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

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MARCIANO PLATA, et al.,  
*Plaintiffs,*  
v.  
ARNOLD SCHWARZENEGGER, et al.,  
*Defendants.*

Case No. C01-1351 TEH

**RECEIVER'S REPLY MEMORANDUM  
IN SUPPORT OF HIS SUPPLEMENTAL  
APPLICATION NO. 2 FOR ORDER  
WAIVING STATE CONTRACTING  
STATUTES, REGULATIONS AND  
PROCEDURES, APPROVING  
RECEIVER'S SUBSTITUTE  
PROCEDURE FOR BIDDING AND  
AWARD OF CONTRACTS**

1 Receiver Robert Sillen ("Receiver") submits this Reply Memorandum in support of his  
2 Supplemental Application No. 2 for an order (1) waiving any requirement that the Receiver  
3 comply with State statutes, rules, regulations and/or procedures governing the notice, bidding,  
4 award and protests with respect to contracts (collectively "State Contracting Procedures")  
5 necessary for the retention of consultants to assist in the investigation, analysis, design and  
6 implementation of quality improvement programs within the prison medical system for the  
7 purpose of eliminating preventable deaths, including specifically a pilot project for preventing  
8 deaths from asthma; and, (2) approving substituted notice, bidding and contract award  
9 procedures for such projects identical in form to the procedures approved by this Court in its  
10 order, dated June 4, 2007, granting Receiver's Master Application for a Waiver of State  
11 Contracting Law for certain projects (the "June 4, 2007 Order").

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**PLAINTIFFS' OPPOSITION IS BASED ON FAULTY PREMISES, A  
MISUNDERSTANDING OF THE RECEIVER'S PLANS AND/OR A LACK OF  
ESSENTIAL INFORMATION**

15 In their opposition to this Application, Plaintiffs contend that "two years is not required"  
16 to address asthma-related issues in the prisons; the Receiver has failed to explain the need for  
17 outside expertise to assist with the Asthma Initiative; "other, shorter term actions... would reduce  
18 the risk to inmate patients;" remedial actions exist "which would far more directly address the  
19 problems identified;" and "adequate asthma treatment model(s)" exist and can be applied,  
20 throughout CDCR. *See generally* Plaintiffs' Response To Receiver's Supplemental Application,  
21 etc. ("Pl. Resp.").

22 They then argue that the Receiver can fully address preventable deaths from asthma by  
23 (1) providing doctors and nurses with proper guidelines and training and then disciplining those  
24 who fail to follow the guidelines; (2) providing inmates with asthma-related information; (3)  
25 continuing to monitor and report on asthma-related deaths; and (4) adopting system-wide the  
26 "model" for chronic care that has been implemented at Pelican Bay State Prison ("PBSP") in the  
27 *Madrid* case. Pl. Resp. at pp. 3-4.

28 Plaintiffs' opposition has a number of serious flaws, both factual and conceptual, which

1 are addressed below. The Receiver submits that that Plaintiffs’ objections should be rejected and  
2 that his waiver application should be granted.

3  
4 **A. The Asthma Initiative Is The First Of A Number Of Quality Improvement Initiatives.**

5 At the outset, Plaintiffs seem to have missed the point that the proposed Asthma Initiative  
6 is but the first of a number of anticipated quality improvement initiatives that are addressed by  
7 the waiver application. The Asthma Initiative – in addition to confronting a serious medical  
8 problem in its own right – will lay much of the groundwork for future quality improvement  
9 programs. As such, its design and implementation have broad implications for the medical  
10 delivery system that are not addressed by the narrow and short-term measures suggested by  
11 plaintiffs. As Terry Hill puts it, the Asthma Initiative “will lay down the railway tracks not just  
12 for the Asthma Initiative ‘train,’ but for the other quality initiative trains the Receiver intends to  
13 introduce as he undertakes to improve clinical conditions and processes throughout the prison  
14 system.” Reply Declaration of Terry Hill (“Hill Reply Decl.”), filed herewith, ¶ 25.

