were missing and some prisoner/patients were not receiving their medications.

10 Compounding these problems, implementation of GuardianRx occurred in the midst of
11 the nursing staff’s transition from Medical Technical Assistant (“MTA”) positions to new LVN
12 positions, resulting in a large number of new LVNs at Folsom State Prison who were still being
13 trained to perform medication administration functions. These new LVNs were not prepared to
14 handle prisoner/patients who were irate over not receiving their scheduled medications.

15 A Crisis Response Team including three nurse consultants and additional Maxor staff
16 was put in place on June 7, 2007. The Team performed an exhaustive investigation of the
17 medication delivery process at Folsom State Prison, including collection of orders, filling of
18 prescriptions, delivery of medication and MARs to nursing staff, administration and
19 documentation by nursing staff, and general practices in the pharmacy. The Team found that
20 medication rooms previously available for use by the MTAs had been reallocated to clerks and
21 LVNs were now required to administer medications under completely inadequate conditions.
22 The rooms used for sorting medications and preparing for medication administration were dirty;
23 MARs were scattered about the room; there were many expired medications interspersed with
24 current medications; and bags of medications that had been delivered by the pharmacy one to
25 two days previously had not been opened and prepared for administration. Medication orders
26 written by the providers frequently did not contain all the required information.

27 On June 11, 2007 a second medication room was visited by Maxor staff. Medications,
28 expired medications, and MARs were again in disarray. Maxor staff sorted the medications and

1 MARs, removed expired medications, and separated various medication orders without
2 medications or MARs to be investigated by nursing staff. Missing medications were located.
3 The Regional Director of Nurses met with her staff and members of the Maxor team, explained
4 corrective actions and the importance of working as a team.

5 On June 12, 2007 the Crisis Team, additional members of the Receiver's staff, and
6 Maxor personnel met. It was the consensus of the group that GuardianRx implementation *per se*
7 was not the cause of the crisis at Folsom State Prison. Rather, there were several contributing
8 factors including lack of sharing information by and between Medical and Custody staff,
9 inexperienced LVNs, inadequate space for medication administration nurses, inadequate support
10 by medical leadership at Folsom State Prison, and procedural inefficiencies in the pharmacy.

11 Due to corrective actions by Nursing and Maxor, by early September 2007 Folsom State
12 Prison was no longer in crisis from the GuardianRx System implementation perspective. The
13 nursing medication delivery process using the interim manual system is sustainable until the new
14 Computer Health Care Network is installed in October 2007. The key indicators – 1) missing
15 MARs, 2) incorrect MARs, and 3) missing medications are moving in the right direction. The
16 acting Director of Nursing will continue to monitor medication delivery process metrics to
17 ensure a steady positive trend is sustained. The local Folsom State Prison team with regional
18 oversight will continue to report improvement metrics and escalating issues requiring senior
19 management interventions to the Receiver. Once the new Computer Health care Network is in
20 place, the nurses will go through a formalized GuardianRx System training.

21 2. *Mule Creek State Prison.*

22 GuardianRx computer conversion process went significantly better at Mule Creek State
23 Prison, where Guardian was successfully installed on September 10, 2007. The less than
24 satisfactory experience at Folsom State Prison informed and guided the Mule Creek conversion.
25 The nursing medication delivery process went smoothly, without interruption to patients
26 receiving the right medications in a timely fashion. Neither patient care nor custody services
27 were disrupted. "Post-go-live" feedback from the stakeholders, including CMOs, mental health
28

1 personnel, dental staff, custody officers, the Warden, and the Inmates Advisory Committee, were
2 all positive.

3 Armed with knowledge of the implementation problems experienced at Folsom State
4 Prison, a collaborative project management and pre-implementation process was established and
5 deployed by Maxor, the Office of the Receiver and Mule Creek State Prison leadership in the
6 second week of July 2007. Preparation began with the development of a Guardian Site
7 Implementation Assessment Template which was developed to standardize the medication
8 delivery process. This redesign of the medication delivery process also included medications for
9 mental health and dental prisoner/patients. Preparation for the impacts of GuardianRx
10 implementation on the medication management process also focused on training nursing staff in
11 the new processes and creating contingency plans, with designated leadership for every area, to
12 manage problems that would arise.

13 Illustrative of the importance of pre-implementation preparation, was the way in which
14 Mule Creek State Prison leadership handled communications errors which arose between
15 pharmacy and nursing staff. On the Sunday before the designated “go live” date of Monday,
16 September 10, 2007 the pharmacy printed the updated MARs. The on-site leadership at Mule
17 Creek State Prison immediately recognized that almost 100% of the MARs were in error. The
18 on-site leadership notified the on-call staff and identified a contingency plan that allowed the
19 GuardianRx implementation plan to continue. The nursing leadership at Mule Creek State
20 Prison, working with the Maxor staff, analyzed the MARs, corrected the problem, printed new
21 MARs and placed all the new MARs into the proper binders in the appropriate yard or clinic
22 before the “go live” date. In all, more than 2,000 pieces of paper were reviewed and updated by
23 the nursing leads, the pharmacy staff, and the Maxor staff. There was no negative impact on
24 patient care. The contingency plan worked perfectly. This example stands in direct contrast to
25 the handling of problems with incorrect MARs at Folsom State Prison (discussed above), which
26 caused the inability of staff to provide medications to every prisoner/patient and took almost six
27 weeks to correct.

1 Mule Creek State Prison's Guardian Site Implementation Assessment Template
2 (discussed above) will become part of a manual that is being developed to create a systematic,
3 standardized approach for GuardianRx pre-implementation preparation and implementation at
4 subsequent prison sites.

5 3. *Additional Guardian Pilot Prisons.*

6 According to the Maxor *Roadmap*, GuardianRx will be implemented at all 33 prisons.
7 Maxor and Receiver staff met to establish a rapid installation plan of GuardianRx at other pilot
8 prisons, primarily to quickly obtain many of the fiscal management tools offered by GuardianRx
9 pending clinical staff training, and in some cases, work process redesigns. The next two prisons
10 to "golive" will be California Men's Colony on November 9, 2007 and Correctional Institute for
11 Women on January 11, 2008.

12 The success of GuardianRx's implementation will be dependent on interdisciplinary
13 proactive planning, process redesign, and training, as well as continued support. Given the
14 lessons learned from GuardianRx implementation at Folsom State Prison and Mule Creek State
15 Prison, the Maxor team recognized the importance of including the users during the pre-
16 implementation phase. The Maxor team also recognized the importance of one of the major
17 information system implementation guiding principles -- "Information system implementation
18 must be driven by business and user requirements not the other way around." For example, the
19 user requirements include accurate and complete MARs print out, real time access to
20 GuardianRx via reliable information system network to generate refill orders, and access to
21 medication profiles. These basic user requirements were not addressed proactively before
22 GuardianRx was implemented at Folsom State Prison. Moving forward, key stakeholders, such
23 as nursing, custody, mental health, and dental professionals will be included in the planning
24 phase for subsequent sites.

25 In response to the increasing project scope and long-term focused efforts required by the
26 GuardianRx implementation and nursing medication delivery process redesign, the Receiver has
27 determined that a deployment of a dedicated Clinical Process Improvement Team will be
28 necessary to provide ongoing support to the local leadership teams at each institution. This

1 permanent Team will include five members-- one project manager, two nursing Quality
2 Improvement Advisor/Consultants, one analyst, one Occupational Technician, and one Custody
3 Support Liaison. Recruitment and hiring for these positions is underway.

4 g. Development of a Central Pharmacy.

5 Work continues on site selection for the central fill pharmacy as well as automation and
6 design planning. Maxor has received cost proposals and detailed explanations of tenant
7 improvement costs for sites under consideration for the central fill location. Maxor will be
8 meeting with the Receiver in late September 2007 to finalize site selection as well as discuss the
9 direction for automation selection.

10 h. Centralization of Clinical Services.

11 Maxor continues to work with the CDCR P&T Committee to support clinical pharmacy
12 management processes. The official CDCR Formulary was released in June 2007 and reports
13 have been designed to track formulary compliance. During this reporting period, the P&T
14 Committee approved two additional policies and procedures and two new disease medication
15 management guidelines ("DMMG"). A therapeutic interchange program was designed and
16 implemented to help facilitate the transition to the new formulary. Implementation of the new
17 hyperlipidemia³ DMMG is anticipated to result in an annual cost savings of approximately \$7
18 million dollars by switching patients to the newly preferred formulary agents.

19 Particular problems being faced by the Receiver in accomplishing remedial goals:

20 The substantial progress made over the reporting period has been coupled with
21 challenges, primarily in two areas: contracting and pharmacy software installation.

22 1. Contracts.

23 Maxor's approach to contracting continues to challenge traditional State and CDCR
24 purchasing policies. The CDCR statewide P&T Committee, on a consensus basis represented by
25 medical, dental and mental health clinician leaders, determine appropriate treatment alternatives,
26 and Maxor with CDCR contracting staff, negotiate purchasing agreements for those

27 _____
28 ³ Hyperlipidemia is an elevation of lipids (fats) in the bloodstream. These lipids include cholesterol, cholesterol esters (compounds), phospholipids and triglycerides.

1 medications. The negotiations have been facilitated, and finalized in many cases, by Maxor.
2 However, attempts to formalize by contract these negotiated direct agreements with P&T
3 approved drug manufacturers has been complicated by traditional purchasing systems, policies
4 and rules within CDCR.

5 The Receiver's Chief of Staff and his Staff Attorney have met and conferred about this
6 problem and have arranged a series of meetings between Maxor and Contracts staff from the
7 Plata Support Division. All parties are confident that, over time, a streamlined contract process
8 will be developed which will provide for Maxor's needs.

9 2. Pharmacy Software Installation.

10 The implementation of GuardianRx has been delayed from original timeline goals.
11 GuardianRx is essential to providing data for monitoring and evaluative purposes. For example,
12 one of the Receiver's top priorities, the Asthma Initiative, is dependent on the pharmacy data to
13 proactively identify and manage patients with severe asthma to prevent further deaths related to
14 undiagnosed or uncontrolled asthma.

15 Delay in the implementation of GuardianRx is mainly attributed to disruption in the
16 nursing medication delivery process caused by the GuardianRx implementation as well as the
17 dependence on the failure-prone CDCR computer network which significantly impeded nurses'
18 access to the GuardianRx system. As discussed above in the sections on Folsom State Prison
19 and Mule Creek State Prison pilots, the nurses are depending on the system's timely output of
20 medication dispensing information to administer the right medication, to the right patient, at a
21 right time, through the right route, using complete MARs based on accurate patient's medication
22 profile. The pharmacists also depend on the providers or designee to input new orders timely.
23 Therefore, a successful pharmacy system implementation is dependent on interdisciplinary
24 proactive planning, process redesign, training, and post "go live" support as well as an effective
25 reliable computer network system.

26 In an effort to ensure a rapid implementation of GuardianRx without adversely impacting
27 patient care, a phased-in approach to GuardianRx implementation will be utilized during
28 subsequent pilots. The new approach will include two phases: Phase I includes the limited

1 installation of GuardianRx on a revamped health care network, to the pharmacy only. Phase II
2 will provide nurses access to the GuardianRx on the new health care network. During Phase I,
3 the nursing staff and Psychiatric Technicians will be trained on the critical changes in work
4 processes resulting from the new GuardianRx while maintaining minimal change to the existing
5 nursing medication process. For example, the nurses will learn how to use the new MARs and
6 how to initiate refill orders. Instead of training the entire nursing staff, PTs, and clinical staff,
7 only selected nursing “super users” will be trained before GuardianRx installation in the
8 pharmacy. The local institution will also be given time to proactively prepare for the
9 GuardianRx installation in the pharmacy, such as provide prisoner/patients notification of the
10 changes, hire additional support staff, allow for space modification and upgrade the Health care
11 Network to assure access to GuardianRx. This two-phased approach should provide for both
12 increased patient safety and timely conversions. Its success will be measured during the next
13 two GuardianRx conversions at the California Mens Colony and the California Institute for
14 Women.

15 Tasks and metrics - degree of completion and date of anticipated completion for each task
16 and metric:

17 The Maxor pharmacy project, since implementation, has been guided by specific goals,
18 metrics and timelines as set forth in Maxor’s *Roadmap.*, attached as Exhibit 1. Maxor’s
19 monthly report for June and July 2007 are attached as Exhibits 2 & 3. The status of Maxor
20 related projects as of the close of this reporting period is set forth in Maxor’s Monthly report
21 dated August 2007, attached as Exhibit 4. Pursuant to Judge Henderson’s Order of September 6,
22 2007, the Receiver will be filing, no later than November 15, 2007, a revised Plan of Action
23 which addresses, among other things, his plans for pharmacy operations that defines objectives
24 and metrics as of 12 months, 24 months and 36 months from the date of the November 15, 2007
25 Plan of Action. Concerning pharmacy, for example, issues, timelines, and metrics discussed will
26 address centralization, GuardianRX rollouts, etc. Concurrent with filing his revised Plan of
27 Action the Receiver will file with the *Coleman, Perez, and Armstrong* Courts those sections of
28

1 the revised Plan of Action which pertain to the Joint Coordination Order of May 29, 2007 and
2 *Armstrong* Coordination Order of August 24, 2007.

3 4. *Developments in Recruiting and Hiring.*

4 a. Plata Workforce Development Section.

5 The Plata Workforce Development (“PWD”) Section took control of all aspects of
6 recruitment for *Plata* classifications from CDCR effective July 1, 2007. To increase recruitment
7 and hiring efforts throughout CDCR health care, the PWD is building its own infrastructure. In
8 addition to the 14 previously approved positions, PWD received approval for 25 more, for a total
9 of 39 positions focused on the recruitment and hiring of *Plata* classifications. These resources
10 have been put to work developing new recruitment programs; following up on leads from events
11 and referrals; responding to inquiries from potential candidates; developing mailers to send to
12 licensed practitioners; advertising in professional journals and local newspapers; and recruiting
13 at career fairs, medical association meetings, universities, colleges and schools.

14 As the Plata Support Division is growing to satisfy the administrative support needs of
15 the medical system, PWD developed and implemented a recruitment plan to hire managers,
16 analysts, clericals and other administrative classifications. Advertisements were run in *The*
17 *Sacramento Bee* and *Capitol Weekly* and staff participated in a career fair for government
18 employers in the Sacramento area. These efforts have helped provide a viable candidate pool for
19 Personnel, Contracts and Budgets to fill many of their vacancies.

20 1. *Progress Made in Clinical Hiring.*

21 In June 2007, 1,550 or 31% of the 5,066 *Plata* positions were vacant statewide. Nearly
22 500 hires were made since that time bringing the net statewide vacancies for *Plata* classifications
23 to 1,056 or 21%. Some of the major success in hiring include: 118 RNs, 189 LVNs, 18
24 Physicians and Surgeons, 2 Nurse Practitioners, and 2 Physician Assistants. These hires brought
25 the vacancy rates for RN from 12% to 10%, for LVN from 58% to 42%, and for primary care
26 providers from 39% to 27%. In addition, Certified Nursing Assistants, Health Record
27 Technicians and Supervisors, Pharmacy Technicians, Pharmacists, Health Program Advisors and
28

1 Specialists, Lab Assistants, Clinical Lab and Radiologic Technologists, Public Health Nurse,
2 Nurse Instructor, and Supervising RNs were hired.

3 Although efforts to hire have proven successful, there is still much work to be done in not
4 only filling vacancies, but in retaining staff once they are hired. There has been a significant
5 turnover in the LVN classification over the past few months. While hiring nearly 200 LVNs was
6 a great success, another 91 left during this same period of time. Voluntary resignations account
7 for 79 of those separations, while 8 were separated for being absent without leave, and 4 were
8 rejected on probation.

9 Because of the high turnover rate of LVNs over a short period of time, a review of the
10 classification was undertaken. A number of factors were found to contribute to the high turnover
11 rate for LVNs including: less than competitive salaries, increased dependent health care costs,
12 and the challenging work environment. Recommendations are under review to address this
13 issue.

14 *2. Recruiting Efforts Aimed at Clinical Staff*
15 *Positions.*

16 The Plata Support Division is building its infrastructure to implement recruitment
17 strategies to attract and hire quality health care professionals. Both a toll-free phone line 1-877-
18 793-HIRE (4473) and e-mail address MedCareers@cdcr.ca.gov were established to provide the
19 public with direct access to a live person to answer questions and help guide them through the
20 selection process for the *Plata* classifications. Many contacts are generated from advertisements,
21 mass mailers, recruitment events, and referrals.

22 Efforts to attract quality physicians include the development of a physician loan
23 repayment program and centralized physician hiring. The loan repayment program is currently
24 under review. If approved, the program will provide additional incentive for physicians to
25 commit to working within CDCR for a specified period of time, during which they will hopefully
26 become vested in a career in correctional medicine. A centralized process for physician hiring
27 will expedite the hiring of physicians and relieve the administrative burden of hiring on local
28

1 institutions while simultaneously maintaining patient care. A similar effort to centralize the
2 hiring of nurses is in the planning stages.

3 Maxor and the Plata Support Division have worked together to implement a recruitment
4 and hiring plan for pharmacy employees. On August 8, 2007, a letter was sent to over 32,000
5 licensed pharmacists in California sharing the great opportunities a career with the Department
6 may provide. The mailing has generated approximately 170 phone calls from potential
7 candidates throughout August. Staff are answering questions and guiding potential candidates
8 through the examination and selection process. More mass mailings to licensed practitioners are
9 planned in the near future, beginning with physicians.

10 In addition to the above recruitment efforts aimed at physicians, nurses and pharmacists,
11 individual recruitment plans are being developed for other classifications. Those completed to
12 date include Clinical Dietician, Clinical Laboratory Technologist, Food Administrator I,
13 Occupational Therapist, Pharmacist I and II, and Respiratory Therapist. These plans will be used
14 to help focus recruitment and hiring efforts for each classification.

15 In addition, a successful on-site hiring workshop took place at San Quentin State Prison,
16 targeting RNs, LVNs, and several support classifications. The workshop was advertised widely
17 in bay area newspapers and radio stations, and resulted in approximately 70 participants. The
18 event offered opportunities to learn about the civil service selection process, to meet with
19 professionals working in the various areas in need of additional staff, to submit applications and
20 have them reviewed in person, to tour the institution, to have on-site interviews, and to take on-
21 line exams on-site. Follow-up with the participants from this event, as well as other past
22 recruitment events, are planned in order to maintain interest while walking candidates through
23 the selection process.

24 Upcoming recruitment efforts are planned for physicians, nurses, pharmacists and mid-
25 level practitioners at various meetings and conventions including: the National Commission on
26 Correctional Health Care, the American College of Physicians, the American Health Services
27 Association, the Emergency Nurses Association, the American Osteopathic Association, the
28 California Academy of Physician Assistants, the American Society for Health-System

1 Pharmacists, the Association of California Nurse Leaders, the California Association of Family
2 Physicians, the California Association for Nurse Practitioners and the American Pharmacists
3 Association.