15 As the first of a series of initiatives, it is therefore very important that adequate time,  
16 resources and expertise be devoted to the Asthma Initiative. Procedures, protocols and skills  
17 developed during this initiative can be applied to increase the likelihood of success in future  
18 initiatives and of quality improvement in the medical care system generally.

19  
20 **B. Plaintiffs Lack A Clear Understanding Of The Receiver’s Asthma Initiative And Have An Unsophisticated View Of The Work Required To Accomplish Quality Improvement In The Medical Care Delivery System.**

21  
22 **1. Most of the clinical interventions as part of the Asthma Initiative will occur within the first 12 months.**

23 In arguing that “two years” is not required to complete the Asthma Initiative, plaintiffs  
24 misunderstand the Receiver’s Request for Proposal (“RFP”) and the Initiative itself. The primary  
25 clinical interventions to be accomplished as part of the Initiative – and this is critical – are to be  
26 accomplished within *about 12 months*. On November 19, 2007, the Receiver posted “Questions  
27 and Answers” pertaining to the RFP for the Asthma Initiative that discussed the Receiver’s  
28 proposed timeframes. *See*

1 [http://www.cprinc.org/docs/projects/CPR\\_RFP\\_AsthmaInitiativeOaA111907.pdf](http://www.cprinc.org/docs/projects/CPR_RFP_AsthmaInitiativeOaA111907.pdf).

2 In response to questions posed by potential bidders about the work to be undertaken and  
3 the time within which it must be accomplished, the Receiver suggested to proposed bidders that  
4 they begin with the prisons that have implemented the Maxor pharmacy information system,  
5 GuardianRx. By June 2008, six prisons are scheduled to be using GuardianRx. But the Receiver  
6 has emphasized that:

7 *[T]he Asthma Initiative will move at a faster pace than GuardianRx implementation.*  
8 *Furthermore, the Asthma Initiative need not necessarily progress incrementally, one or*  
*two facilities at a time.*

9 In addition to implementing the asthma package where GuardianRx is in place, the  
10 contractor should be able to engage facilities with some asthma interventions prior to  
11 GuardianRx implementation and then assist these facilities through the GuardianRx  
12 transition. Development and testing of this second package will also be essential to  
13 successful movement from intensive engagement strategies, including use of contractor  
14 experts on site, to less-intensive, rapid dissemination strategies that do not require on-site  
15 visits. . . . *[T]he limited heterogeneity and autonomy of the prisons should allow faster*  
*implementation of practice improvement than could be achieved among separate*  
16 *organizations.* Furthermore, as the project progresses, all the regional medical directors  
17 and directors of nurses and all the physician and nurse consultants who report to them  
18 will become familiar with the Asthma Initiative interventions and will act as change  
19 agents on their behalf.

20 \*\*\*

21 *As mentioned above, the contractor should anticipate developing less-intensive, rapid-*  
*spread dissemination strategies to engage a larger volume of facilities in the final phase*  
22 *of the project. This final phase should be at least on the way to completion at the 12-*  
23 *month point.*

24 “Questions and Answers,” pp. 2, 6; emphasis added. *See also* Hill Reply Decl., ¶¶ 6-10.

25 As discussed in more detail in the Hill Reply Declaration, a 12-month time frame in  
26 which to implement collaborative quality improvement programs, particularly in settings such as  
27 this in which there are multiple sites, is standard in the industry. Hill Reply Decl., ¶¶ 7-8. As an  
28 example, Dr. Hill discusses the Health Disparities Collaboratives sponsored by the Health  
Resources and Services Administration (“HRSA”) of the U.S. Department of Health and Human  
Services. Organizations participating in those collaboratives “will typically spend about 12-13  
months learning and applying the models to improve their healthcare delivery systems by  
adapting the general principles to their unique environments and communities.” *Id.*, ¶ 8. Indeed,  
the potential bidders with whom the Receiver has communicated have expressed the view that

1 the Receiver’s proposed time frames are aggressive. Id., ¶ 9.