4 *5. Credentialing and Privileging of Health Care Providers.*

5 Credentialing is the process used to validate professional licensure,
6 clinical experience, and preparation for clinical practice. It is critical that health care
7 professionals (medical, dental, and mental health) undergo the appropriate credentialing prior to
8 being hired and certainly before they are granted prisoner/patient care privileges. Privileging is
9 the process used to grant to a specific practitioner the authorization to provide specific
10 prisoner/patient care services. Privileging ensures that the individual requesting clinical
11 privileges is capable of providing those services in accordance with the standard of care of the
12 facility granting the privilege.

13 Historically, the CDCR has had difficulty ensuring that all health care providers have
14 adequate licensure and experience prior to providing health care services to prisoner/patients on
15 an on-going basis. For example, CDCR did not always verify the credentials of providers prior
16 to allowing them to provide services. Additionally, it had been CDCR's practice to leave the
17 responsibility of verifying licensure standing and work-histories to the 33 individual institutions,
18 with no centralized oversight or monitoring by CDCR headquarters. Without a centralized
19 process in place, there has been little to no control over unqualified providers being hired or
20 moving from institution to institution to avoid disciplinary action or, in the case of registry
21 employees, even after termination.

22 Although the serious nature of this problem had been identified, the CDCR had not made
23 significant headway in improving the credentialing/privileging process. It was not until Plata
24 Personnel Services took control of the function that process improvements were put into place.

25 Particular successes achieved by the Receiver in accomplishing remedial goals:

26 Plata Personnel Services has and continues to take several corrective actions. For
27 example, additional staff has been hired to assume the responsibilities that were identified as
28 necessary by both Plata Personnel Services and an independent audit conducted by the Bureau of

1 State Audits (“BSA”) at the request of the Receiver. Plata Personnel Services has provided
2 contract language to be included in every registry contract that establishes a minimum standard
3 that must be met by all registry care providers referred to an institution. To address the issue of
4 both registry and State providers moving between institutions and/or registries to avoid
5 disciplinary action or to gain employment after being terminated by a given institution, the
6 Credentialing Unit has established a new centralized reference bank whereby the work history of
7 former registry and civil service employees can be checked by potential CDCR employers prior
8 to hire. Furthermore, to ensure all parties who are involved in employing health care providers
9 understand the license and credentialing requirements for specific providers, a policy was
10 developed and disseminated that defines allied health professionals, contract providers, standards
11 for review and a Credentialing and Privileging Overview. These policies clarify the
12 credentialing/licensing verification protocols. Additionally, a directive was distributed
13 designating which classifications require a credentialing verification by the Credentialing Unit
14 prior to allowing any provider to perform services as both Plata Personnel Services and the BSA
15 had identified confusion in that area.

16 Two additional issues require discussion:

17 a. Credentialing/Privileging Coordination Agreement.

18 A coordination agreement has been entered into by the Receiver and the representatives
19 of the plaintiffs in the *Perez, Coleman, and Armstrong* cases and affirmed by each respective
20 Court, which consolidates reform of CDCR’s credentialing and privileging processes under the
21 Receiver’s remedial umbrella. (Filed in *Plata, Perez, and Coleman* cases: Order Approving
22 Coordination Agreements Attached to Joint May 29, 2007 Order, hereinafter “Joint Coordination
23 Order”; Filed in the *Armstrong* case: August 28, 2007 Order Approving Coordination Statements
24 Attached to June 26 2007 Order, hereinafter “*Armstrong* Coordination Order”.) Under the
25 coordination agreement, the Receiver assumes responsibility for the credentialing and privileging
26 functions for the medical, mental health, and dental programs, including direct oversight of the
27 Pre-Employment Credentialing Unit. According to the Joint Coordination Order, the *Coleman*
28 Special Master and the *Perez* Court experts will consult with the defendants’ mental health and

1 dental administrators and will participate in, and have final approval of the establishment of
2 credentialing/privileging standards within their respective disciplines. This coordination
3 agreement arose out of many meetings in which each health care discipline discussed
4 credentialing issues common to medical, mental health, and dental prisoner/patients and agreed
5 that a coordinated statewide process would be the most efficient and cost effective way to ensure
6 qualified care throughout each of the health care disciplines.

7 Once the internet based solution (discussed below) is in place, all three disciplines will be
8 fully included in the new centralized process.

9 b. Internet-based Credentialing Solution

10 The Plata Personnel Services has selected a vendor to provide an internet based
11 credentialing solution. The contract to secure the service is currently being drafted and once in
12 place, this service will provide a method to ensure all health care providers are appropriately
13 credentialed in a timely fashion prior to being allowed to provide care to any prisoner/patient and
14 that the license status of all providers is adequately monitored on an on-going basis.

15 The soon-to-be implemented web-based solution will enable the user to request
16 practitioner information from a single source rather than searching multiple databases to verify
17 credentials and privileges for an applicant or currently employed provider, including registry
18 staff. The service will also continuously collect up-to-date information regarding the status of a
19 provider's license and provide automatic notification should an employee or registry staff's
20 license be suspended, revoked or otherwise sanctioned. System capability also includes tracking
21 the expiration date of all providers' licenses and board certification. Currently, it is left up to
22 each individual personnel office to manually track license and board certification expiration
23 dates and to contact the provider to request verification of renewal. At best, it is hit and miss
24 whether such tracking is being done and basing such verification on the receipt of a hard copy
25 license is not real proof that the provider possesses an active, non-restricted license. The ability
26 to stay informed as to the status of a provider's license is critical to ensure those providing care
27 to prisoner/patients are in fact, competent to do so.

1 Additionally, the ability to immediately verify the credentials of applicants from a single
2 entry of information into a data base will go a long way towards speeding up the pre-
3 employment clearance portion of the hiring process. One of the most burdensome requirements
4 of the current process is that the same credential verification must be done multiple times for a
5 single applicant if the applicant has applied at more than one institution as each institution is
6 considered a separate hiring authority and only hiring authorities are permitted to verify
7 credentials. With the implementation of the web-based solution, an applicant's credentials will
8 only require a single verification regardless of the number of institutions where he/she is
9 applying to work. The system will also maintain the continuing education requirements of each
10 provider, including what is needed, what classes have been completed, the dates completed and
11 the associated costs. The system also contains the capability to produce numerous ad hoc reports
12 regarding the status of all licensed and certificated providers. Overall, the new system will
13 undoubtedly greatly enhance the Department's ability to ensure the appropriate licensing and
14 credentialing of providers in all three disciplines; medical, mental health and dental as it will
15 systematically automatically collect information from the licensing boards of all three and will
16 automatically generate notification regarding license/certificate activity.

17 Particular problems being faced by the Receiver in accomplishing remedial goals:

18 As of the date of this report, the Receiver has not encountered particular problems that
19 have risen to a level which inhibit his credentialing-related remedial plans. Cooperation between
20 the disciplines has been appropriate and gradual but steady progress is being made concerning
21 this effort.

22 Tasks and metrics - degree of completion and date of anticipated completion for each task
23 and metric:

24 The tasks and metrics, including timelines, have not yet been fully developed and
25 reviewed concerning the Receiver's remedial plan to improve credentialing services. Pursuant to
26 Judge Henderson's Order of September 6, 2007, the Receiver will be filing, no later than
27 November 15, 2007, a revised Plan of Action which addresses, among other things, his plans for
28 credentialing, plans which will provide timelines, objectives, and metrics as of 12 months, 24

1 months and 36 months from the date of the November 15, 2007 Plan of Action. Concerning
2 credentialing, for example, issues, timelines, and metrics discussed will address unit staffing,
3 standards for clinical credential approvals, time parameters for the completion of specific
4 credentialing tasks, etc. Concurrent with filing his revised Plan of Action the Receiver will file
5 with the *Coleman, Perez, and Armstrong* Courts those sections of the revised Plan of Action
6 which pertain to the Joint Coordination Order of May 29, 2007 and *Armstrong* Coordination
7 Order of August 24, 2007.

8 6. *Specialty Care Contracts Pilot.*

9 In previous Bi-Monthly and Quarterly Reports, the Receiver has detailed the serious
10 problems with the CDCR's more than \$400 million clinical contracting process, which by late
11 2005 had all but collapsed, jeopardizing patient care and wasting limited public resources. (*See,*
12 *First Bi-Monthly Report* at 23-26.) In response, the Receiver established a Project Team to
13 develop and streamline contract processes, including effectuating the payment of all outstanding
14 invoices; developing modified conceptual bidding; and developing procurement and payment
15 processes necessary for the management of all CDCR health care contracts. The new contract
16 management system (which serves all disciplines, medical, dental, and mental health) is
17 supported by a newly created, computerized statewide Health Care Document Management
18 System ("HCDMS"), replacing the former paper-based system. As reported in the Receiver's
19 *Fifth Quarterly Report*, on February 20, 2007, pilot testing began on HCDMS at four
20 institutions: California Medical Facility; Central California Women's Facility; Pelican Bay State
21 Prison; and San Quentin State Prison. (*See, Fifth Quarterly Report* at 27-28.)

22 Particular successes achieved by the Receiver in accomplishing remedial goals:

23 a. Contracting Functions.

24 During this reporting period, the Receiver's overhaul of contracting functions has
25 progressed on schedule. Upgrades were made to the negotiations and data gathering processes;
26 rate analysis spreadsheets and boilerplates/templates were developed to improve the processing
27 timeframes and the accountability of rate determinations. The number of contracts processed
28 through the HCDMS has increased from the last reporting period to a total of 28 fully executed

1 contracts (including eight Service and Expense Orders); with nine additional contracts pending
2 final approval. These contracts include negotiated specialty medical contracts and bid physical
3 therapy services. Additionally, desktop manuals are being developed in order to facilitate step-
4 by-step training for staff in the new contract processes.

5 Negotiations with community hospitals have become more streamlined during this
6 reporting period. As data gathering and rate analysis spreadsheets have been developed, a select
7 number of hospital contracts are currently being negotiated within the pilot, with one contract
8 awaiting signature by the provider.

9 While there have been improvements to contracting processes, difficulty remains for staff
10 to renew existing contracts and engage new contractors in a timely and cost effective manner for
11 several reasons: (1) significant staff turnover due to workload and other quality of work issues;
12 (2) the sheer volume of contracts requiring negotiation, renewal and/or renegotiation; (3)
13 resistance from hospital and physician providers to base negotiations on more reasonable
14 payment methodologies; and (4) the complexity of contract negotiations, including payment,
15 market changes, and availability of willing providers.

16 To assist contracting staff, the Office of the Receiver recently retained Chancellor Group,
17 a consulting firm with national and statewide experience in health care provider contract
18 development, negotiation and management, to perform rate negotiations, facilitate formal
19 training, and implement a negotiations methodology for the contracts unit. Chancellor Group
20 has begun providing immediate assistance to the Plata Support Division to identify the priority
21 contracts among the over 164 hospitals and 1,138 physicians and physicians groups currently
22 providing health care to CDCR prisoner/patients. It is anticipated that Chancellor Group will
23 also review the current rate setting strategy and provide strategies in negotiating with hospitals
24 and medical specialty providers that are currently being paid under Court order.

25 b. Invoicing and Data Gathering Functions.

26 Improvements continue to be made in the Invoice Processing Pilot with an average
27 processing time of 18 days for all four pilot institutions. The centralized processing of San
28 Quentin State Prison invoices, which is housed at headquarters, in concert with continued

1 performance at the other three pilot institutions, has increased the percentage of invoices paid
2 within 30 days up to 93% at all four pilot institutions, a significant improvement over the pre-
3 pilot system. As in the contracts arena, desktop manuals are currently being developed in order
4 to facilitate step-by-step training for staff in the new invoice processes.

5 Advancements have been made following incorporation of the San Quentin State Prison
6 Health Care Cost Utilization Program (“HCCUP”) functions into the headquarter pilot in March
7 2007. The transfer of these functions to headquarters allowed for testing of the centralization
8 and streamlining of health care data gathering in conjunction with invoice adjudication and
9 processing. The HCCUP functions for the three remaining pilot institutions will be integrated at
10 headquarters in October 2007. The Pilot Project Team, in conjunction with Information
11 Technology Unit, is evaluating the various database structures utilized by HCCUP statewide in
12 order to streamline the pilot invoice processing and health care data gathering to allow for the
13 continued timely and accurate payment of invoices.

14 c. Administrative Support Unit.

15 To assist the Specialty Care Contracts Pilot, the Receiver established an Administrative
16 Support Unit responsible for special projects, unique contract requests, and negotiations with key
17 hospitals. In addition, this unit will oversee the training of staff in the new contract and invoice
18 processes.

19 d. Independent Assessment of the Pilot.

20 On August 10, 2007, the Receiver issued a Request for Proposals (“RFP”) to obtain an
21 independent assessment of CDCR’s health care contracting unit and the development of a plan
22 for improved management and operation of the unit. The engaged contractor will be required to
23 evaluate and make recommendations regarding all essential service contracting functions, such
24 as: provider network development; rate analysis and setting; competitive bidding; contract
25 negotiations; contractor credentialing; quality and utilization monitoring; claims processing and
26 payment; and internal audit. In examining such functions, the contractor will be required to
27 review the contract unit’s organizational structure and staffing; work flow; performance metrics;
28 technical infrastructure; training; and policies and procedures. Ultimately, the contractor will

1 provide an improvement plan that will include a detailed strategy for implementation, an
2 estimated timeline for implementation of the plan, and a draft scope of work to be used by the
3 Office of the Receiver for the purpose of engaging a subsequent contractor to provide executive
4 level direction and implementation of the improvement plan.

5 Proposals for the assessment were due to the Receiver on September 10, 2007. At that
6 time, only one proposal (from MGT of America, Inc.) was received. As a result, and in
7 accordance with the Court's June 6, 2007 Order, the Receiver intends to solicit additional
8 proposals by re-issuing the RFP [*See Master Contracts Waiver Order at p. 6* ("If fewer than three
9 bidders respond to the RFP, the Receiver shall make reasonable, good faith efforts to identify
10 additional bidders and solicit their responses to the RFP.")]. The Receiver will contact each of
11 the management consulting firms solicited to determine why proposals were not submitted,
12 encourage those firms to submit proposals, and endeavor to identify additional firms that may be
13 interested in the project.

14 Particular problems being faced by the Receiver in accomplishing remedial goals:

15 The primary problem faced by the Receiver in accomplishing his contract related
16 remedial goals is the need to properly sequence and manage contract remedial operations. To
17 summarize, almost all of the old CDCR system is defective. The resulting problems, which
18 range from no workable IT system, inadequate training, unnecessarily scattered procurement,
19 review, and invoice processing, no central planning concerning hospital and specialty needs,
20 arbitrary and unworkable processing separations and a host of other problems, calls for a
21 remedial plan that both (1) completely re-works all processing standards, policies and
22 organization and, in the most appropriate sequence (2) completely re-works all negotiation
23 policies and practices. Significant workflow improvements have already been achieved;
24 however future IT related and negotiation related remedial programs will severely tax both the
25 management and the staff of the contract unit throughout 2008.

26 Tasks and metrics - degree of completion and date of anticipated completion for each task
27 and metric:
28

1 The tasks and metrics, including timelines, have not yet been fully developed and
2 reviewed concerning the Receiver's remedial plan to improve specialty contract services.
3 Pursuant to Judge Henderson's Order of September 6, 2007, the Receiver will be filing, no later
4 than November 15, 2007, a revised Plan of Action which addresses, among other things, his
5 plans for contracts, plans which will provide timelines, objectives, and metrics concerning the
6 contract remedial program as of 12 months, 24 months and 36 months from the date of the
7 November 15, 2007 Plan of Action. For example, issues, timelines, and metrics discussed for
8 contracting will address unit staffing, the creation of a post review unit, the roll out of the new IT
9 system, centralization of review and invoice processing, etc. Concurrent with filing his revised
10 Plan of Action the Receiver will file with the *Coleman*, *Perez*, and *Armstrong* Courts those
11 sections of the revised Plan of Action which pertain to the Joint Coordination Order of May 29,
12 2007 and the *Armstrong* Coordination Order of August 24, 2007.

13 7. *Health Care Appeals Update.*

14 a. Health Care Appeals Statewide.

15 The number of health care appeals from prisoner/patients who disagree with aspects of
16 their health care treatment continues to increase. In the first six months of 2007, the total
17 number of appeals received increased over the same period last year by 11,186 or 32.8% . On
18 average, each institution receives approximately 228.5 appeals per month or an average of 6.2
19 appeals per 100 prisoner/patients. There are a variety of reasons for the increase such as: 1) an
20 increase in the patient/prisoner population; 2) high vacancy rates for medical providers which
21 impacts access to care for patient/prisoners; 3) an expectation by the patient/prisoners of an
22 increased level of care due to litigation; and 4) the success of a more effective appeals program
23 which allows patient/prisoners the opportunity to voice concerns over their own health care.

24 As explained above in the POA update, the Receiver has authorized the formation of a
25 committee, under the direction of the Receiver's Chief of Staff, to review proposed
26 recommendations for a new statewide health care appeals program. The new program would
27 combine health care appeals, prisoner/patient correspondence, and implement a patient advocacy
28 support program to promptly address prisoner/patient health care issues. The goal of the new

1 program is to reduce the volume of appeals as a result of implementing a more responsive
2 complaint process, streamline health care appeals at every State prison by ensuring that health
3 care appeals are reviewed by appropriate medical staff, and prisoner/patient health care related
4 issues are addressed appropriately and in a time-sensitive manner. A wide range of stakeholders,
5 including the Prison Law Office and Office of the Attorney General, will be invited to participate
6 in this process.

7 b. Health Care Appeals Pilots at California State Prison - Sacramento,
8 Wasco State Prison, and San Quentin State Prison.

9 California State Prison-Sacramento has implemented a patient advocacy support program
10 to address prisoner/patient health care related issues. This program was patterned after a similar
11 program originally implemented at Wasco State Prison. The health care appeals analysts hold an
12 “open line” in each facility which allows direct communication with prisoner/patients regarding
13 health care related issues and attempting to resolve those issues immediately. Wasco State
14 Prison Health Care Appeals staff report the patient advocacy support program has continually
15 resulted in fewer health care related appeals received over the last several years. California State
16 Prison-Sacramento Health Care Appeals staff documented approximately a 30% decrease in
17 health care appeals during the first month of operation.

18 The pilot health care appeals process at San Quentin State Prison continues to improve as
19 evidenced by the decline of overdue appeals. In addition, the pilot is continuing to revise its
20 policies and procedures in response to the myriad of issues the pilot program has encountered
21 and the knowledge gained through the resolution of issues.

22 8. *Medical Transport Vehicles.*

23 Historically, each institution was responsible for managing its own transportation fleet
24 which included medical transport vehicles. Lack of oversight and centralization led to a
25 substandard transportation fleet. The deficient number and condition of medical transport
26 vehicles posed a significant barrier to prisoner/patients’ access to medical care, placing the health
27 of prisoner/patient’s at risk. The Office of the Receiver charged the Custody Support Team with
28 conducting a needs assessment of each institution’s medical transportation fleet. The Team’s

1 initial findings identified immediate needs for para-transit vehicles and secure medical
2 transportation vans.

3 In response to the Custody Support Team's findings, a total of 119 vehicles have been
4 purchased. Before vans can be used for medical transport, all vans must undergo retrofitting.
5 Retrofit includes hardening of the van walls and installation of steel partitions or van cells,
6 secure window coverings, gun racks, decals and radios; only the radios must be installed at the
7 institutions.

8 During April and May 2007, 89 passenger vans were purchased. Three were retrofitted
9 and delivered to an institution. The remaining 86 vans were received at the dealership during the
10 week of August 27, 2007, and were delivered to vendors for security retrofitting and van cell
11 installation. Six of the remaining 86 passenger vans are completed and the rest will be retrofitted
12 and distributed to the institutions by early December 2007.

13 In May and June 2007, the purchase of 30 para-transit vehicles was initiated. As of
14 September 17, 2007, 20 of the 30 para-transit vans have been delivered to institutions and an
15 additional 10 para-transit vans are in the process of being retrofitted. All para-transit vans will
16 be retrofitted and distributed by the end of September 2007.

17 Additionally, the Plata Support Division is working collaboratively with the CDCR and
18 the Department of General Services to develop policies and procedures for the procurement of
19 vehicles which will streamline the process and standardize the way in which vehicles are
20 purchased. (Plata Support Division Procurement and Purchasing Unit, Vehicle Procurement,
21 Exhibit 5.) The Plata Support Division and the Custody Support Team have developed a system
22 to track the various priorities, schedules for delivery, modification, retrofitting, and
23 distribution. (Vehicle Completion Schedules, Exhibit 6.) The Plata Support Division is also
24 developing strategies to ensure that additional vehicles are readily available in the future to
25 eliminate the delay when new medical transportation vehicles are needed at the prisons.

26 9. *Improvements in Nursing Services.*

27 The quality of nursing services improved during the reporting period. Improvements
28 spearheaded by the Receiver's Nursing Team included the reorganization of nursing services to

1 address medication management, enhanced tracking of patient transfers, and analysis of
2 procedures to ensure appropriate clinical input into patient care related policies. In addition, a
3 core component of the Receiver's remedial efforts has been its continued evaluation of the
4 clinical competency of the nursing staff, conducting orientation and continuing education in-
5 services to increase nursing competency, and increased supervision of nursing staff. The
6 Receiver will further highlight these successes below, detail some of the continuing challenges
7 facing reform of CDCR nursing services, and discuss the nursing priority initiatives that the
8 Receivership will focus on in the coming months and years.

9 a. Enhanced Medication Management.

10 Management of prisoner/patient medication has been an enormous task given the array of
11 medications utilized at each facility and the number of patients on complex medication regimens.
12 Organization of medication administration is made more complex by the movement of
13 prisoner/patients between facilities and in and out of the prison system.

14 To address these issues, the Receiver has convened a multi-disciplinary committee,
15 consisting of representatives from medical, dental, mental health and pharmacy units. The
16 committee meets twice monthly to discuss issues related to processes and policies to improve
17 medication administration. Custody staff from CDCR's Division of Adult Institutions have been
18 invited but have not attended as of yet.

19 In addition, tracking of patient transfers between facilities and in and out of CDCR has
20 also been enhanced, significantly reducing the risks associated with poor medication
21 management.

22 b. Analysis of Policies and Procedures.

23 During this reporting period, an analysis of the Medical Policy Unit was prepared for the
24 Receiver, including recommendations for streamlining the manner in which medical policies are
25 developed and revised. Significantly, reorganization of the reporting structure of the Medical
26 Policy Unit was highlighted as a roadblock. Currently, the Medical Policy Unit reports through
27 the CDCR custody chain of command. This causes delays, process and tracking challenges, and
28 hinders the development and revision of medical policies. It is recommended that the Policy

1 Unit be placed under the medical section, reporting to clinical medical and nursing staff. This
2 reorganization will allow medical and nursing staff to have appropriate clinical input into patient
3 care-related policies.

4 c. Orientation, Continuing Education, and Leadership Training.

5 During this reporting period, the Receiver's efforts to improve the quality of nursing care
6 included the development and institution of new education programs held for CDCR nursing
7 staff. These education programs included orientation training for all new facility Public Health
8 ("PHN") and Infection Control ("ICN") RNs held in Sacramento. The statewide PHN, Nancy
9 Snyder, developed the orientation in collaboration with the statewide Nursing Educator,
10 Katheryn Kray. In addition, the nursing education staff has completed development of a
11 comprehensive orientation for all clinical staff. This orientation includes a one week didactic
12 component and three additional weeks of orientation with a staff preceptor. Also, two CDCR
13 RNs are participating in the statewide HIV advisory board.

14 The nursing leadership team has continued development of the nursing division, focusing
15 on leadership and supervision skills at the local facility level, competency evaluation and
16 development of a statewide education plan. In addition, all Supervising Registered Nurses
17 ("SRN") attended a three-day nursing leadership workshop during this reporting period, provided
18 by the Association of California Nurse Leaders Leadership Institute. The workshop focused on
19 developing basic leadership skills specific to nurse managers. The results of this workshop will
20 provide improved supervision of front line staff—one of the most important and basic needs in
21 nursing operations. In the past, the only option available for SRNs was to attend custody
22 supervision training, sponsored by CDCR.

23 As of this reporting period, the Statewide Nursing Officer has completed site visits and
24 met with nursing staff in every prison and several fire camps since her start in March, 2006.
25 Evaluation of clinical competency of nursing staff continues to be assessed at the local prison
26 level. Nurses' care is being reviewed by Regional Directors of Nursing, local Nursing Directors,
27 and program review nursing staff.

28 d. Staffing.

1 The Receiver requested additional nursing positions in Governor’s 2008 May Budget
2 Revise. These new positions would provide a minimum of one PHN or Infection Control Nurse
3 for every facility, eighteen nurse instructors at facilities that did not already have a dedicated
4 position, and office technicians for facility DONs to assist with office work, staffing and
5 scheduling documentation thus freeing nursing management from basic clerical duties.

6 Seven facility Directors of Nursing (“DON”) have been hired, in some instances
7 replacing ineffective DONs and, in other instances, creating new nurse management positions.
8 The newly hired DONs ensure that there is now a DON at every facility, providing the
9 transformational leadership that is needed at the local level. The effectiveness of prison DONs,
10 however, has been limited by their dual reporting responsibilities. Currently, prison DONs
11 report daily operations issues to the Health Care Manager, who is often a physician, but report
12 clinical practice issues to the Regional DON. This has created power struggles and the continual
13 need for role and functional collaboration clarification to Health Care Managers, especially
14 concerning disciplinary issues.

15 As for front-line staff, the staffing mix (types of licensed staff used, e.g. LVN vs. RN)
16 continues to be evaluated in individual prison clinics and patient care areas. It is expected that
17 there are currently sufficient nursing staff positions in many facilities, but the wrong combination
18 of staff, inefficient use of staff due to space constraints, lack of support staff, IT (computers),
19 etc.. Regional DONs are working with individual facility DONs to evaluate and revise staffing
20 requirements based on patients’ severity of condition and need for nursing care. Additional
21 clinical supervision of front-line nursing staff is needed. Individual facilities are requesting
22 additional clinical nursing supervisors to meet the demand of 24/7 clinical nursing supervision
23 coverage.

24 Nursing leadership has begun to participate in meetings with the Plata Support Division’s
25 Human Resources and Recruiting departments. Continual communication with these
26 departments is necessary, as many of the policies and processes implemented by these
27 departments affect facility nursing staff, or pull facility nurses to headquarters positions, leaving
28 the facilities with difficult-to-fill vacancies in key positions.

1 10. *Improvements to Physician Services.*

2 During this reporting period, the Receiver has also made some progress in reforming
3 physician related medical services within the CDCR. These accomplishments are outlined
4 below.

5 a. HIV Advisory Committee.

6 The HIV Advisory Committee was formed in June 2007 and has met three times. This
7 committee consists of CDCR physician and nursing managers, CDCR custody staff, and experts
8 in the field of HIV disease management from the Office of AIDS and from UCSF . The
9 committee has been charged with advising the CDCR on HIV-related issues. Current activities
10 include reviewing and advising the CDCR on the Delivery of HIV provider services (onsite and
11 through Telemedicine), the CDCR Drug Formulary and HIV housing policy. It also assists in
12 the coordination of care between the Primary Care Providers and HIV specialty providers.

13 b. Quality Improvement in Correctional Medicine (“QICM”).

14 As reported in previous reports to the Court, the Division of Correctional Health Care
15 Services (“DCHCS”) has partnered with the University of California at San Diego (“UCSD”) for
16 the baseline competency evaluation of physicians and mid-level providers. At the conclusion of
17 this reporting period, virtually all of the providers that are required to participate in the QICM
18 program have completed their evaluations. During this reporting period, all of the providers that
19 participated in the QICM evaluation passed the competency examination. The QICM program
20 will continue for a limited number of new hires and for the evaluation of providers for whom
21 there is cause for concern.

22 c. Training Accomplishments.

23 The Office of the Receiver remains committed to training and the professional
24 development of practitioners. All of the physical medicine providers in the CDCR are required
25 to attend a course on Ethics and Communication conducted by UCSD. At the conclusion of this
26 reporting period, four classes have been held and 45 providers have completed the four-day
27 training. This training is scheduled to continue until 2009. In addition, all of the CMOs attended
28 Clinical Policy and Guideline training which encompassed training on the new CDCR Drug

1 Formulary, Diabetes Guidelines, Asthma Guidelines, Lipid Disorder Guidelines, the care of the
2 Transgender Patient and a new Mid-Level Provider Policy.

3 d. The Professional Practice Executive Committee.

4 The Office of the Receiver is committed to effective peer review as the only effective
5 way to evaluate allegations of clinical misconduct and effectively monitor the practice of
6 providers. While the goal is that each institution conducts periodic self review and evaluation, at
7 this time it continues to be necessary to conduct peer review centrally. The Professional Practice
8 Executive Committee (“PPEC”) is the central peer review body that is responsible for the review
9 of clinical practice. During the reporting period the PPEC has been active and committed to
10 ensuring patient safety. The committee met 14 times from June 2007 to September 2007 and
11 reviewed 33 initial allegations of clinical misconduct or neglect and the findings of 23 peer
12 review investigations. The committee acted by suspending the clinical privileges of 12
13 practitioners and restricting the privileges of an additional three physicians. They also restored
14 the privileges of two physicians. In addition to conducting clinical reviews, the PPEC is
15 involved in expanding the Professional Development capabilities of the CDCR. The Death
16 Review Committee continues to review all deaths and report any suspected clinical misconduct
17 to the PPEC and other quality committees.

18 e. Hiring Successes.

19 As reported above in the discussion of the Receiver’s progress made in clinical hiring
20 during this reporting period (Section II.D.4), 18 physicians and surgeons have been newly hired.
21 Among those hired are several physician managers: three CMOs were hired in the Central
22 Region and one CMO and one Chief Physician and Surgeon in the North. In addition, for the
23 first time since it was formed the clinical assessment team’s (formerly the Quality Management
24 Assessment Team) positions are all filled or hiring commitments have been made. The
25 institutions report that they are now interviewing more highly qualified applicants for vacant
26 CDCR provider positions. All of the recently hired physicians are residency trained and board
27 certified in family practice or internal medicine, or recent graduates pending certification. The
28 newly hired mid-level practitioners are all nationally certified or recent graduates. Much remains

1 to be done regarding the recruitment and hiring of Primary Care Providers. It is anticipated that
2 the Physician Loan Repayment Program will be a major incentive for qualified practitioners to
3 join in the CDCR medical efforts. This program is planned to be implemented within the next 90
4 days.

5 f. Avenal State Prison.

6 Due to ongoing severe staffing deficiencies, Avenal State Prison has been a focal point of
7 Receivership activity over the last nine months. Since the dramatic loss of leadership in 2006,
8 steady improvements have been made in Avenal's clinical leadership. Under the guidance of the
9 CDCR Regional Leadership Team a Health Care Manager, Chief Physician and Surgeon and a
10 CMO has been appointed. The current leadership team is making steady progress in the delivery
11 of health care at Avenal. The critical lack of clinical providers has been addressed by the hiring
12 of qualified contract providers which has stabilized the primary care provider staffing while
13 more permanent solutions are implemented.

14 11. *Information Technology Update.*

15 a. Beginning a Systemic Information Technology Rollout and
16 Operational Support on Existing Computer Systems.

17 CDCR's computer network that connects the 33 prisons, regional offices, and
18 headquarters sites is well over 15 years old. It can currently only support e-mail and very limited
19 data. Daily, the CDCR network has multiple outages and system failures that prevent its use as a
20 system to house, access, and share clinical data. In addition, facilities simply lack computers that
21 are connected locally to each other or between multiple prisons, preventing the sharing of
22 prisoner/patient health care data such as basic laboratory, pharmacy or other information that is
23 essential for patient safety. Given the high recidivism rate among prisoner/patients and the
24 frequency of transfers between facilities, an effective computer network is essential to providing
25 medical staff access to clinical information.

26 In effect, the Office of the Receiver is moving the prison health care data system from a
27 pre-1990 computer and paper-based system to one that is based in 2007 (and beyond) technology
28 and clinical data guidelines. The Receiver's staff will achieve this 15-year technology leap by

1 first bringing high-speed, highly reliable computer data lines to each prison, ensuring the sharing
2 of data statewide. These same high-speed data connections will then be brought, wirelessly, to
3 each point of care within the prison walls, including yard clinics, bed sites, telemedicine,
4 pharmacy, radiology, laboratory, medical records, mental health, and dental.

5 In addition to building reliable data connections, the Receiver's IT Team will construct a
6 clinical data system, housing all of the various clinical data used for treatment such as laboratory
7 and radiology results, pharmacy system information, patient medical histories, etc. Once the
8 Receiver has these basic tools in place statewide and where clinical care is delivered, then more
9 advanced clinical applications can be developed. To achieve these ends, the Office of the
10 Receiver has engaged consultants to build a state-of-the-art information system that is highly
11 reliable, cost effective and accessible to all clinical services. The system will also dramatically
12 increase the speed of installation of the information networks to all the needed healthcare points
13 of care within the prison system, including medical, mental health and dental care areas as
14 iterated in the Joint Coordination Order issued in *Plata, Coleman and Perez* and the *Armstrong*
15 Coordination Order issued in *Armstrong*.

16 This new system will utilize new statewide purchasing contracts systems to ensure access
17 to the most cost effective products and services that are currently available in State government.
18 The California Department of Technology has also begun assisting the Receiver to ensure that all
19 State services and purchasing contracts can be used in a reliable fashion to provide clinical data.

20 The Receiver's IT Team will also be continuing to improve the reliability of computer
21 operations through the conversion of many of the more problem-plagued computer programs that
22 have been a long standing barrier to improving health care as well as providing Court required
23 reports that today are almost entirely compiled manually. In addition, computer operations'
24 reliability will improve with the adoption of industry standard programming guidelines and as
25 operational improvements are made to all hardware support systems. As well, the clinical
26 systems being developed by the Receiver will be interfaced with existing and newly developed
27 CDCR custody systems.

1 Particular successes achieved by the Receiver in accomplishing remedial goals:

2 b. The Health care Information Technology Executive
3 Committee.

4 CDCR's decades of neglect and mismanagement of information systems has left a legacy
5 of antiquated, incompatible systems that repeatedly fail to satisfy the health care needs of the
6 organization. As a result, the Receiver's IT staff has received numerous requests for assistance
7 and support from nearly every health care function for modern information systems, including
8 scheduling, credentialing, results reporting, enterprise resource planning, e-mail, and numerous
9 others. Furthermore, as a result of the coordination agreements with the *Perez, Coleman, and*
10 *Armstrong* Courts, the Office of the Receiver has assumed responsibility for creating and
11 maintaining IT systems that support Court-ordered priorities beyond those of *Plata*. Specifically,
12 the Receiver has agreed to assume responsibility to support the current Mental Health Tracking
13 System until it can be integrated into the long-term IT program. (IT Coordination Agreement at
14 2 attached to Joint Coordination Order and Armstrong Coordination Order.)

15 Objective D.7 of the Receiver's Plan of Action states that CDCR will "establish a
16 statewide project governance model for integrated health information system(s) and related
17 applications." In keeping with this objective, and to help coordinate and prioritize the numerous
18 CDCR IT needs, the Receiver established the Health care IT Executive Committee ("HITEC").
19 Membership of HITEC is limited to the Office of the Receiver's Chief Information Officer
20 ("CIO"), Chief Medical Information Officer ("CMIO"), Chief Medical Officer, Chief Nurse
21 Executive, Chief Financial Officer ("CFO"), Chief of Staff, the Director of the CDCR Plata
22 Support Division, and representatives of the *Coleman, Perez, and Armstrong* Courts (or their
23 designees).

24 The HITEC's charter states that it will make recommendations to the Receiver on overall
25 strategic direction to IT planning and initiatives. The HITEC duties include, but are not limited
26 to recommendations in the following areas: prioritization of IT projects and initiatives;
27 determination of appropriate pilot sites for IT projects; coordination of IT project resources for
28 improved efficiency; evaluations of vendors and products; provision of feedback from the user

1 community regarding IT expectations and needs; communication to stakeholders regarding IT
2 project progress; facilitation of the development and implementation of policies consistent with
3 the needs of the project, including privacy, quality, training and control; provision of a forum for
4 the escalation of IT issues and their resolution; and provision of advise and support to the Chief
5 Information Officer, the Chief Medical Information Officer, and their teams. The HITEC is also
6 charged with recommending and helping to create appropriate HIT End-user Group Forums and
7 Committees to ensure all IT projects are designed and implemented with the end-users in mind.

8 The HITEC will serve in an advisory role regarding the initiation or strategic
9 development of IT projects. Ultimately, all encumbrance of resources or funding for IT projects
10 will require formal approval of the CIO, CMIO, the Chief of Staff, the Receiver, and, when
11 appropriate, the representatives of the *Coleman*, *Armstrong*, and *Perez* Court cases. (See, IT
12 Coordination Agreement at 2, “The *Coleman* Special Master, the *Perez* Court experts, and
13 defendants’ mental health and dental administrators will be kept informed of the progress of this
14 long-range project and will provide necessary input concerning mental health and dental clinical
15 data needs.”)

16 The HITEC will meet monthly, and has met twice to date. Topics discussed at the first
17 two meetings included IT project prioritization; the Receiver’s plan to create a state-of-the-art
18 health care network infrastructure; the clinical data repository project; and the Madrid Pelican
19 Bay Information System.

20 c. The Clinical Data Repository Project.