2 The purpose for requiring a two-year commitment by the vendor with whom the Receiver  
3 contracts is to ensure that the vendor “remain[s] available for further quality data analysis for up  
4 to two years.” Id., ¶ 10. Most of the clinical interventions will have been completed within the  
5 first year. Id.

6  
7 **2. Outside expertise is necessary to assist in improving the quality in the  
medical care delivery system.**

8 Plaintiffs object that there is no need for outside expertise in developing and  
9 implementing the Asthma Initiative. This bespeaks an unsophisticated understanding of how  
10 change occurs in health care organizations and of the challenges that must be overcome in  
11 improving quality. Dr. Hill stresses that even the very best health care organizations, such as  
12 Kaiser Permanente and many of the clinics participating in the HRSA collaboratives, regularly  
13 draw upon assistance from outside their organizations to bring about change and improvement.  
14 Id. at ¶ 11. He notes that CDCR clinics “do not share the same internal stability and expertise” as  
15 organizations such as Kaiser. Therefore, “it would unfair to insist that an organization as  
16 dysfunctional as CDCR must use only internal resources” in connection with the Asthma  
17 Initiative. Id.

18 **3. The Receiver is taking and will continue to take short term remedial  
19 measures to address asthma care, in addition to the Asthma Initiative.**

20 Plaintiffs criticize the Receiver’s proposal by suggesting that he is not taking appropriate  
21 short term remedial measures and that, if he would only do so, there would be no need for the  
22 Asthma Initiative. Plaintiffs are misinformed; the Receiver has taken a number of short term  
23 measures that are pertinent to asthma care. Dr. Hill has identified a number of those short term  
24 measures in his Declaration:

- 25 • The death review analysis itself and asthma care performance in particular have  
26 been discussed at length at statewide and regional meetings of both the  
institutional directors of nursing and the chief medical officers.
- 27 • As noted in the death review analysis: “As of July 2007, 62 CDCR practitioners  
28 (56 MDs and DOs and 6 Nurse Practitioners) have had adverse action taken by  
the PPEC. Of these, 41 were initiated by the death reviews.” This activity  
continues apace.

- 1 • There have been intense efforts to get qualified physicians and nurses at both  
2 line-staff and supervisory levels who will focus attention on “red flag” symptoms.
- 3 • The statewide clinical leadership has already initiated improvements in  
4 emergency response, and those efforts will multiply in the new emergency  
5 response initiative.
- 6 • The Pharmacy and Therapeutics Committee not only wrote a new asthma  
7 medication guideline, the guideline was discussed with clinical leadership from  
8 each institution and distributed throughout the medical staff.
- 9 • The statewide leadership distributed a teaching toolkit on asthma developed for  
10 CDCR by UC San Diego.

11 Id., ¶ 12.

12 The Receiver’s staff will continue to take short term measures to improve asthma care.  
13 The Asthma Initiative will be in addition to these short term measures and is designed to ensure  
14 that short term measures are part of a larger, improved and sustainable program.

15 **4. Plaintiffs mistakenly assume that an appropriate chronic care model, notably**  
16 **the program at PBSP, exists in the CDCR medical system and can be applied**  
17 **system-wide.**

18 Plaintiffs argue that an adequate chronic care model for asthma treatment, particularly  
19 that being used at PBSP, already exists in the prison system and that it can be easily applied  
20 system-wide. Plaintiffs are mistaken.

21 As Dr. Hill emphasizes, “no prison in California is even attempting to meet the standards  
22 of the National Asthma Education and Prevention Program (“NAEPP”) Expert Panel Report  
23 (Update 2007). None is using the panel’s classification system, and none is using individualized  
24 written asthma action plans, which have proven critical to improving outcomes. More broadly,  
25 plaintiffs are clearly unfamiliar with the chronic care *model* described in the Asthma Initiative  
26 RFP as distinct from a “chronic care program” that simply tries to ensure that patients with  
27 chronic illness return regularly to see a provider who tries to follow a simple guideline.” Id. at ¶  
28 13.