21 Objective D.2 of the Receiver’s Plan of Action states that CDCR will “compile medical
22 data across all compliant data sources into a unified [system] that can be used to generate
23 information valuable for patient care and health care management.” Beyond the basic technical
24 infrastructure, such as networking, connectivity, etc., critical to any information system, the
25 Office of the Receiver intends to establish the foundational data infrastructure necessary to
26 enable the collection/aggregation of clinical data for clinical care, management, and analysis.
27 Thus, one of the Receiver’s first major IT projects will be a clinical data repository with a
28 clinical portal.

1 A clinical data repository (“CDR”) is a database designed and optimized to store patient
2 health information, such as current medications, lab results, encounter history, problems, etc., in
3 a standardized manner. This can serve as the central “bridge” between all current and future
4 CDCR patient data sources. A clinical portal is a web browser-based application that will allow
5 providers access to CDR information at the point-of-care. When implemented, a provider will,
6 for example, be able to search for a prisoner/patient and, when identified, view the
7 prisoner/patient’s list of current medications, most recent lab test results, etc. Unlike all previous
8 CDCR health care IT efforts, this project will be implemented as a statewide, enterprise system,
9 rather than as a stand-alone system in each of 33 prisons.

10 The first key data component needed will be the ability to accurately identify/track the
11 CDCR’s patient population and manage key demographic information, especially given the
12 current system’s problems with data accuracy, completeness, and availability. High quality
13 sources of clinical data will need to be established, as much of the currently available data is
14 unreliable. Medication data from Maxor (pharmacy) and lab results from current reference labs
15 are two immediate sources.

16 Unlike all previous CDCR information systems, the CDR will adhere to widely
17 recognized technical standards and terminologies. As a result, the CDR will be able to import
18 clinical information from outside providers such as community hospitals and jail medical units.
19 Furthermore, for the first time, CDCR will be able to apply standardized health care analytical
20 tools to obtain useful and accurate management information.

21 The Office of the Receiver expects to issue a RFP to create a CDR and clinical portal in
22 September 2007. There will be future updates on this important IT infrastructure component in
23 future Quarterly Reports.

24 Particular problems being faced by the Receiver in accomplishing remedial goals:

25 The primary problem faced by the Receiver concerning his IT-related remedial goals
26 relates to the CDCR culture; the “trained incapacity” referred to in Judge Henderson’s Findings;
27 a deep and all encompassing negative attitude concerning automation, on the part of clerical,
28 clinical, and management personnel; and an abiding faith in the status quo by too many

1 participants in the remedial process. To some extent this cultural problem is the result of
2 decades of State failures concerning IT implementation; on the other hand, it is also reflective of
3 an attitude on the part of State IT personnel that they, the computer experts, are in a position to
4 tell the users, nurses and doctors, how to perform clinical tasks, regardless of possible negative
5 impacts on prisoner/patient services. This problem is not unsolvable. Infact it is and will
6 continue to be addressed, but a negative culture will have an impact on both the timeliness and
7 the possible sequencing of IT system roll-outs.

8 Tasks and metrics - degree of completion and date of anticipated completion for each task
9 and metric:

10 The tasks and metrics, including timelines, have not yet been fully developed and
11 reviewed concerning the Receiver's remedial plan to provide adequate IT programs to support
12 prison health care delivery programs. Pursuant to Judge Henderson's Order of September 6,
13 2007, the Receiver will be filing, no later than November 15, 2007, a revised Plan of Action
14 which addresses, among other things, timelines, objectives, and metrics concerning the IT
15 remedial program as of 12 months, 24 months and 36 months from the date of the November 15,
16 2007 Plan of Action. Concurrent with filing his revised Plan of Action the Receiver will file
17 with the *Coleman, Perez, and Armstrong* Courts those sections of the revised Plan of Action
18 which pertain to the Joint Coordination Orders of May 29, 2007 and *Armstrong* Coordination
19 Order of August 24, 2007.

20 12. *Housing Prisoner/Patients Outside of CDCR's 33 Institutions:*
21 *Out-Of-State Prisons, Return-To-Custody Facilities, and Community*
22 *Correctional Facilities.*

23 a. Transfer of Prisoner/Patients to Out-of-State Institutions.

24 As first reported in the Receiver's *Third Bi-Monthly Report*, the State and the Office of
25 the Receiver continue to work together in a timely and cooperative manner to effectuate the out-
26 of-State transfer of California prisoners/patients. Since first initiated by the State in November
27 2006, a total of 862 California prisoners/patients have been transferred out-of-State, as of August
28 31, 2007. It is anticipated that by September 20, 2007 a total of 1,140 California

1 prisoner/patients will be housed in out-of-State facilities and that number will increase
2 (according to CDCR estimates) to 8,000 prisoners/patients over the next 12-18 months.
3 Currently, California inmates are housed at three sites: West Tennessee Detention Facility,
4 Tennessee; Florence Correctional Center, Arizona; and Tallahatchie County Correctional
5 facility, Mississippi; however, the State is actively negotiating to begin housing California
6 prisoners/patients at additional sites throughout the country.

7 The process of providing health screenings to transferring prisoner/patients and
8 conducting on-site inspections on the out-of-State detention facilities at locations thousands of
9 miles away has taxed CDCR's already limited nursing resources. Nursing staff at each facility
10 involved in out-of-State placement activities have conducted a health record review and a face-
11 to-face assessment of each patient/prisoner identified by custody for transfer. Each of the sites
12 currently housing California prisoners/patients have been inspected by nursing staff to ensure the
13 adequacy of the on-site medical staffing, health care operations, health care space, and medical
14 equipment. As of this date, all sites appear to meet minimum levels of staffing and to contain
15 sufficient medical equipment; however, additional on-site inspections are necessary to determine
16 the adequacy of the medical care provided to California prisoners/patients. (See, Exhibit 7,
17 Memorandum by Director of Nursing Operations, Jackie Clark, reporting the costs *thus far* on
18 the nursing staff.)

19 The continued use and expansion of out-of-State housing for California prisoners/patients
20 as a solution to the prisoner overcrowding problem, has and will continue to complicate the
21 remedial efforts of the Office of the Receiver in bringing the California prison system up to
22 constitutional standards. Existing institution and headquarters' health care staff who are already
23 charged with the enormous and complicated task of providing care to the prisoners/patients
24 housed at existing CDCR institutions—a task made more difficult by the CDCR's current state
25 of dysfunction and chaos—are now being pulled away to screen prisoners/patients for housing
26 out-of-State. This is a diversion of institution and headquarters' resources that was not
27 contemplated at the time of the Court's appointment of the Receiver.

28

1 b. Return-to-Custody Facilities.

2 As part of the State's solution to prison overcrowding, the Office of the Receiver has
3 been verbally informed that the State has proposed a new type of non-institutional
4 prisoner/patient housing called Return-to-Custody Facilities and that AB-900, discussed at length
5 in the Receiver's *Fifth Quarterly Report*, is the vehicle to create and build these new facilities. It
6 has been reported that the Return-to-Custody Facilities will be built as semi-autonomous 200 to
7 500 beds facilities at locations that have not yet been selected. These facilities will be used to
8 house prisoners/patients that have returned to CDCR as a result of parole violations and have a
9 short period of time to serve, i.e., less than six months and/or prisoners/patients that have less
10 than six months to serve on their current term. It is intended that this alternate housing option
11 would reduce the existing burden on CDCR's 33 institutions of processing thousands of
12 prisoner/patient transfers, releases and arrivals a month.

13 Since Return-to-Custody Facilities are still in the very early stages of conception, the
14 Receiver hopes to engage early on with CDCR to ensure that all prisoner/patient health care
15 needs, including adequate space, staffing, and medical equipment is included in these new
16 facilities to ensure constitutional standards are met when they begin operating. Again, this scope
17 and depth of workload/activity was not anticipated at the time of creation of the Receivership.

18 c. Community Correctional Facilities and Other Community Based
19 Prisoner/Patient Housing.

20 The medical care provided for prisoner/patients housed in CCF and other community
21 based housing programs is sub-standard. Initial inspections have found inadequate health care
22 screening of prisoner/patients' upon entrance to the CCF, inadequate medical staffing, no clinical
23 oversight of prisoner/patients' care, a lack of control over medications, and poor or non-existent
24 medical policies. In addition, many CCFs utilize the local hospital emergency room to provide
25 routine medical care—costing far more than other alternatives.

26 There are 13 CCFs under contract with CDCR, which as of August 15, 2007, housed
27 approximately 5,600 prisoners/patients. In addition, another 764 prisoners/patients are housed in
28 other community based housing as part of drug treatment, work furlough, and prisoner mothering

1 programs. An additional 1,201 State prisoner/patients are housed in four different county jails
2 throughout the State. In sum, there are a total of 7,565 State prisoners/patients housed outside of
3 the 33 CDCR institutions, as of August 15, 2007.

4 The system of medical care at all of these community based sites is based on the model of
5 transporting the prisoner/patient who needs medical care to a designated HUB institution. The
6 designated medical "HUB" institutions, however, have not, in fact, been providing health care
7 services to this additional population. For example, North Kern State Prison is the designated
8 medical care HUB institution for more than 1,900 CCF prisoner/patients; Wasco State Prison is
9 the designated medical HUB for more than 1,300 CCF prisoner/patients; and California State
10 Prison, Los Angeles County is the designated medical HUB for more than a 1,000 CCF
11 prisoner/patients. None of these institutions, however, received any additional medical staff to
12 provide health care services to these State prisoner/patients.

13 The housing of prisoners/patients in CCFs and other non-institutional housing provides
14 substantial challenges to the Office of the Receiver. The challenges include but are not limited
15 to: most CCFs have only one LVN on duty eight hours a day; there are no written medical
16 screening criteria, including criteria for mental health and dental, as part of the
17 acceptance/transfer process; as described above, the CDCR HUB institutions which are
18 designated to provide medical care for these community based housing have never actually been
19 allocated medical providers for this additional prisoner/patient population; the existing contracts
20 between CDCR and these community based housing facilities do not require compliance with
21 *Plata, Coleman, or Perez*; standard medical policies and procedures, including those standards
22 governing medication delivery, may not be in compliance with applicable State law; and there is
23 no clinical oversight of prisoner/patient care.

24 Due to the gravity of this situation, the Office of the Receiver has instructed the CDCR
25 not to enter into any new contracts or amend existing contracts relating to community-based
26 housing, unless and until the Office of the Receiver has approved the health care component.

1 The general impression of the inspection team was that the facility was very clean and
2 well organized, including the child play areas. However, the health care office and examination
3 rooms were not clean, organized, or equipped to provide even basic medical care. The facility
4 does not have any medical emergency response equipment, including an Automated External
5 Defibrillator (“AED”). There is no equipment in the event of a precipitous birth. The
6 examination room does have an examination table; however, there is no medical equipment for
7 the LVN other than a blood pressure cuff and thermometer. Moreover, there was no child or
8 infant medical equipment in order to perform even basic assessments.

9 The FFP does have in place multiple subcontracts for the provision of care for the
10 women, children, and infants with community providers. However, a significant portion of the
11 care is provided via the local hospital’s Emergency Room (“ER”) which is not conducive to
12 either continuity of care or cost effectiveness. It was the inspection team’s understanding that
13 when a prisoner/patient or their child has a medical complaint, they advise the on-duty LVN or
14 other FFP staff. The staff then calls the subcontracted Advice Nurse at a local hospital or urgent
15 care line for direction. This results in an appointment being made for the same day, direction to
16 go to the ER, or an appointment is made for a future date as no medical care is actually provided
17 on site. On the day prior of the inspection, there were 15 off-site medical appointments. In
18 review of documents, there appears to be an average of 10 off-site medical appointments each
19 day for the total population of 35 inmates and 40 children. Each of these off-site medical visits
20 is paid for by CDCR via California Institute for Women as they are the identified HUB
21 institution for the provision of health care for this community-based program. Based on a review
22 of data in 2004 at California Institute for Women, the cost of medical care for community-based
23 programs far exceeds the cost of medical care for inmates housed at an institution.

24 Medications, including controlled substances are stored in a locked room in cabinets that
25 the prisoner/patients access under the observation of FFP staff. The FFP staff does not dispense
26 the medication, but rather only observes the women take their medication and logs this into the
27 medication administration logbook. It is the prisoner/patient’s responsibility to give the right
28 medication to their children in the correct amount. However, in reviewing the contents of the

1 medication cabinet and individual bins for each woman we located expired medications, empty
2 medication bottles, and multiple bottles of the same prescription. It is evident that there is no
3 control over what is maintained in these bins. This lack of control is of particular concern for the
4 controlled substances and the appropriate dosing of pediatric patients as well as adults.

5 Furthermore, the inspection team did not find an organized sick-call tracking system,
6 effective communication (in writing or verbally) from the community provider to the FFP LVN
7 staff, or up-to-date policies and procedures for the provision of health care consistent with the
8 requirements of the *Plata* Stipulation for Injunctive Relief.

9 The inspection team made the following recommendations:

10 1. Revise the current method of prisoner approval for placement at the FFP and put
11 into place a health care screening including medical, mental health and dental examinations prior
12 to placement at the FFP.

13 2. Immediately hire an RN to work a minimum of eight hours a day seven days a
14 week.

15 Establish clinical competency requirements in the areas of adult medicine, pediatrics, and
16 obstetrics. Establish sick-call protocols for adult medicine, pediatrics, and obstetrics.

17 Additionally, the RN must have a primary care provider to confer with when necessary.

18 3. Procure the necessary medical equipment for the RN to perform evaluations and
19 provide treatment. The purchase of equipment needs to include appropriate child/infant medical
20 equipment as well as emergency medical equipment such as AEDs.

21 4. Establish improved accountability procedures for medication management,
22 especially controlled substances.

23 5. Conduct an in-depth review of the medical care costs for the FFP.

24 6. Consider assigning additional CDCR staff to the FFP.

25 7. Conduct inspections at the other community based programs to ensure adequate
26 and appropriate health care services are being provided to this segment of the inmate population.

27 For the inspection team's findings and conclusions see Exhibit 8.
28

1 addition, the *Coleman* Special Master will consult with defendants' mental health administrators
2 to assist in establishing clinical guidelines for the mental health component of the telemedicine
3 program. (IT Coordination Agreement at 2, attached to Joint Coordination Order and *Armstrong*
4 Coordination Order.)

5 b. Telemedicine Providers.

6 Currently, the OTS contracts with four services providers for telemedicine specialty
7 services. University of California at Davis ("UCD") provides Orthopedic, Endocrinology,
8 Dermatology, Hepatology, infections disease and pain management services. UCSF provides
9 HIV and transgender services both on-site, as well as via telemedicine. Centennial Medical
10 Group provides Dermatology, Endocrinology, Neurology, Pulmonology and Orthopedic
11 services. Bay Area Translation provides sign language interpretation services.

12 The OTS also provides in-house telemedicine appointments for infectious disease and
13 mental health services.

14 Staff from OTS and UCSF met on August 23, 2007, to discuss the coordination of the
15 telemedicine services program. During the meeting an action plan was agreed upon by both
16 parties. Some of the highlights of the action plan include: scheduling coordination between
17 OTS, UCSF and the receiving institution; uniformity of the program forms; integration of the
18 OTS training sessions; utilization of OTS policies and procedures; and the sharing of program
19 data and information. UCSF has also offered to assist with the recruitment of medical specialty
20 service providers from within their organization.

21 c. Equipment.

22 As of April 5, 2007, all CDCR institutions have received the equipment for a
23 Telemedicine system. OTS is currently in the process of installing the equipment statewide and
24 estimates the final installation will be completed by September 30, 2007.

25 d. Process Mapping and Workload Analysis.

26 For the fourth quarter of fiscal year 2006-2007, the OTS scheduled 4,923 telemedicine
27 appointments and conducted 3,399 telemedicine visits. Currently, the OTS is researching the
28 maximum number of provider appointments available to determine if the OTS is utilizing those

1 appointments to their fullest extent. Additionally, the OTS staff is currently mapping and
2 defining all in-house processes, and reviewing task assignments to determine if areas of
3 inefficiency exist, and if the unit is staffed with appropriate classifications. Once tasks are
4 identified, a workload time study will be conducted to determine the appropriate level of staffing.

5 e. Assistance from the University of Texas Medical Branch.

6 The Receiver has engaged consultants from the University of Texas Medical Branch
7 (UTMB) to assess CDCR's existing OTS, create a vision for future telemedicine services, and
8 develop a roadmap for implementation of the program which includes cost estimates and an
9 implementation schedule for optimizing services delivery and enhancing quality improvement.

10 UTMB's engagement kicked off on July 30, 2007 with a visit to 501 J Street in
11 Sacramento to meet the OTS team, and to the Center for Health and Technology at UCD, which
12 provides telemedicine services to CDCR. The engagement will continue in September and
13 October 2007 with site visits to selected State prisons. Prisons were chosen for visits because of
14 their frequent usage of telemedicine, their interest in increasing telemedicine services, or their
15 inability to sustain telemedicine services in the past.

16 By November 2007, at the conclusion of their engagement, the UTMB team will make
17 recommendations to the Receiver regarding telemedicine technical and operational
18 infrastructure, facilities, staffing and personnel, workflow, and perceptions of telemedicine. At
19 the request of the *Coleman* and *Perez* Courts, UTMB will also make specific recommendations
20 regarding the improvement of mental health and dental telemedicine services.

21 Particular problems being faced by the Receiver in accomplishing remedial goals:

22 Almost every aspect of the existing CDCR telemedicine system is deficient, from a
23 failure of management in the CDCR's central office, to outdated equipment, inadequate support
24 staff in the prisons, inadequate programs for custody escorts to telemedicine clinics, the failure to
25 provide an adequately wide range of clinical telemedicine services, etc. Telemedicine is a classic
26 example of a problem which will require enhancements and improved management concerning
27 every element of the program, but when the enhanced program is fully operational will provide a
28 wide range of improved clinical services impacting *Plata*, *Coleman*, and *Armstrong* in a fiscally

1 responsible manner. While short-term improvements will be limited, medium and long-term
2 improvements will be significant.

3 Tasks and metrics - degree of completion and date of anticipated completion for each task
4 and metric:

5 The tasks and metrics, including timelines, have not yet been fully developed and
6 reviewed concerning the Receiver's plan to provide enhanced telemedicine services for *Plata*,
7 *Coleman*, and *Armstrong* class members. Pursuant to Judge Henderson's Order of September 6,
8 2007, the Receiver will be filing, no later than November 15, 2007, a revised Plan of Action
9 which addresses, among other things, his plans for telemedicine, plans which include timelines,
10 objectives, and metrics concerning the new telemedicine remedial program as of 12 months, 24
11 months and 36 months from the date of the November 15, 2007 Plan of Action. Concurrent with
12 filing his revised Plan of Action the Receiver will file with the *Coleman*, *Perez*, and *Armstrong*
13 Courts those sections of the revised Plan of Action which pertain to the coordination orders of
14 May 29, 2007 and August 24, 2007.

15 *14. Health Care Access Units.*

16 As originally discussed in the Receiver's *Fourth Bi-Monthly Report*, the Receiver
17 initiated a Health Care Access Unit pilot at San Quentin State Prison State Prison, to ensure
18 prisoner/patient's access to medical services. (*See, Fourth Bi-Monthly Report* at pp. 22-23.) In
19 the pilot, correctional staff assigned to the Access Unit are responsible for escorting,
20 transporting, and the security of prisoner/patients to and from medical appointments within the
21 institution and off prison grounds. After identifying existing resources, determining census and
22 workload, establishing new custody positions based on overtime expenditures, and establishing a
23 new post assignment schedules and master rosters for Access Units, the San Quentin State Prison
24 pilot commenced on June 11, 2007. Staff from the Receiver's Office have continued to closely
25 monitor the progress of the Access Unit, making adjustments and modifications as necessary to
26 help the unit attain the level of service and efficiency for which it was designed.

27 The implementation of the Access Unit at San Quentin State Prison included a
28 modification to the organizational structure. The Associate Warden for Health Care Services is

1 responsible for all access to care operations including clinic security, escorting, transporting and
2 outside hospital guarding. Specific duties and responsibilities for custody posts within the
3 Access Unit were redesigned to improve accountability. Clear written direction has been
4 provided to designated Access Unit custody officers by developing new operational procedures,
5 delineating the objectives and goals of the new Unit.

6 Despite the preceding milestones, the Office of the Receiver has been seriously hampered
7 in its ability to attain the full impact the Access Unit is capable of delivering because of the
8 ongoing shortage of Correctional Officers to fill vacant positions. The CDCR continues to
9 graduate cadets from the Basic Correctional Officer Academy in insufficient numbers to meet
10 existing operational needs and satisfy existing custody requirements, let alone hire the additional
11 number of officers required to fully establish the Health Care Access Units. For example, in
12 order to fully staff the outside transportation and hospital guarding functions at San Quentin
13 State Prison it would require approximately 50 additional or new Correctional Officers. These
14 positions have not been established because San Quentin State Prison already has approximately
15 40 vacant Correctional Officer positions (recently down from over 100) and presently has no
16 hope of filling 50 new positions if allocated. These 50 unbudgeted posts are being filled daily on
17 an "overtime basis" which drives staff burnout to an unacceptable level and creates expenditures
18 which exceed the cost of utilizing additional full time permanent staff.

19 a. Development of Additional Health Care Access Units.

20 It is the intention of the Receiver to replicate the San Quentin State Prison Health Care
21 Access Unit systemwide. On June 19, 2007, the Office of the Receiver initiated a fact finding
22 and information gathering process at the California Medical Facility in Vacaville. Taking into
23 consideration the mission of the prison and how a Health Care Access Unit would integrate with
24 the design of the physical plant, the Office of the Receiver is working with institutional staff in
25 making recommendations for changes in operational procedures, staffing and organizational
26 structure. The summary of recommendations for the establishment of the Health Care Access
27 Unit at California Medical Facility will delineate the additional personnel resources (custody and
28 support), and equipment necessary. Implementation of the Health Care Access Unit at California

1 Medical Facility is projected for November 1, 2007, with continued monitoring and
2 modifications through the early part of 2008.

3 The Office of the Receiver will continue the design and implementation of the Health
4 Care Access Units at other California prisons as well. Review and evaluation of the California
5 State Prison, Sacramento will occur during February 2008. Staff will again work in concert with
6 institutional staff addressing site specific needs. Implementation for the California State Prison,
7 Sacramento Access Unit is anticipated in June 2008.

8 Continued monitoring and data analysis of each Access Unit will enable the Office of the
9 Receiver to accurately evaluate and subsequently validate the functionality and efficiency of the
10 Health Care Access Units at each location.

11 b. Preliminary Reviews of Health Care Access Operations.

12 In the spring of 2007, onsite preliminary reviews of Health Care Access operations and
13 custody staffing were completed at five institutions to determine the scope and magnitude of
14 problems that may be anticipated prior to initiating a detailed work plan to develop Access Units
15 at each institution. These reviews were completed at Avenal State Prison, Ironwood State
16 Prison, Sierra Conservation Center, Wasco State Prison and the Correctional Training Facility.

17 Based on these reviews, it has been determined that all institutions should be subjected to
18 a preliminary or interim operational review as a precursor to the more thorough and time
19 consuming work required to replicate the San Quentin State Prison Health Care Access Unit
20 Pilot i.e., establishing dedicated "Access Units" at each institution. Information obtained in the
21 initial five operational reviews underscored serious system-wide access to care deficiencies.
22 These deficiencies included a shortage of dedicated custody staff to supervise clinics and
23 medication lines, a lack of transportation vehicles and in some cases, role confusion between
24 nursing and custody staff. All of these issues presented serious barriers to prisoner/patient access
25 to care.

26 As a result of these findings, the Receiver has assigned staff to complete "preliminary
27 reviews" as they have become known, of all remaining institutions because of the urgent need to
28 bridge these system-wide deficiencies that impede the delivery of health care.

1 Since July 2007, preliminary operational reviews have been completed at High Desert
2 State Prison, California Correctional Center, California State Prison, Solano, R.J. Donovan
3 Correctional Facility and Folsom State Prison. Operational reviews were also completed at the
4 hemodialysis programs at Kern Valley State Prison and at the California Substance Abuse
5 Treatment Facility. The remaining 22 institutions are scheduled to be completed by April 2008.

6 c. Preliminary Reviews Have Uncovered Multiple Barriers To
7 Access to Care.

8 The preliminary reviews have proven to be crucial in identifying barriers to patient care.
9 For example, the reviews have discovered a host of inappropriate (and potentially dangerous)
10 practices in those areas where custody and nursing duties intersect. In one institution for
11 example, in the clinic waiting area designed for 43 prisoner/patients, nearly 80 prisoner/patients
12 were held sometimes for hours without being seen. In another instance, the local emergency
13 medical response plan required the nurse to drive the medical transport vehicle while custody
14 officers remained in the back with the prisoner/patient. In more than one institution, nursing
15 staff were required to unlock cell door food tray ports in administrative segregation housing units
16 to dispense medication with little or no custody support. In more than one instance, medical
17 appointments scheduled with outside specialty providers were cancelled or delayed based on the
18 lack of custody resources and transportation vehicles. Another inappropriate custody/clinical
19 practice uncovered was that some institutions were requiring prisoner/patients to place their arms
20 through the cell door food tray ports in order to initiate blood draws or take blood pressure
21 readings. These practices are clinically inappropriate as well as dangerous.

22 Conducting preliminary reviews has enabled basic reporting, supervision and
23 accountability structures to be initiated at each institution under the direction of the Associate
24 Warden for Health Care Services. At the conclusion of each review, appropriate new staffing
25 resources have been recommended that are specifically tailored to address the shortcomings
26 identified during the review. These resources have been approved by the Receiver and
27 instructions are being transmitted to the respective Wardens and CMOs to implement the
28 recommendations and to establish the new personnel resources which have been authorized in

1 this process. Additionally, recommendations are made to Wardens and Health Care Managers on
2 how existing resources may be utilized more efficiently through operational changes.

3 The preliminary reviews have enabled the Receiver to address the most significant
4 deficiencies at each institution reviewed as expediently as possible. Consequently, when the
5 complete "Access Unit" review is conducted at these prisons in the months and years ahead, the
6 basic elements of organization and operation will already be in place. This approach has enabled
7 the Office of the Receiver to develop solutions to individual problems that are specific to each
8 location in a timely manner rectifying custody/clinical practices that interfere with good access
9 to and quality of care. However, it must be reiterated that CDCR must increase the output and
10 availability of Correctional Officers. Not only patient transportation and access to health care
11 are being sacrificed due to the Correctional Officer vacancies; basic security and safety of prison
12 personnel and inmates is jeopardized as well.

13 *15. Licensure and Operation of Dialysis Clinics.*

14 Historically, the male prisoner/patient population received dialysis treatments on-site at
15 California Medical Facility, Deuel Vocational Institution, and San Quentin State Prison State
16 Prison with an overall capacity of approximately 81 prisoner/patients. CDCR was unable to
17 maintain the required regulatory licensure at Deuel Vocational Institution and San Quentin State
18 Prison and closed those dialysis clinics in mid 2001, leaving California Medical Facility as the
19 only CDCR facility to operate a licensed dialysis clinic. By April 2006 there were 154 male
20 prisoner/patients requiring dialysis, housed at 10 institutions throughout the State. Lacking the
21 capacity to treat this population on-site, CDCR utilized community-based dialysis clinics. This
22 required custodial transportation teams escort prisoner/patients off-site to community dialysis
23 clinics, while maintaining security and providing protection to the public during treatment.
24 Transporting prisoner/patients into the community for any medical treatment impacts patient
25 health care, reduces public safety, and significantly increases the overall costs of treatment. The
26 cost of providing custody escorts and transportation to outside clinics for approximately 150
27 prisoner/patients ranged between 11 and 15 million dollars per year.

1 A plan was developed by CDCR to provide hemodialysis on-site statewide. In addition
2 to reinstating the license of the existing dialysis facility at CMF, the plan called for dialysis
3 clinics to be established, licensed, and operated at the California Substance Abuse Treatment
4 Facility, Wasco State Prison, and Kern Valley State Prison. The plan had three primary goals:
5 (1) improving patient health by providing more consistent treatment and care; (2) improving
6 patient and public safety by providing dialysis treatments within the secure perimeters of
7 designated CDCR institutions; and (3) reducing the custody and transportation costs associated
8 with providing treatment at outside facilities.

9 The CDCR was unable to implement the plan due to lack of focused coordination and
10 leadership. With the involvement of the Receiver, stumbling blocks were worked through and
11 timelines were expedited. The Substance Abuse Treatment Facility clinic was completed in two
12 phases: the first phase consisted of six dialysis treatment stations, while the second phase created
13 a 19-station dialysis clinic. The six-station clinic at Substance Abuse Treatment Facility began
14 operating as a licensed dialysis clinic in late September 2006 with a capacity of 36 patients. The
15 dialysis clinic at Kern Valley State Prison began operating in early October 2006, with a capacity
16 of 24 patients. The clinic at Wasco State Prison, which also provides dialysis treatment for RC
17 prisoner/patients, began operating as a dialysis clinic in early November 2006, with a capacity of
18 36 patients. The Plan was fully implemented by late May 2007 with the licensure and operation
19 of the 19-station dialysis clinic at Substance Abuse Treatment Facility, with a capacity of 114
20 patients.

21 At present, almost all male dialysis patients are receiving dialysis within the secure
22 perimeters of designated institutions, resulting in improved patient care, improved
23 prisoner/patient and public safety, and the reduction of custody and transportation costs of up to
24 \$15 million per year.

1 16. *Cleaning Up Specialty Services in the Wake of Medical*
2 *Development International's Failures at California Correctional*
3 *Institution and California State Prison, Los Angeles County.*

4 In March 2007, the Medical Development International (MDI) arrangement for providing
5 specialty services at or for California Correctional Institution and California State Prison, Los
6 Angeles County was terminated by the Receiver due to MDI's failure to produce proof of a
7 license to operate in the State of California. In addition, MDI's poor management had resulted in
8 a breakdown of prisoner/patient access to necessary specialty care, placing the lives of
9 prisoner/patients at risk.

10 The Office of the Receiver ordered an immediate evaluation of specialty services at CCI
11 and LAC to identify the deficiencies related to the delivery of specialty care, discover the root
12 causes of those deficiencies, and develop and implement corrective actions. The Receiver's
13 evaluation team identified the following inadequacies and barriers to access to specialty services:
14 a large backlog of specialty care at CCI and LAC (at LAC alone there were 450 unscheduled
15 appointments, 135 of which were over 90 days old); inadequate coordination between the
16 Specialty Scheduler, Telemedicine, and Utilization Management ("UM") Nurses at each
17 institution; poor coordination between medical scheduling and custody; inadequate triage of
18 cases; lack of adequate transportation vehicles for off-site appointments; lack of designated
19 medical transportation officers; and inadequate space for Telemedicine in all needed area
20 services.

21 Under the direction of the Receiver's Chief of Staff, the evaluation team has continued to
22 meet bi-monthly, providing LAC and CCI with the tools, processes, staff, and contract providers
23 necessary to ensure timely access to quality specialty services on-site, off-site, and via
24 telemedicine. The team also continues to evaluate the remedial measures that have been taken
25 by each institution for quality and efficiency, reviewing every request for specialty services. The
26 goal of the team is to replace and improve the functions previously performed by MDI and to
27 enable LAC and CCI to independently and effectively manage specialty services.

1 a. Progress Made Toward Overhauling Specialty Services at
2 California Correctional Institution and California State Prison, Los
3 Angeles County.

4 An experienced team of nursing, medical, IT, custody, support services personnel, and
5 the approval of additional staff resources at both institutions, enabled the institutions to
6 implement solutions for the scheduling and tracking of specialty care; ensure adequate numbers
7 of trained staff are available to schedule appointments, escort and transport prisoner/patients, and
8 assist with telemedicine services; ensure adequate numbers of contract physician specialists are
9 available to provide specialty services on-site and in the community; implement a Fast-Pay
10 system, which includes retrospective reviews to ensure contract physician specialists are paid in
11 a timely manner; augment current local vehicle pools to ensure vehicles are available for
12 prisoner/patient transportation to off-site specialty care appointments; and improve Telemedicine
13 services.

14 While the majority of specialty services have improved, it is not the case at present for
15 optometry specialty care at both California Correctional Institution and California State Prison,
16 Los Angeles County, since they both lost their contractor recently. California Correctional
17 Institution and California State Prison, Los Angeles County, have engaged replacement
18 optometry contractors and plan to attend to the backlog in the coming weeks.

19 The Receiver highlights two reform efforts made by the California Correctional
20 Institution and California State Prison, Los Angeles County Team: implementation of the Patient
21 Scheduling System Pilot and improved access to telemedicine services.

22 1. *Patient Scheduling System Pilot.*

23 A new patient scheduling system is being piloted at California Correctional Institution
24 and California State Prison, Los Angeles County. The pilot has begun by establishing several
25 new workflow processes to resolve various scheduling issues before they are computerized. The
26 UM Nurse has been designated as the case coordinator for all telemedicine, outpatient and
27 specialty care patient needs. This one individual is now responsible for tracking the scheduling
28 and compliance of all off-site appointments. The UM Nurse must interact with the various

1 departments and scheduling staff to process requests and follow-up on all prisoner/patient
2 refusals of care. The development of a new cancellation form for specialty care has also assisted
3 in the tracking of services. This form is used as a Quality Improvement Process Tool to identify
4 and correct deficiencies and ensure specialty care is provided in a timely manner.

5 While the new processes have been successful at both locations, resulting in
6 improvements to appointment scheduling, decreased patient refusals and increased attendance at
7 off-site appointments, attempts to computerize the scheduling function on a pilot basis has been
8 far less successful. To begin, the need for basic infrastructure repairs to ensure local computer
9 connectivity and phone system access delayed computerization. In addition, staff at the prison
10 have not assimilated the work load requirements of computerized scheduling. Finally, because
11 the pilot program is designed to “schedule” but not to “track” appointments, questions have been
12 raised concerning whether this interim solution is adequate. This scheduling pilot will receive
13 additional attention during October and its status will be discussed in the next Quarterly Report.
14 At this time, there are no plans to expand the pilot to other prisons.

15 *2. Access to Telemedicine at California Correctional*
16 *Institution and California State Prison, Los Angeles County.*

17 Since March 2007, the Receiver’s OTS has conducted site visits at California
18 Correctional Institution and California State Prison, Los Angeles County, to evaluate space needs
19 and make modifications, provided additional equipment, and provided training to institution
20 staff. The telemedicine nurses are now working with the UM Nurse who is in charge of
21 coordinating all telemedicine scheduling functions at both institutions (discussed above). Since
22 April 2007, California Correctional Institution has increased Telemedicine specialty services by
23 an average of 53% and California State Prison, Los Angeles County, by 30%.

24 Just one example of the level of dysfunction plaguing specialty services was uncovered
25 by the Receiver’s Telemedicine Services Team. When arriving at California State Prison, Los
26 Angeles County, the Team discovered that telemedicine utilization had dropped for the
27 preceding seven weeks to almost zero due to the Regional Accounting Office’s refusal to pay a
28 phone bill due to a contract dispute with the phone provider. As such, the phone line was

1 disconnected and telemedicine services were inaccessible throughout the institution.
2 Compounding the problem was that the *one* CDCR telemedicine repair person in the State, who
3 is based in Pelican Bay, was on vacation during this phone outage and there is no back-up CDCR
4 telemedicine repair person. Furthermore, staff at California State Prison, Los Angeles County
5 failed to communicate initially with the Receiver's Team and did not indicate that the unpaid bill
6 was the primary cause of the telemedicine outage for almost two weeks. Once the phone bill was
7 paid, the usage of Telemedicine services jumped back up above what it was before MDI's
8 arrangement was terminated.

9 *17. Construction Update on the 10,000 Bed Project.*

10 During this reporting period, significant activity transpired regarding the planning, design
11 and building of 5,000 new medical beds and 5,000 new mental health beds. This 10,000 bed
12 project is developed to implement Goal F of the Receiver's Plan of Action. Goal F mandates:
13 "Create new clinical and administrative space to provide a safe environment for staff and patients
14 based on the new clinical process redesign and on projections of future bed capacity needs."

15 Significantly, Abt Associates and Lumetra completed its Final Report, providing the
16 Office of the Receiver with the necessary data on the burden of chronic disease and physical and
17 cognitive functioning on the current CDCR prisoner/patient population. (*See, Exhibit 9, Chronic*
18 *Care and Long-term Care in California's Prisons: Needs Assessment.*) This report will serve as a
19 basis for the planning and building of the necessary medical bed space to accommodate CDCRs
20 prisoner/patient population through 2017. The Office of the Receiver acquired the services of
21 URS-Bovis Lend Lease Company to plan and establish the construction of the above needed
22 beds. (*See, Exhibit 10, URS-Bovis' Initial Progress Report for August 2007.*) Details of the
23 Receiver's agreement with URS-Bovis are discussed in section 2 below. Weekly facility design
24 planning sessions with URS-Bovis, custody and health care staff from the Office of the Receiver,
25 mental health, dental and CDCR program staff and *Coleman* Special Master designees will begin
26 the last week of September and run through early November 2007. The facility design team has
27 established November 21, 2007 as the due date for the first draft of a design report.

1 One of the biggest challenges for the Office of the Receiver is deciding where to build
2 these 10,000 medical and mental health beds. A total of nine sites have been identified as
3 potentially viable. Selection was based on their proximity to urban areas that should be able to
4 provide the clinical staff necessary to operate these new beds and the availability of useable land.
5 During the week of August 20, 2007, site visits of four Northern California potential locations
6 were completed by staff from URS-Bovis, CDCR's Office of Facilities Management, the
7 Governors AB-900 strike team, DCHCS, and Office of the Receiver. A second set of visits was
8 conducted for Southern California locations the week of September 11, 2007, and a third set of
9 visits in Central California is scheduled for the week of September 24, 2007.