While it is certainly the case that some prisons are doing a better job than others at  
providing asthma care, no mechanism exists for applying what may working in one facility and  
applying it in others. As Dr. Hill states, “[T]here are no data specific to asthma available, other  
than mortality (which is statistically limited by the low-number problem), to suggest which

1 prisons actually perform better. Our knowledge of variations in performance is principally via  
 2 managerial impressions. Furthermore, local performance tends to be leadership-dependent.  
 3 Even competent line-level clinicians cannot overcome profound system problems, so if good  
 4 nursing and physician managers leave—or even divert their attention—then asthma care will  
 5 break down in the absence of quality monitoring.” Id. at ¶ 14.

6 Specifically, plaintiffs contend that the experience at PBSP need only be replicated  
 7 throughout the system and the Initiative would be unnecessary. This is simplistic and would  
 8 reproduce the very same kinds of failures that led to the Receivership. No one is better positioned  
 9 to opine on whether the model at PBSP can be effectively implemented system-wide than John  
 10 Hagar, the Special Master in the *Madrid* litigation and the Receiver’s Chief of Staff. It is his  
 11 opinion that it would be a serious mistake to attempt to replicate throughout the entire prison  
 12 system the chronic care program developed at PBSP. *See* Declaration of John Hagar (“Hagar  
 13 Decl.”), filed herewith. First, the model developed at PBSP, a single prison, took years to  
 14 develop and implement. Rather than speed the remedial process in *Plata*, attempting to replicate  
 15 the PBSP program, even if it could be done, would result in unnecessary delay and more deaths  
 16 in the interim. Mr. Hagar writes:

17 As the Court is aware, the State of California, counsel, and I, as Special Master, devoted  
 18 *two full years* to developing an adequate health care remedial plan (including a chronic  
 19 disease program) at PBSP. Thereafter, it took *five more years*, years of monthly on-site  
 20 monitoring by the Special Master, regular on-site inspections by numerous Court experts,  
 21 and countless meetings and hearings, before PBSP’s chronic disease program rose to a  
 22 level of remedial plan compliance sufficient to permit monitoring to be limited, and then  
 discontinued. Given the systemic problems which continue to plague California’s prison  
 medical care delivery system, it would take far more than five years to “apply” the  
*Madrid* model to thirty two disparate institutions. And waiting even five more years is  
 far too long. Five more years will result in deaths which can be, and will be avoided if the  
 Receiver’s waiver application is granted.

23 The remedial program implemented over a painfully long period of time at one prison  
 24 under the watchful eye of the Federal Court, the Special Master, and Court experts cannot  
 be simply “applied” to thirty two other institutions.

25 (Hagar Decl., ¶¶ 4-5; emphasis in original.)

26 Second, Mr. Hagar notes that the original *Plata* remedial plan was quite similar to the  
 27 *Madrid* plan and the goal was simply to roll it out system-wide. As the Court is acutely aware,  
 28

1 that approach failed miserably and led to the Receivership. It would be a huge step backward to  
2 return to this same failed remedial approach with the quality improvement programs generally,  
3 and the Asthma Initiative specifically. Again, Mr. Hagar writes:

4 In many respects, the original *Plata* remedial plan mirrors *Madrid*; the same Court  
5 experts and the same lawyers representing the parties in *Madrid* developed and stipulated  
6 to the *Plata* program.

7 When, however, the *Madrid* model was “applied” via time-phased *Plata* “roll outs” to  
8 other institutions, it not only failed, it did so to such an extent that the extraordinary  
9 remedy of a Receivership was required. The Receiver and his staff, including myself, are  
10 familiar with the real life “practices” at CDCR institutions. We have concluded that a  
11 simplistic “copying” of alternative models will fail, and that this failure will result in  
12 additional preventable deaths.