10 Based on the complexities of this project and other construction projects being planned
11 by other entities within DCHCS and CDCR, the Receiver established regular construction
12 coordination meetings which occur approximately every two weeks. These meetings have been
13 vital to ensuring a coordinated effort for all construction work being planned and completed
14 relating to medical, mental health, dental, in-fill bed projects, and Prison Industry Authority
15 expansion projects. Coordination meetings have been held on June 5, 14 and 21, July 10 and 26,
16 and August 9 and 24, 2007.

17 a. Coordination with *Coleman, Perez, and Armstrong*.

18 The Receiver anticipates filing with the Court a proposed coordination agreement
19 between the representatives in *Coleman, Perez, and Armstrong*, which provides for the Office of
20 the Receiver taking the lead for many, but not all, of the various construction projects relating to
21 the health care class actions. As the construction lead, the Office of the Receiver will collaborate
22 and coordinate with the representatives of the other health care class actions in order to ensure
23 that what is built is constitutionally adequate for all plaintiff class members. The coordination
24 agreement will assist the remedial process in all four cases by avoiding inefficiencies and
25 duplication of effort.

26 b. Contracts and Fiscal Oversight.

27 Contracting activity related to the 10,000 bed project has been limited, to date, to the
28 engagement of the Receiver's Program Manager(s)—URS Corporation; Bovis Lend Lease;

1 Brookwood Program Management (Brookwood); LBL Architects (LBL) and Robert Glass &
2 Associates (RGA) (collectively "URS-Bovis"). Ultimately, URS-Bovis will contract with the
3 Receiver through a Joint Venture between the URS Corporation and Bovis Lend Lease (which
4 will subcontract with Brookwood, LBL and RGA). Currently, however, the Receiver has only
5 executed a Letter of Intent with the URS Corporation, effective June 19, 2007, which sets forth
6 interim terms and conditions until the Joint Venture is formalized and a comprehensive scope of
7 work developed. The letter of intent is attached as Exhibit 11. The remainder of the program
8 management firms listed above are currently providing services as subcontractors of the URS
9 Corporation. The Receiver anticipates finalizing the contract with the Joint Venture this month.

10 During this interim period while the contract with the Joint Venture is being finalized,
11 URS-Bovis is providing services at cost and has been submitting successive, short-term budget
12 proposals for prior approval by the Receiver. URS-Bovis will ultimately be able to charge an
13 additional professional fee for services retroactive to June 19, 2007, after the terms of the
14 contract with the Joint Venture are finalized. All budget approval documents are being reviewed
15 by the Receiver's Staff Consultant, Richard Engler, who has more than 35 years of experience in
16 corrections planning, programming, design and construction efforts. In addition, all budget
17 proposals have been reviewed by the Receiver's, Staff Attorney, CFO and Chief of Staff prior to
18 final approval by the Receiver. To date, the Receiver has authorized the expenditure of
19 \$1,267,555 on this project for direct labor expenses, overhead, travel expenses, limited relocation
20 expenses, and management information system hardware, software and equipment leases. These
21 costs have not necessarily been incurred. Approved URS-Bovis budget recommendations are
22 attached as Exhibit 12.

23 *18. Building Upgrades At All Prisons.*

24 On June 26, 2007, the Receiver met with Vanir Construction Management to finalize
25 program goals and implementation approaches to providing facility upgrades at all 33 California
26 State prisons. These construction projects will create new clinical and administrative space,
27 providing a safe, appropriate environment for staff and patients based on new clinical process
28 redesigns and on projected future bed/clinic capacity needs. (See, Plan of Action, Goal F &

1 Objective F.1.) As directed by the Plan of Action, the overall project goals are to increase the
2 ability of the medical staff at each facility to be able to see more patients, in a more timely
3 manner, and to provide high quality modern clinical space so that the medical health services
4 team at each prison can effectively attract high quality medical professionals to their facilities
5 and improve patient care.

6 a. Design, Planning, and Construction.

7 There are two types of facility upgrades that will be utilized to effectively enable all
8 Medical Health Services teams at each of the State facilities to increase the level of clinical care
9 given, and to do so in as short a time frame as possible. (1) The *Emergency Facility Solution*
10 provides the quickest method of providing immediate additional temporary clinic space, through
11 the use of both space reallocation and prefabricated trailers with finished interiors, creating turn-
12 key space for clinical exam rooms, administration areas, supply storage, etc. The emergency
13 facility solution can provide additional clinic space in as little as 60 to 90 days after procurement
14 approval. This solution allows for quick relocation of staff out of existing inadequate spaces,
15 effectively re-allocates existing permanent space for clinical use without the drawback of longer
16 timeframes associated with an interim solution. (2) The *Interim Facilities Solution* makes use of
17 modern prefabricated trailers which are assembled in standard sizes and placed on concrete slabs
18 for more long-term uses. This solution in some instances may more be used as a permanent
19 solution depending upon particular programmatic needs and the facility conditions within which
20 they are developed.

21 Site Planning Teams will first conduct facility needs assessments and evaluations of
22 existing health care facilities. This planning phase includes coordination with representatives
23 from the *Coleman, Perez and Armstrong* class actions as well as CDCR DCHCS. The Teams
24 will then design the emergency or interim facilities solution and then implement projects in
25 accordance with project schedules.

26 b. Timetables for Construction Upgrades.

27 The Receiver has developed a master schedule for the completion of all construction
28 upgrades to clinical, treatment, and support spaces at all 33 prisons. The master schedule

1 establishes a very aggressive timetable, anticipating the completion of all construction upgrades
2 by the end of 2011 – assuming that funding is available.

3 At Avenal State Prison, the Site Planning Team completed its needs assessment and
4 evaluation of existing health care facilities. On August 28, 2007 a plan was finalized with a
5 projected timetable and costs estimates. The Office of the Receiver is working with the
6 Department of Finance to identify funding for this project estimated at \$27.5 million.
7 Simultaneously, the Office of the Receiver is evaluating the specific details of the project to
8 determine whether to pursue a waiver of State law to facilitate the construction of this project
9 with a “design build” approach. Once funding is identified and any needed waivers are in place,
10 it is anticipated that the design and construction would be completed in approximately fourteen
11 months.

12 The site planning phase began at the Correctional Training Facility on September 5,
13 2007.

14 *19. De-licensing of General Acute Care Hospital at California*
15 *Institute for Men.*

16 On July 31, 2007 the Office of the Receiver notified the California State Department of
17 Health Services that the CDCR was voluntarily surrendering the 80-bed GACH license at the
18 California Institute for Men. This decision was made in response to the ongoing substandard
19 conditions of the hospital, inability to meet almost any of the licensure standards, inadequate
20 management of hospital staff, poor leadership and oversight, as well as the ongoing serious
21 misuse of the facility which placed patients at undue risk and caused needless suffering. In
22 addition, the physical plant was in a state of disrepair and out of compliance with licensing
23 standards. It was determined that it was not economically nor operationally feasible for the
24 hospital to be brought into compliance with current licensing and community care standards. As
25 such, the Receiver determined the facility should be converted to an unlicensed correctional
26 infirmary, providing appropriate care to patients with long-term and sub-acute care needs, while
27 prisoner/patients in need of acute care would be transported to community based medical facility.
28 This action was taken in accordance with Receiver’s Plan of Action which mandates conversion

1 of “inappropriately used GACH beds to infirmary and long-term care medical beds.” (Plan of
2 Action, May 2007, B.5.2.4.)

3 a. Conversion of the GACH to an Infirmary.

4 The two month conversion process from the GACH to an unlicensed infirmary was a
5 collaborative effort between the Office of the Receiver and the local institution leadership,
6 involving an evaluation of the physical plant, medical services, nursing services, support
7 services, policies and procedures. During the conversion process, prisoner/patients were
8 evaluated by a RN to determine their medical and nursing needs. To ensure appropriate
9 placements of the patients, the conversion process involved coordination with local acute care
10 hospitals, county jails and the CDCR Health Care Placement Unit. In addition, the surgical suite
11 was permanently closed. A staffing matrix was developed for each medical unit to reflect the
12 appropriate levels of care needed and the staffing was reconfigured to efficiently deliver an
13 infirmary level of care.

14 b. Mental Health Crisis Beds at CIM.

15 Closure of the GACH also affected prisoner/patients suffering from mental illnesses.
16 Conversion of the GACH to an unlicensed infirmary involved thorough assessments of all
17 mental health patients, conducted by a RN. The conversion process involved extensive
18 coordination with mental health staff and the Special Master in *Coleman v. Schwarzenegger*.
19 The mental health unit nursing staffing was reconfigured, ensuring that the CDCR will continue
20 to provide adequate care for up to 45 Mental Health Crisis Beds. Through the coordination
21 efforts, the *Coleman* Special Master concurred with the de-licensure and accepted responsibility
22 for pursuing, if necessary, separate licensure of the MHCBS.

23 E. Establishing the Office of the Receiver.

24 1. *New Appointment to the Office of the Receiver.*

25 During this reporting period the Receiver appointed a consultant (retained for
26 approximately six months): Ellen Gallagher Parsons, M.P.H. Ms. Parsons is a Staff Consultant
27 and will be assisting the Receiver with improvements to the DCHCS contracts unit. Ms. Parsons
28 is a principal at Chancellor Consulting Group (CCG) and has over 25 years of experience in

1 Coordination Order.) To facilitate such coordination, the Courts have agreed that the Receiver
2 will be responsible, in addition to his management of the medical system, for the oversight and
3 implementation of certain mental health and dental functions, including pharmacy operations,
4 long-term IT planning, and certain contracting functions.

5 In addition to coordinating efforts concerning contracting functions, IT and pharmacy
6 operations, the representatives of each inmate health care class action have agreed to further
7 consolidate their remedial efforts. Specifically, an agreement is currently under development to
8 consolidate the management of all CDCR medical and mental health construction projects.
9 Another area of agreement is over the need to coordinate nursing and psychiatric technician
10 duties and psychiatric medication management. Such coordination is to be accomplished
11 through the efforts of a working group made up of representatives of the Office of the Receiver
12 and the *Coleman* Special Master. Furthermore, initial discussions have begun among the
13 representatives on the design of a Governance Model which is envisioned to be on organizational
14 structure to manage health care in the prison system. The tentative plan is to carefully design a
15 system that can be piloted in a small number of prisons. In addition, the Office of the Receiver
16 has created an IT Advisory Committee to better coordinate and communicate the design of the
17 Health Care IT System. Representatives of *Armstrong*, *Coleman*, and *Perez* are a part of this
18 advisory body. Coordination efforts also include a monthly meeting between the Receiver and
19 the representatives of each of the class actions.

20 III.

21 PROBLEMS BEING FACED BY THE RECEIVER, INCLUDING ANY SPECIFIC 22 OBSTACLES PRESENTED BY INSTITUTIONS OR INDIVIDUALS

23 The Receiver focuses his discussion of obstacles in this quarterly report on problems
24 concerning the funding of needed additional prison medical beds.

25 As the Court is aware, the State, with considerable fanfare, recently announced the
26 passage of Assembly Bill 900 ("AB 900") which supposedly provided funding for the
27 construction of prison facilities, including medical and mental health facilities. Repeatedly, the
28 defendants in this case have cited AB 900 in support of the proposition that the State of

1 California is prepared to deal with the serious issues which plague its prison system, including
2 constitutionally inadequate medical and mental health care and chronic overcrowding.

3 However, during the week of September 10, 2007 the Receiver was informed of two
4 developments which indicate that, in fact, AB 900 funds may not be available for the
5 construction of medical beds. Indeed, AB 900 funds may not be available if the Federal Court is
6 involved in any form of expedited prison construction.

7 The first development involves the apparent diversion of AB 900 funding from the
8 construction of additional medical facilities and long-term in-patient mental health and facilities
9 to fund mental health and dental facilities which the State had committed to construct long
10 before the passage of AB 900 (in some cases, years earlier). As a result of this diversion,
11 according to the AB 900 web-site (<http://www.bondaccountability.cdcr.ca.gov>) approximately
12 40% of AB 900 health care funding is already taken, despite the fact that not one new medical or
13 mental health beds has been planned or constructed. In essence, a prison construction plan
14 advertised by the State for future construction appears to be, in fact, used for construction which
15 was promised years earlier and never implemented. It should be noted as well that the allocation
16 of AB 900 funding was unilaterally decided by the Administration without any input from the
17 Receiver's Office, or to the Receiver's knowledge, the *Coleman* court. Thus, the amount
18 allocated in AB 900 was insufficient even before it was "raided" to accomplish pre-existing
19 plans for which it was never intended.

20 The second development is as serious. The Attorney General is responsible for rendering
21 an independent opinion concerning the legitimacy of California bond funding. According to four
22 of his Deputy Attorneys General who met with the Receiver's Chief of Staff and Staff Attorney,
23 AB 900 bond funding may not be available to the Receiver because the Court in this case has
24 authorized the Receiver to begin the process to retain a construction consulting firm and waive
25 certain laws relative to construction contracts (with no objection by defendants). According to
26 the Attorney General, AB 900 funding will not be available for the construction of ANY prison
27 bed if Federal Court orders allow defendants to proceed with construction in any form of
28 expedited construction. Based on this new development, there appear to be only two choices,

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

V.

OTHER MATTERS DEEMED APPROPRIATE FOR JUDICIAL REVIEW

A. Communications with the Media and Public.

1. *Press and Public Information.*

As the Office of the Receiver and its remedial efforts establish a greater presence in California's 33 prisons, the Receiver's public information and media work is broadening from primarily a system-wide perspective to include many prison-specific issues and events. These parallel tracks – big-picture and close-up – reflect the expanding scope and impact of the Receiver's activities. They prompt a corresponding growth in demand for information and attention from the press, public and members of the CDCR's medical staff as we work to move the entire system forward while also putting out fires.

Some examples of the broad range of topics addressed by the Receiver's communications department during this reporting period include:

1. San Quentin State Prison project progress, including the opening of the new TTA and future construction; the Central Health Services Center, and its CEQA process and funding vehicles.
2. A labor-management dispute among nurses at R.J. Donovan Correctional Facility.
3. Valley Fever at Pleasant Valley State Prison and the potential impact on CDCR's plans to build in-fill beds in prisons in areas hyperendemic to Valley Fever.
4. The impact of overcrowding on health care in CDCR's women's facilities.
5. The state of health care in CCFs that contract with CDCR.
6. The voluntary suspension of the acute-care hospital license at the California Institution for Men.
7. Potential sites for building up to 5,000 new medical beds, including the former Fred Nelles Youth Correctional Facility in Whittier, CA.
8. Following up on an inmate death at Avenal State Prison.
9. MRSA at Folsom State Prison and elsewhere.
10. State's prison reform bill (AB900).

- 1 11. Prison overcrowding.
- 2 12. Out-of-State transfers of prisoner/patients.
- 3 13. The Receiver's Plan of Action to create a constitutional medical care system.

4 Throughout the reporting period, the Office of the Receiver remained committed to
5 transparency and public information, and was available to local and national press, CDCR staff,
6 members of State government and the public to provide information and answer questions
7 related to the remedial effort. The Receiver's public outreach included the issuing of press
8 releases, web updates and public information, extensive background discussions and interviews
9 with journalists and meetings with key constituents. In addition, members of the public
10 contacted the Receiver through his web site which continues to be expanded and updated.
11 (www.cprinc.org) Additional details of public outreach activities are listed below.

12 a. Public Information Produced by the Receiver:

- 13 Press Release re: Fifth Quarterly Report to the Court – June 20, 2007
14 “Recommendations for Coccidioidomycosis (Valley Fever) Mitigation in Prisons in the
15 Hyperendemic Areas of California” by Dwight Winslow, M.D., Statewide Medical Director,
16 Report Commissioned by the Receiver — June 2007
17 “San Quentin Under the Microscope,” Multimedia presentation about the San Quentin Project
18 and the new Triage and Treatment Area, posted on Receiver's website – July 27, 2007
19 Response to the Fresno County Grand Jury's Report on Pleasant Valley State Prison – August 1,
20 2007
21 Press release re: “San Quentin Under the Microscope” – August 2, 2007
22 Methicillin-resistant staphylococcus aureus (MRSA) Fact Sheet – August 2007

23 b. Receiver's Radio and TV Coverage:

- 24 KPCC Southern California Public Radio 89.3 – June 26, 2007, “Federal Court to Consider
25 Population Cap for California Prisons”
26 KQED Capitol Notes – July 10, 2007, “We'll Do It From Here”
27
28

1 Capitol Public Radio – July 10, 2007, “Federal Receiver to Look Into Prison Deaths: The man
2 who oversees health care in state prisons says he’s concerned about several recent deaths of
3 California inmates. They were housed in out-of-state facilities”

4 KPCC Southern California Public Radio 89.3 – July 11, 2007, “Sillen Investigating Out-of-State
5 Deaths of Californian Inmates: The court-appointed federal receiver in charge of reforming
6 prison medical care is looking into the deaths of four California inmates serving sentences in
7 other states”

8 KQED Capitol Notes – August 27, 2007, “San Quentin Medical \$\$ Stuck”

9 KPCC Southern California Public Radio 89.3 – August 27, 2007, coverage of *Plata* hearing
10 regarding Receiver’s Plan of Action

11 c. Receiver’s Public Appearances:

12 Address at the Sacramento Press Club Luncheon – July 10, 2007

13 Testimony before the California Assembly Public Safety Committee – August 28, 2007

14 Address at the Sacramento Rotary Club Luncheon – September 10, 2007

15 d. Editorial Coverage:

16 Sacramento Bee Editorial – June 3, 2007, “Prison reform, for real”

17 Sacramento Bee Editorial – June 10, 2007, “Prison progress”

18 The Vacaville Reporter Editorial – June 29, 2007, “No rap on cap: Judges could complement
19 prison plans”

20 Sacramento Bee Editorial – July 25, 2007, “Last chance to regain control of state’s prisons:
21 Politicians’ scare tactics can’t obscure their refusal to act as overcrowding grew”

22 Los Angeles Times Editorial – July 26, 2007, “California’s criminal neglect: State lawmakers’
23 failure to deal with prison overcrowding has resulted in the threat of a population cap”

24 Whittier Daily News Editorial – August 03, 2007, “No prison for Nelles site”

25 Hi-Desert Star Op-Ed – August 24, 2007, “Guest Soapbox: Prison cap would imperil
26 Californians” by Assemblyman Paul Cook

27 Mountain Democrat Editorial – August 31, 2007, “Prison caper”

28 e. Examples of News Coverage:

1 The California Nurses Association/National Nurses Organizing Committee Journal of Patient
2 Advocacy – May 2007, “Inside Job”
3 Los Angeles Times – June 14, 2007, “Medical care at center spurs lawsuit”
4 California Progress Report – June 20, 2007, “Federal Court Receiver in Charge of California
5 State Prison Medical System Report to Judge on Progress Being Made”
6 Sacramento Bee – June 25, 2007, “Prisons job for official who quit under fire”
7 Medical News Today – June 26, 2007, “Receiver Details Substantial Progress Addressing Prison
8 Medical System Crisis, California”
9 Marin Independent Journal – June 27, 2007, “Prison health center draws few public comments”
10 Sacramento Bee – June 28, 2007, “Hearing looks at limit on inmates”
11 Los Angeles Times – June 28, 2007, “Judges seem willing to cap prison population: The two
12 jurists assigned to force change doubt that Schwarzenegger will reform the system”
13 California Progress Report – June 28, 2007, “Prison Reform: Romero Predicts Three Federal
14 Judge Panel Will Be Appointed -- One That May Cap California’s Prison Population”
15 Los Angeles Times – July 02, 2007, “Judge expands pay raises at state hospitals: Ruling says the
16 wages of mental health workers treating inmates must be within 5% of the salaries earned by
17 their counterparts in prisons”
18 San Diego Union Tribune – July 05, 2007, “Prison medical staff express mistrust of nursing
19 director”
20 San Jose Mercury News – July 05, 2007, “Nurses at San Diego prison petition against
21 management”
22 New York Times – July 06, 2007, “California Investigates a Mother-and-Child Prison Center”
23 Fresno Bee – July 08, 2007, “No More Room: Medical care close to a crisis in the state’s
24 crowded women’s prisons”
25 Sacramento Bee – July 09, 2007, “Female inmates: Jammed behind bars? Chowchilla lockups
26 are at more than double their capacity, provoking health concerns”
27
28

1 Advances for Nurses – July 09, 2007, “New CNE for California Prisons: Betsy Chang Ha, MS,
2 BSN, RN, CPHQ, has been named chief nursing executive for the California Prison Health Care
3 Receivership”
4 San Jose Mercury News – July 10, 2007, “Receiver: Three inmates have died in out-of-state
5 prisons”
6 Sacramento Bee – July 11, 2007, “Prison-building plan hit: Federal receiver says it will set his
7 health care efforts back by five years”
8 Sacramento Bee – July 12, 2007, “Medical money for San Quentin: Assembly vote today could
9 shift bond funds to replace prison’s crumbling health care center”
10 Sacramento Bee – July 13, 2007, “Prison med center plan OK’d: Assembly votes to fund San
11 Quentin facility with hospital-bed bond money”
12 Los Angeles Times – July 15, 2007, “Schwarzenegger accused of being MIA: With the budget
13 and other big issues unresolved, lawmakers cite ‘wanderlust’ in saying the governor isn’t
14 engaged. An aide denies the claim”
15 Inland Valley Daily Bulletin – July 25, 2007, “CIM hospital to forfeit license: Facility won’t
16 provide acute care, will transform into an infirmary”
17 Inland Valley Daily Bulletin – July 27, 2007, “Prison health system in flux: Changes at CIM
18 facility part of many”
19 The New Yorker – July 30, 2007, “Dean of Death Row”
20 Whittier Daily News – July 30, 2007, “Official weighs new use for Nelles: Site could be used as
21 prison hospital”
22 New York Times – July 31, 2007, “States Export Their Inmates as Prisons Fill”
23 Sacramento Bee – August 08, 2007, “Claim hits prison health czar: Payment demanded after
24 federal official cancelled services”
25 Sacramento Bee – August 16, 2007, “Prison report cites Valley Fever risks: Construction may
26 release spores that cause disease, increasing inmates’ cases”
27 Sacramento Bee – August 26, 2007, “Capital man’s prison death probed by federal watchdog:
28 Fatalities bring scrutiny of medical care provided to inmates at Avenal facility”

1 New York Times – August 27, 2007, “Using Muscle to Improve Health Care for Prisoners”
2 Sacramento Bee – August 28, 2007, “San Quentin hospital loses Senate fund vote”
3 Sacramento Bee – August 28, 2007, “Prison guards union alleges unsafe conditions at Folsom
4 Prison”
5 San Francisco Chronicle – August 28, 2007, “Prison guards say staph infection plaguing Folsom
6 Prison”
7 Sacramento Bee – August 30, 2007, “Staph a rising problem in state: Once considered limited to
8 ‘at-risk’ populations, infection now common”
9 KPCC Southern California Public Radio 89.3 -- August 27, 2007 coverage of Plata hearing on
10 Plan of Action
11 Sacramento Bee -- September 7, 2007, “Prison health czar loses bid”
12 Sacramento Bee -- September 9, 2007, “Disease clouds a prison's future: A deadly outbreak of
13 valley fever is sparking doubts about expanding the Pleasant Valley lockup in Fresno County”
14 San Jose Mercury News -- Editorial, September 11, 2007, “Time running out on prison reform”

15 2. *Additional Public Outreach Activities.*

16 The Receiver continued to make progress on his commitment to visit all of California’s
17 33 adult prisons. During the reporting period, he visited R.J. Donovan Correctional Facility near
18 San Diego, Mule Creek State Prison in Ione, and California Rehabilitation Center in Norco
19 bringing the total number of prisons visited to 27. A running tally of prisons visited can be
20 found on the Receiver’s web site at <http://www.cprinc.org/faq.htm#visited>.

21 The Office of the Receiver also worked with wardens, public information officers and
22 local medical leaders to facilitate visits to several prisons for members of the media interested in
23 prison medical issues. These visits included California Institution for Men, San Quentin State
24 Prison, Folsom State Prison, and Pleasant Valley State Prison.

25 The Receiver accepted invitations to meet with members of the State Legislature,
26 including Assemblyman Jared Huffman (June 19), Assemblyman Juan Arambula (June 27) and
27 Assemblyman Jose Solario (August 21). He also met with a delegation of criminal justice experts
28 visiting from Turkey (July 12).

1 In connection with the Receiver's ongoing project to improve medical care at San
2 Quentin State Prison, the CDCR held a June 26, 2007 public hearing on the Environmental
3 Impact Report for the new San Quentin State Prison Central Health Services Center. The
4 hearing was attended by members of the Office of the Receiver, the CDCR Office of Facilities
5 Management and Office of Communications, and members of the press and public. During
6 public comment, two people spoke in support of the project and three opposed San Quentin State
7 Prison's continued presence at its Marin location.

8 B. Prisoner/Patient Complaints and Correspondence Program.

9 In the Fifth Quarterly Report, the Receiver provided a summary of the numbers and types
10 of complaints and correspondence received for the first quarter of 2007. The Receiver provides
11 below an update on the prisoner/patient complaints and correspondence program, as well as a
12 summary of the numbers and types of complaints and correspondence received for the second
13 quarter of 2007.

14 *1. Growth of the Prisoner/Patient Complaint and Correspondence*
15 *Program.*

16 The volume of prisoner/patient mail sent to the Receiver is consistently growing.
17 Between the first and second quarters of 2007, the volume of correspondence has increased by
18 over 25 percent. The increase is expected to continue due to several factors: the growth in the
19 number of incarcerated patients; the decision of the Governor's office to forward all their inmate
20 mail to the Receiver; growing inquiries from members of the Legislature to look into complaints
21 coming through their offices, and perhaps most importantly, a recognition in the part of inmates
22 and their representatives that their complaints and comments are actually being reviewed and in
23 most cases responded to. This was not the case prior to the Receivership. While the Office of
24 the Receiver has successfully reduced the number of call-in complaints, the incidence of emailed
25 complaints from prisoner/patients' family members and friends is also increasing, despite posted
26 guideline instructing them to write us via U.S. mail. The recent addition of administrative help
27 to the Prisoner/Patient Complaint and Correspondence Program has helped to streamline the
28 Receiver's investigation and response time despite this ever increasing volume of letters from

1 prisoner/patients seeking the Receiver's assistance. Even so, the spike in volume has created a
2 significant backlog. The Receiver has already taken steps to reduce this backlog by engaging
3 additional staff to process the letters.

4 As explained above, to improve quality, and to alleviate delays and the duplication of
5 efforts, the Receiver also initiated the development of a comprehensive inmate appeals pilot
6 program to handle existing health care inmate appeals (CDC 607's); Receiver correspondence
7 received via mail; habeas corpus cases; and health care-related letters submitted to the CDCR
8 and the Receiver by legislators and the Governor. This new priority for the Receivership will
9 combine these four administrative functions that are currently being handled
10 separately, streamline the process, and eliminate some of the duplicate efforts occurring in the
11 area of correspondence.

12 The purpose of the current Prisoner/Patient Complaint and Correspondence Program is
13 three-fold: (1) to respond to those who write the Receiver; (2) to gain insights into on-the-ground
14 experiences of inmates that can help inform our clinical priorities; and (3) to intervene in
15 clinically serious matters as appropriate. The Program is not a substitute for either the CDCR
16 Correspondence and Appeals Program or the activities of the Prison Law Office. In addition, the
17 Receiver is not solving the prison system's medical care crisis one inmate at a time. With this
18 understanding, the Receiver has routinely set aside letters regarding pain management and
19 pharmacy problems, for instance, because those areas are being tackled on a systemic basis.

20 2. *Quarterly Summary (April – June 2007).*

21 During the second quarter of 2007, the Office of the Receiver processed approximately
22 818 letters. This is an increase of 239 over the 579 letters received during the first quarter of
23 2007. Of the 818 letters, 286 were from people who have written to the Receiver more than
24 once, some several times, regarding either the same or a different issue. (*See, Receiver's Third*
25 *Bi-Monthly Report, page 41 for a description of the letter review process.*) The number of letters
26 clinical staff designates for further investigation currently remains at approximately 20 percent.
27
28

1	Pelican Bay State Prison	14
2	Pleasant Valley State Prison	83
3	R.J. Donovan Correctional Facility	14
4	California State Prison, Sacramento	12
5	California Substance Abuse Treatment Facility	33
6	Sierra Conservation Center	18
7	California State Prison, Solano	46
8	San Quentin State Prison State Prison	32
9	Salinas Valley State Prison	55
10	Valley State Prison for Women	6
11	Wasco State Prison	4

4. *Types of Complaints.*

The majority of letters (487) concern the prisoner/patient's disagreement with the medical care provided. Other types of complaints include lack of access to care, problems with the medical appeals process and complaints against medical staff. (See, Receiver's Fifth Quarterly Report, p. 43 for specific examples of medical care issues brought to the Receiver's attention.)

The categories of complaints are set forth below:

Issue Category	Statewide Total
Access to Care	21
Medical Appeals Problems	6
Complaint v. Staff	28
Disagree with Care	487
Miscellaneous	252
Suspicious Death	7
Custody Interference w/ Medical Care	17

1 The second largest number of letters the Office of the Receiver receives is those
2 categorized as miscellaneous. The miscellaneous letters have been separated into sub-categories
3 in the table below. (See, Receiver's Fifth Quarterly Report, pp. 44-45 for a description of the
4 miscellaneous sub-categories.)

Miscellaneous Category	Statewide Total
Mental Health	16
Dental	28
Transfer	15
Diet	3
Optometry	0
Chrono	6
Legal	3
Pharmacy	16
Other	165
Total	252

17 The "repeat letters" category includes letters from individuals who previously wrote the
18 Receiver regarding the same or a different issue. This category continues to grow each month
19 and is a measurable factor in the growing number of correspondence overall. Repeat letters on
20 the same topic slow down the processing of all letters. In some cases, they are reflective of the
21 prisoner/patient's emotional state, and sense of urgency. In others, they indicate an expectation
22 that the Receiver's intake process moves faster than it does. There was a total of 286 repeat
23 letters received in the second quarter of 2007.

24 The number of "repeat letters" is set forth below.

25 Avenal State Prison 30

26 Calipatria State Prison 2

27 California Correctional Center 0

28 California Correctional Institution 3

1	Centinela State Prison	0
2	Central California Women's Facility	5
3	California Institution for Men	0
4	California Institution for Women	7
5	California Men's Colony	7
6	California Medical Facility	14
7	Corcoran State Prison	25
8	California Rehabilitation Center	1
9	Correctional Training Facility	12
10	Chuckawalla Valley State Prison	2
11	Deuel Vocational Institute	1
12	Folsom State Prison	5
13	High Desert State Prison	9
14	Ironwood State Prison	3
15	Kern Valley State Prison	5
16	California State Prison, Los Angeles County	2
17	Mule Creek State Prison	32
18	North Kern State Prison	2
19	Pelican Bay State Prison	3
20	Pleasant Valley State Prison	42
21	R.J. Donovan Correctional Facility	6
22	California State Prison, Sacramento	3
23	California Substance Abuse Treatment Facility	11
24	Sierra Conservation Center	1
25	California State Prison, Solano	13
26	San Quentin State Prison	11
27	Salinas Valley State Prison	25
28	Valley State Prison for Women	3

1 Wasco State Prison 1

2 Prisoner/patient letters often confirm findings about the prison medical care system.

3 Many prisoner/patients relate experiences of delays in access to care, lack of communication of
4 test results, slow follow up after specialty procedures or appointments and a disorganized
5 approach to chronic care. Among the cases that prompt follow up, the Receiver's staff often
6 learns that the required appointment, prescription or procedure did ultimately take place, after
7 considerable delay. This information helps to focus our efforts on systemic change that features
8 not only an infusion of qualified medical staff but also attention to processes such as medical
9 records, laboratory, intra- and inter-prison communication and the importance of timely and
10 accurate medical information accompanying an inmate transfer. Factors such as lack of clinical
11 and support space and staff shortages also contribute to the delays and confusion. The Office of
12 the Receiver has identified these problems in other forums, and their urgency is underscored by
13 the correspondence of the incarcerated.

14 C. Evaluation of Prisoner Deaths During 2006.

15 In September 2007 the Receiver released an analysis of CDCR prisoner deaths in 2006.
16 The report found that 66 of all prisoner deaths during 2006 (15%), were either "preventable" (18
17 deaths) or "possibly preventable" (48 deaths). The reasons for these deaths included both
18 provider error and systemic breakdowns in such areas as medical records, laboratory and test
19 results, delays in accessing care and transport difficulties. The report highlights the degree to
20 which the flaws in the infrastructure and medical delivery system contribute to patient deaths,
21 providing a level of detail and understanding that had not been reached before. The report also
22 appears to confirm the findings of court experts who, prior to the Receivership, assessed needless
23 deaths at the rate of approximately one every six to seven days.

24 This report will be utilized as a baseline going forward from which to measure the
25 improvements being initiated by the Receiver. The Receiver is committed to making this type of
26 medical services information public. The report underscores the urgency of the crisis and the
27 extent to which long-term systemic fixes will be required to correct it. To summarize, the causes
28 of preventable prisoner deaths extend far beyond so-called "bad doctors." The most serious and

1 difficult to resolve problems are systemic in nature. The Receiver has taken several steps to
2 improve the provider pool and working conditions and the Plan of Action reflects the strategy of
3 a broad systemic approach to transform the medical delivery system. The report is attached as
4 Exhibit 15.

5 D. Contracts Entered Into by the Receiver to Assist the Receiver's Internal
6 Operations and Contracts Entered Into by the Receiver for the Benefit of
7 CDCR.

8 As the Court is aware, the Receiver operates through the auspices of a non-profit
9 corporation, the CPR. The Receiver has understood the Order Appointing Receiver
10 ("Appointing Order") to contemplate two distinct capacities in which he functions: those
11 activities necessary for the internal operation of CPR and the Receivership as a legal entity
12 separate from CDCR and those functions in which the Receiver has supplanted the Secretary of
13 CDCR with respect to the development and delivery of constitutional medical care within CDCR
14 and its prisons.⁴ These differing capacities have implications for how the Receiver has treated
15 contracts with third parties.

16 *1. Receiver's Contracts with Vendors Providing Services to Assist the Operation*
17 *of the Receiver's Non-Profit Corporation, the California Prison Health Care*
18 *Receivership.*

19 The Order provides that generally the Receiver must exercise his duties "in a manner
20 consistent with California State laws, regulations, and contracts, including labor contracts" and
21 may seek waivers of such law only under specified circumstances. Particularly because of the
22 context in which this requirement is imposed, the Receiver has understood it to refer to particular
23 State laws as they may apply to the CDCR as a State agency. Thus, the Receiver has understood
24 this requirement to apply to the Receiver's functions insofar as he has supplanted the CDCR
25 Secretary with respect to the delivery of medical care. The Receiver has not understood this
26 requirement to impose any special obligation upon him to the extent he administers and manages
27

28 ⁴ The Receiver understands that there is not always a bright line between these two sets of functions; but they are nevertheless conceptually distinct.

1 the internal operations of CPR and the Receivership itself. The Receiver does not believe, for
2 example, that CPR, as a non-profit corporation, is subject to the substantive and procedural
3 contracting constraints imposed by State law on State agencies. If he was subject to such
4 constraints with respect to the internal operations of CPR, it would be akin to requiring an
5 organization that provides services with State funding (*e.g.*, community based organizations) to
6 run its internal operations in accordance with the State's own business practices and procedures.
7 There is no dispute that State law constraints on State agencies do not reach that far. It follows,
8 therefore, that since CPR as a non-profit corporation is not subject to such constraints, the
9 Receiver is not required to seek waivers of State laws imposing such constraints when
10 undertaking contracts for the operation of CPR and the Receivership itself.

11 The distinction between the Receiver's capacities and functions discussed above has
12 implications for other provisions of the Appointing Order as well. The Appointing Order
13 provides that "Upon approval from the Court, the Receiver shall set reasonable compensation
14 and terms of service for each member of his staff, (including employees and/or consultants) and
15 shall be authorized to enter into contracts with the employees or consultants of the Office." (*Id.*
16 at 6.) The Appointing Order also provides that:

17 The Receiver and his staff shall have the status of officers and agents of this Court, and as
18 such shall be vested with the same immunities as vest with this Court. Additionally, Defendants
19 shall indemnify the Receiver and members of his staff to the same extent as Defendants are
20 obligated to indemnify the Secretary of the CDCR.

21 (*Id.*)

22 The Receiver has interpreted "staff (including employees and/or consultants)" to mean
23 those persons actually employed by the Receiver and independent contractors retained to assist
24 directly in the development and implementation of policies and procedures designed to bring the
25 prison medical care system up to constitutional standards. Put another way, the Receiver has
26 drawn a distinction between those individuals performing functions that CDCR employees and
27 contractors either could have or should have undertaken for the development and delivery of
28 adequate medical care and outside vendors and professionals engaged to provide goods and

1 services to assist the operations of CPR itself, even if those vendors are providing goods and
2 services that may assist the Receiver in his overarching task of improving the delivery of medical
3 care. For example, the Receiver has not considered outside counsel he has retained to be
4 “consultants” (and thus “staff”) within the meaning of the Order.⁵ Similarly, the Receiver has
5 engaged outside contractors to provide, for example, IT or financial services to CPR and does
6 not consider them to be “staff” within the meaning of the Order.