13 *Id.*, ¶¶ 5-6.

14 Mr. Hagar concludes that based on his direct experience in both *Madrid* and *Plata*,  
15 plaintiffs’ suggestion is doomed to failure. Instead, he believes that the Receiver’s proposal “will  
16 lead to timely, adequate, and sustainable improvement” (*id.*, ¶ 6) in the quality of medical care  
17 delivery and recommends that the Court grant the requested waiver so that the Receiver can  
18 proceed with his quality improvement plans.

19 In the end, the primary shortcoming in plaintiffs’ critique of the Asthma Initiative is that  
20 they do not grasp the difference between the Chronic Care Model that underlies the Initiative and  
21 the prior, failed remedial approach.

22 The Chronic Care Model is a dramatic departure from the physician-centric, episodic  
23 model that relies primarily upon the interaction between physician and patient. The  
24 Chronic Care Model involves the patient and multiple staff members learning new roles  
25 and using data in new ways, supported by information technology and quality measures.  
26 Its success in diverse settings has led multiple systems to initiate practice change  
27 initiatives to make the Chronic Care Model a reality, as illustrated above by the efforts of  
28 HRSA and Kaiser.

Hill Decl., ¶ 15. The Receiver has said it before and will say it again: the approach he is  
undertaking and will continue to undertake is different from the methods that were tried  
previously and failed.

**5. The alternative “solutions” proposed by plaintiffs are already under way but are not sufficient in themselves to result in sustained and sustainable improved quality in the delivery of care.**

Plaintiffs propose four specific steps that they contend could be taken which, together,

1 would be sufficient to improve asthma care. Once again, plaintiffs are simply misinformed about  
2 the facts and misunderstand the approach to be taken in the Asthma Initiative.

3 Plaintiffs propose that (1) clinicians implicated in asthma-related deaths be subjected to  
4 discipline; (2) clear guidelines and expectations be developed and implemented; (3) inmates with  
5 asthma be provided with educational materials; and (4) reviews of asthma deaths and asthma-  
6 related emergencies commence. All of these steps are already being taken, to the extent that the  
7 current system permits. *See Hill Decl.*, ¶¶ 17-20.

8 The appropriate committees have already taken action with respect to doctors and nurses  
9 implicated in asthma-related deaths. *Id.* at ¶ 17. “Within the limits of the educational and  
10 managerial infrastructure currently in place,” guidelines and expectations have been developed  
11 and implemented. *Id.* at ¶ 18. Inmate educational materials and programs that are culturally and  
12 linguistically appropriate are being developed and reviews of asthma-related deaths, emergencies  
13 and hospital visits are continuing or underway. *Id.* at ¶¶ 19-20.

14 These steps may be necessary, but they are not sufficient, for sustained and sustainable  
15 quality improvement. More is required than simply developing a guideline and insisting that  
16 staff follow it. All of the study and analysis that has been done on quality improvement in the  
17 health care industry in the last 20 years has shown that: “Developing and disseminating practice  
18 guidelines alone has minimal effect on clinical practice.” *Id.* at ¶ 22, quoting IOM, *Crossing the*  
19 *Quality Chasm*. Instead, combinations of “education, administrative changes, incentives,  
20 penalties, feedback, and social marketing” are required to bring about change. *Id.* “[T]he greater  
21 the number of QI [Quality Improvement] strategies, the more likely [the] improvements in  
22 clinical outcomes. In particular, . . . patient and provider education interventions that also  
23 included an element of organizational change . . . were often associated with improvements in  
24 outcomes for patients.” *Id.* at ¶ 23, quoting *Closing the Quality Gap*.

25 The Asthma Initiative is intended to apply the research and analysis on quality  
26 improvement that has developed over the last two decades and make quality improvement a  
27 reality in the prison medical care system.

28