7 Although, as discussed above, the Receiver does not believe that his contracts with
8 outside vendors for the operation of CPR as an entity are subject to the contracting constraints
9 imposed on State agencies or to the waiver procedure under the Order, the Receiver does believe
10 that it is best to keep the Court advised of his practices and confirm that his approach meets with
11 the Court’s approval. Until more formal policies and procedures are developed it has been, and
12 continues to be, the Receiver’s general practice to obtain information from multiple contractors
13 prior to awarding contracts with outside vendors. In addition, all contracts are reviewed by the
14 Receiver and reviewed as to form and legality by counsel. Note, however, that several
15 engagements were awarded by sole source during the early stages of the Receivership given the
16 urgency of establishing the Receiver’s offices.

17 A list of the vendors that the Receiver has engaged to date is attached as Exhibit 16
18 hereto. In most cases the goods and services provided are self-explanatory. Specifically with
19 respect to outside counsel, the Receiver has retained counsel to assist with construction-related
20 matters, litigation, and general government law advice. The Receiver has negotiated fee caps
21 with all such counsel so that the highest hourly rate does not exceed \$350. In some cases, this
22 represents a substantial discount from the normal hourly rates charged by such counsel. In June
23 2007, the Receiver engaged Deloitte and Touche LLP to assist CPR with the assessment of
24 current internal controls and business processes and the creation of improved internal controls
25 and business processes based on any gaps identified. This will include, among other business
26

27
28 ⁵ Nor does the Receiver believe it is necessary to afford outside counsel the protection of the
Receiver’s immunities since lawyers customarily assume responsibility for their own
professional liability.

1 practices, recommended policies and procedures related to contracting and procurement control.
2 A copy of the engagement letter is attached as Exhibit 17.

3 2. *Receiver's Contracts with Vendors Providing Services to Assist the*
4 *Receivership in the Development and Delivery of Constitutional Medical*
5 *Care within CDCR and its Prisons.*

6 On June 4, 2007, the Court approved the Receiver's Application for a more streamlined,
7 substitute contracting process to in lieu of State laws that normally govern State contracts. (*See,*
8 *Order Re Receiver's Master Application for Order Waiving State Contracting Statutes,*
9 *Regulations, and Procedures, and Request for Approval of Substitute Procedures for Bidding and*
10 *Award of Contracts, hereinafter "Master Contract Waiver Order."*) Specifically, the Court
11 approved three alternative bidding processes, depending on the type and amount of contract at
12 issue that are "streamlined when compared to State procedures [yet] are designed to be
13 transparent and fair and to obtain, in the Receiver's exercise of reasonable judgment, high quality
14 goods and services at the best price." (*Id.* at 5.) While the Receiver will not reiterate the
15 substitute bidding procedures herein which are fully articulated in the Court's Order, the
16 Receiver will briefly describe the three alternative bidding procedures and the Receiver's
17 corresponding reporting obligations (previously detailed above in I.E., page 7.)

18 Under the Order, the Expedited Formal Bidding Process is to be utilized on all higher
19 cost contracts, i.e., where the total contract price is estimated to be valued at \$750,000 or more.
20 This process shall also presumptively apply to contracts whose total contract price is estimated to
21 be valued at between \$75,000 - \$750,000, unless the Receiver determines that urgent
22 circumstances require the use of the urgent informal bidding process set forth below. (*Id.* at 6.)

23 The Order further specifies,

24 "The Receiver shall list all bidders in his quarterly progress reports to the Court and
25 identify the successful bidder. If fewer than three bidders responded to the RFP and/or any
26 bidder responded to a direct solicitation by the Receiver, the Receiver will so note that fact in the
27 report."

28 (*Id.* at 7.)

1 The Order also identifies a second process, Urgent Informal Bidding, to be utilized for
2 any contract whose total contract price is reasonably estimated to be valued at less than \$75,000.
3 This process may also be utilized for contracts whose total contract price is estimated to be
4 valued at between \$75,000 - \$750,000 if the Receiver determines that urgent circumstances do
5 not permit sufficient time to utilize the expedited formal bidding process because: (1) the
6 additional delay that would result from utilizing the expedited formal bidding process would
7 substantially risk endangering the health or safety of inmates or staff, or (2) the contract is
8 essential to the "critical path" of a larger project, and the additional delay that would result from
9 utilizing the expedited formal bidding process would significantly interfere with timely or cost-
10 effective completion of the larger project. (*Id.* at 7.) The Order further mandates,

11 "The Receiver shall identify all bidders, including the successful bidder, in his quarterly
12 progress reports to the Court. For contracts whose total contract price is estimated to be between
13 \$75,000 - \$750,000, the Receiver shall also provide the explanation for his determination that
14 one (or both) of the criteria for using the urgent informal bid process were satisfied. If the
15 Receiver is unable to obtain at least three bidders, he shall note that fact in the report."

16 (*Id.* at 8.)

17 The third process is designed to permit the Receiver to utilize a sole source when the
18 Receiver has determined, after reasonable effort under the circumstances, that there is no other
19 reasonably available source. Sole Source Bidding shall only be used as a last resort. "The
20 Receiver shall identify any contract that is sole-sourced in the Receiver's quarterly progress
21 reports to the Court along with an explanation as to the basis for the Receiver's determination
22 that no other sources are reasonably available." (*Id.* at 8.)

23 The following are the contracts entered into by the Receiver during the last reporting
24 period on behalf of CDCR under the Court's alternative bidding procedures.

25 a. Contracts Entered Into Under the Expedited Formal Bidding
26 Process.

27 The Receiver issued a Request for Qualifications for a contractor for construction
28 program management services to advise and consult with the Receiver and to provide capital

1 facilities development expertise for the renovation of existing facilities and the design,
2 contraction, and commissioning of new facilities. URS/Bovis Lend Lease, Jacobs/ Lee,
3 Burkhart, Liu, Heery International/HDR/Cumming, Vanir Construction Management, Louis
4 Berger Group/Carter Goble Lee/Luster National), Parsons, and Swinerton Management
5 Consulting submitted responses. URS/Bovis Lend Lease was selected to provide program
6 management services with respect to the Receiver's "5,000 bed" project and Vanir Construction
7 Management was selected to provide program management services with respect to the
8 renovation of existing facilities. With the exception of Parsons, the Receiver solicited
9 qualifications directly from all the above teams.

10 The Receiver issued a RFP for an assessment of CDCR's existing telemedicine program
11 and assistance in developing a plan for future development of telemedicine services. Only two
12 bidders responded: the UCD and the UTMB. The Receiver awarded the contract to the
13 University of Texas. Both proposals were solicited directly by the Receiver.

14 The Receiver issued a two stage solicitation for the selection of a design/build contractor
15 for the San Quentin State Prison Central Health Facility. The first stage involved
16 prequalification of firms. Two firms submitted qualifications: Hansel-Phelps (with Hellmuth,
17 Obata & Kassabaum) and Clark Construction Group (with KMD Architects). Both firms met the
18 prequalification requirements. The Receiver then requested these firms to submit technical
19 proposals. Both firms submitted proposals, and the Receiver selected the Hensel-Phelps/HOK
20 team. Both teams were solicited directly by the Receiver.

21 b. Contracts Entered Into Under the Urgent Informal Bidding
22 Process.

23 Due to the large volume of unused and reclaimed drugs which have historically not been
24 disposed of properly by CDCR institution staff, the Receiver solicited proposals for the
25 engagement of a reclamation and destruction firm. The Urgent Informal Bidding process was
26 utilized because of the immediate and substantial risk posed of the unused and reclaimed drugs
27 to the health and safety of institution medical staff and prisoner/patients. In addition to the
28 health and security risk posed, the presence of the large quantities of drugs awaiting return or

1 destruction and the presence of the large quantities of unusable drugs posed an environmental
2 hazard as well. Proposals were obtained from MedTurn, Capital Returns and Guaranteed
3 Returns. Guaranteed Returns was selected.

4 Utilizing the informal bidding process on the grounds that the estimated cost of the
5 contract is under \$75,000, the Receiver solicited proposals for a clinical laboratory subject matter
6 expert to assist the Receivership with the review of vendors' proposals for the pending contract
7 for an assessment of the CDCR clinical laboratory system. After careful review of all applicants,
8 the Receiver engaged Irene Chen. The Receiver also solicited proposals from the following
9 individuals and vendors who were not selected: Sandra Tye; Cathy Hawes; maxIT Healthcare,
10 LLC; and Suzanne Spradley.

11 Utilizing the informal bidding process on the grounds that the estimated cost of the
12 contract is under \$75,000, the Receiver solicited proposals for health information management
13 subject matter experts to assist the Receivership with the review of vendors' proposals for the
14 pending contract for an assessment of the CDCR health information management system. After
15 careful review of all applicants, the Receiver engaged two separate experts: D'arcy Myjer and
16 William Didier. The Receiver also obtained a proposal from Lenore Gilbert, which was not
17 accepted.

18 The Receiver solicited proposals for the procurement of a contractor to assist the
19 Receiver in the management of the RFP processes and contract management for various ancillary
20 service assessments, including the clinical laboratory assessment, radiology assessment and
21 health information management assessment. The Receiver utilized the urgent informal bidding
22 process because the awarding of this contract was in the critical path of three other larger
23 remedial projects (i.e., the ancillary service assessments) and the additional delay that would
24 result from utilizing the expedited formal bidding process would significantly interfere with
25 timely completion of those larger projects. The Receiver received proposals from JK Corporate
26 Services, IBM/Healthlink, and Nancy Dorsey & Associates. JK Corporate Services was
27 selected.

28

1 The Receiver informally solicited software to assist in the scheduling of
2 prisoner/patients' medical appointments. As the estimated cost of the contract was \$15,000, the
3 Urgent Informal Bidding process was utilized. The Receiver obtained product information and
4 pricing terms from Timetrade Systems, Medisoft, and SpectraSoft. Timetrade Systems was
5 selected.

6 The Receiver informally solicited proposals for assistance in establishing hospital
7 inpatient and physician payment rates for use in the CDCR provider contracting process. The
8 Urgent Informal Bidding process was used because the contract was estimated to be less than
9 \$75,000. The Receiver solicited proposals from eight qualified consulting firms. Proposals were
10 submitted by Navigant Consulting and MGT of America. Navigant was selected.

11 The Receiver issued a Request for Bids for the construction and delivery of two mobile
12 medical trailers to Avenal State Prison. The Urgent Informal Bidding process was used because
13 of the dire need for additional clinical space at Avenal for medical specialty services. Because
14 there is a near total lack of adequate clinical space, any delay in providing temporary relief with
15 the aid of the mobile trailers would substantially risk endangering the health of inmates. Bids
16 were obtained from K&D Custom Coach, American Custom Coach, LifeLine Mobile, Mobile
17 Specialty Vehicles, Farber Specialty Vehicles, Med-1 Partners, Craftsmen Industries, Oshkosh
18 Specialty Vehicles, Mobile Conversions, Custom Trailerwerks, and Agents Private International.
19 K&D Custom Coach was selected.

20 c. Contracts Entered Into Under the Sole Source Bidding Process.

21 The Receiver selected Enterprise Networking Solutions, Inc. ("ENS"), on a sole source
22 basis, to complete the work of DCHCS's IT Analyst Allan Gaines related to implementing the
23 Health Care Document Management System ("HCDMS") after Mr. Gaines tragic and untimely
24 death. ENS employs IT consultant Jeffery Baker who is the network architect that designed and
25 deployed the Department-wide Active Directory IT structure. Prior to Mr. Gaines death, Mr.
26 Baker worked along side Mr. Gaines, through an existing CDCR contract, on the implementation
27 of HCDMS and its incorporation into the Active Directory. Following Mr. Gaines' death, the
28 Receiver expanded the scope of Mr. Baker's services to assume Mr. Gaines' duties with respect

1 to HCDMS. Had the Receiver not engaged Mr. Baker, the implementation of the Receiver's
2 contracting IT system would have come to a stand still during the indefinite period which may
3 have been required to identify and train Mr. Gaines' replacement.

4 **VI.**

5 **CONCLUSION**

6 As is apparent from this and prior Quarterly and Bi-monthly reports to the Court, The
7 Office of the Receiver and associated staff in CDCR are deeply involved in attempting to
8 refine our understanding of the problems identified by the court's experts during the several year
9 period leading up to the establishment of the Receivership. As has been pointed out previously,
10 the issues are far more difficult, complex, widespread and deep seated than previously indicated.
11 There are no quick fixes or easy solutions. Due to the enormity of the CDCR and its problems,
12 including but not limited to the medical care program, the Receiver, with court approval, has
13 embarked on a journey of pilot projects, priority setting, initiation of temporary remedial actions
14 and planning for wholesale systemic change--transformation of the medical care system and
15 associated systems which are essential to bringing access and quality of care up to constitutional
16 levels. Much success has been documented to date. However, no party is more aware than the
17 Receiver that the surface has hardly been scratched and that viable, sustainable solutions to
18 critical path issues have yet to be initiated, let alone completed.

19 The production of the second iteration of the Receiver's Plan of Action in mid-November
20 will mark the beginning of a new chapter in the Receiverships attempts to accomplish its goals.
21 There will be time frames, albeit all subject to change; there will be metrics established, albeit
22 without the information systems or personnel to adequately enable their accomplishment in the
23 near future; there will be continued resistance from individuals, organizations and State offices
24 and officials who will attempt to maintain the status quo and thwart our efforts, either
25 intentionally or inadvertently. We, The Receivership will not allow these impediments to lay our
26 efforts to waste. The challenges to date, however, have been mild compared to what we
27 anticipate over the next 36 months, the time period that we have been directed by the court to
28 focus on in our revised Plan of Action.

1 It is important for all parties to understand that change will be the constant for our
2 endeavors and that we will not, by design, be even attempting to fix all aspects of this severely
3 broken and dysfunctional system. We will indicate our priorities for the next 36 months. By
4 definition many aspects of the system which also need to be fixed before we can assure the
5 constitutional rights of the plaintiff class will not be addressed until we have substantially met or
6 positioned ourselves and CDCR to meet the highest priority issues. Many, including the Receiver
7 are going to be disappointed that we can not do more, faster. Anyone, however, with even a
8 minor understanding of the issues and the environment, can appreciate that this entire effort is a
9 process, a lengthy, complex set of issues in a complex, mainly uncharted environment.

10 As we actually implement more of what we are planning and designing the impacts will
11 be several fold. Clearly, more resources, financial and human will be required. We will be
12 confronted with more challenges by stakeholders as we change the way work is designed and
13 conducted. The culture will change in conflicting ways, somewhat towards maintaining the status
14 quo/somewhat by stakeholders grasping the new vision and value added proposition of good
15 medical care. We will continue our efforts unabated and be sure to keep all stakeholders
16 informed during the transition. Our goal remains unchanged--working together, custody and
17 medical will ensure the constitutional rights of those presently deprived of them.

18
19 Dated: September 25, 2007

20
21 

22 Robert Sillen
23 Receiver
24
25
26
27
28

1 **PROOF OF SERVICE**

2 I, KRISTINA HECTOR, declare:

3 I am a resident of the County of Sacramento, California; that I am over the age of
4 eighteen (18) years of age and not a party to the within titled cause of action; that I am employed
as the Inmate Patient Relations Manager in *Plata v. Schwarzenegger*.

5 On September 25, 2007 I served a copy of the attached document described as
6 RECEIVER'S SIXTH QUARTERLY REPORT on the parties of record in said cause by sending
a true and correct copy thereof by electronic mail and on September 26, 2007 by United States
7 Mail and addressed as follows:

8 ROBIN DEZEMBER
9 Director
10 Division of Correctional Health Care Services
CDCR
P.O. Box 942883
Sacramento, CA 94102

11 CHARLES J. ANTONEN
12 SAMANTHA D. TAMA
13 ROCHELLE EAST
Deputy Attorney General
455 Golden Gate Ave., Suite 11000
San Francisco, CA 94102

14 STEVEN FAMA
15 DON SPECTER
16 ALISON HARDY
Prison Law Office
General Delivery
17 San Quentin State Prison, CA 94964-0001

18 PAUL MELLO
Hanson Bridgett
19 425 Market Street, 26th Floor
San Francisco, CA 94105

20 MICHAEL BIEN
21 Rosen, Bien & Galvan
155 Montgomery Street, 8th Floor
22 San Francisco, CA 94104

23 JAY SHULMAN
9647 Hilldale Drive
24 Dallas, TX 75231

25 DR. JOSEPH SCALZO
3785 N. 156th Lane
26 Goodyear, AZ 85395

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

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

4 J. MICHAEL KEATING, JR.
285 Terrace Avenue
5 Riverside, RI 02915

6 MATTHEW J. LOPES
Pannone, Lopes & Devereaux, LLC
7 1800 Financial Plaza
Providence, RI 02903

8 BRUCE SLAVIN
9 General Counsel
CDCR – Office of the Secretary
10 P.O. Box 942883
Sacramento, CA 94283

11 KATHLEEN KEESHEN
12 Legal Affairs Division
CDCR
13 P.O. Box 942883
Sacramento, CA 94283

14 RICHARD J. CHIVARO
15 JOHN CHEN
State Controller's Office
16 300 Capitol Mall, Suite 518
Sacramento, CA 95814

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

20 LAURIE GIBERSON
21 Staff Counsel
Department of General Services
22 707 Third Street, 7th Floor, Suite 7-330
West Sacramento, CA 95605

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

26 DONNA NEVILLE
27 Senior Staff Counsel
Bureau of State Audits
28 555 Capitol Mall, Suite 300
Sacramento, CA 95814
WARREN C. (CURT) STRACENER

- 1 PAUL M. STARKEY
Labor Relations Counsel
- 2 Department of Personnel Administration
Legal Division
- 3 1515 "S" Street, North Building, Suite 400
Sacramento, CA 95814-7243
- 4
- 5 GARY ROBINSON
Executive Director
UAPD
- 6 1330 Broadway Street, Suite 730
Oakland, CA 94612
- 7
- 8 YVONNE WALKER
Vice President for Bargaining
SEIU
- 9 1108 "O" Street
Sacramento, CA 95814
- 10
- 11 PAM MANWILLER
Director of State Programs
AFSME
- 12 555 Capitol Mall, Suite 1225
Sacramento, CA 95814
- 13
- 14 RICHARD TATUM
CSSO State President
CSSO
- 15 1461 Ullrey Avenue
Escalon, CA 95320
- 16
- 17 TIM BEHRENS
President
Association of California State Supervisors
- 18 1108 "O" Street
Sacramento, CA 95814
- 19
- 20 STUART DROWN
Executive Director
Little Hoover Commission
- 21 925 "L" Street, Suite 805
Sacramento, CA 95814
- 22
- 23 PETER MIXON
Chief Counsel
California Public Employees Retirement System
- 24 400 Q Street, Lincoln Plaza
Sacramento, CA 95814
- 25
- 26
- 27
- 28

1 I declare under penalty of perjury under the laws of the State of California that the
2 foregoing is true and correct. Executed on September 25, 2007 at Sacramento, California.

3 
4

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