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9 UNITED STATES DISTRICT COURT
10 NORTHERN DISTRICT OF CALIFORNIA
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13 MARCIANO PLATA, et al.,

14 Plaintiffs

15 v.
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17 ARNOLD SCHWARZENEGGER, et al.,

18 Defendants.
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No. C01-1351 T.E.H.

**PLAINTIFFS' RESPONSE TO
RECEIVER'S SUPPLEMENTAL
APPLICATION NO. 2 FOR
ORDER WAIVING STATE
CONTRACTING STATUTES,
REGULATIONS AND
PROCEDURES, APPROVING
RECEIVER'S SUBSTITUTE
PROCEDURE FOR BIDDING
AND AWARD OF CONTRACTS**

21 Pursuant to the Court's November 30, 2007 Order, plaintiffs provide the following
22 response to the Receiver's Supplemental Application No. 2, filed November 20, 2007.

23 This application seeks an order waiving state law and approving substituted notice,
24 bidding and contract award procedures for retention of consultants to assist with quality
25 improvement projects within the prison medical system for the purpose of eliminating
26 preventable deaths, including specifically a pilot project for preventing deaths from
27 asthma. Supplemental Application No. 2 at 1:2-12. The focus or ultimate goal of the
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1 asthma care pilot project is described as a “full-fledged, real-world practice redesign.”
2 *Id.* at 8:5. According to the Receiver, this project will involve selecting a contractor and
3 finalizing an “initial change package” within six months, the piloting of “an
4 implementation plan” in a small number of prisons within a year, and the implementing of
5 “lessons learned” at all prisons within two years. Receiver’s Plan of Action, November
6 15, 2007, Docket No. 929 at 22.

7 Plaintiffs oppose the Receiver’s motion. In seeking waivers to engage a contractor
8 for a project that will implement lessons that will reduce preventable asthma deaths in
9 two years, the Receiver proceeds in the wrong direction. As explained below, the
10 analysis of deaths showing problems with asthma care plainly suggests other, shorter term
11 actions that would reduce the risk to inmate patients. Further, the description provided of
12 the matters to be addressed by the proposed asthma pilot indicates that the questions to be
13 addressed by a consultant should not require extended analysis or special expertise.
14 Finally, the Receiver fails to explain why an outside expert should be engaged for a two
15 year practice redesign project when a model for an adequate asthma treatment model
16 presumably exists at Pelican Bay State Prison. Accordingly, the Court should deny the
17 application and direct the Receiver to promptly take steps and report on actions to more
18 promptly address preventable asthma deaths.

19 The asthma pilot project at the heart of the Supplemental Application No 2 arises
20 from an analysis of all CDCR inmate deaths occurring in 2006, which concluded that
21 asthma accounted for the single highest number of preventable deaths. Supplemental
22 Application No. 2 at 6:12-15. The discussion of the lapses in care for those preventable
23 asthma deaths in the analysis of 2006 deaths stated:

24 *Asthma* – failure of clinicians to follow published guidelines and standards of care
25 in the evaluation and management of asthma, failure of RNs to appropriately triage
26 sick asthmatics to an MD, failure to ensure timely follow-up after treatment of an
27 refractory asthma to a pulmonologist, and a botched handoff in which a steroid
28 dependent asthmatic did not receive steroids for two days following transfer from a
county prison to a CDCR facility.

1 Analysis of CDCR Death Reviews 2006, August 20, 2007, filed herein as Exhibit 15 to
2 Receiver's Sixth Quarterly Report, September 25, 2007 (italics in original).

3 These determinations, by any measure, place significant focus on lapses by
4 primary care providers (PCPs) and RNs. Thus, while the analysis of deaths identifies
5 systemic problems, including "crowding," which justify looking at issues that might be
6 addressed by "a full-fledged . . . practice redesign" (see Supplemental Application No. 2
7 at 6:15-24), the specific analysis regarding preventable asthma deaths points to remedial
8 actions which would far more directly address the problems identified and thus more
9 quickly reduce the risk of preventable death for asthma patients. Specifically, the lapses
10 identified in the analysis of death reviews point to the following remedial actions:

11 (1) Identification by the CDCR and/or the Receiver of the clinicians and nurses
12 who failed to follow published guidelines and standards of care in the cases of
13 preventable asthma deaths, and imposition of appropriate corrective or adverse action on
14 those individuals;

15 (2) Providing clinicians and nurses with adequate asthma evaluation and treatment
16 guidelines and standards of care, and education regarding such matters. In this regard, in
17 approximately May of this year the CDCR Pharmacy and Therapeutics committee, on
18 which the Receiver's Chief Medical Officer sits, approved updated treatment guidelines
19 for both acute and chronic asthma, and charts summarizing those guidelines were
20 published. See Pharmacy Horizons: A CDCR Pharmacy Newsletter, Vol 1, Number 2,
21 May 25, 2007, at pages 4-6 (available on the Receiver's web site at
22 http://www.cprinc.org/docs/projects/PharmacyHorizonsV1_I2_May2007.pdf), copy
23 attached hereto as Exhibit A. These updated guidelines should be published and
24 provided to all CDCR clinicians and nurses, policy or other changes should be made so
25 that there is a clear expectation that clinicians and nurse will consider and follow the
26 guidelines and standards as appropriate when evaluating and treating asthma patients;

27 (3) Provide inmate-patients who have asthma with educational materials regarding
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1 their disease. In this regard, the May 2007 summaries of the new guidelines discussed
2 above included “handy patient education material.” *Id.* at pages 4 and 7-8. This new
3 updated patient education material should be provided to inmate patients (including in
4 Spanish);

5 (5) Review of asthma-related deaths should continue, and review of asthma related
6 emergency department and hospital admissions should be instituted, so as to identify
7 additional clinician failures and other factors contributing to morbidity and mortality. A
8 quarterly report on such reviews should be provided to the court and parties.

9 Supplemental Application No. 2 does not address these obvious and more direct
10 actions, which should be promptly taken to more quickly remedy the problems identified
11 regarding preventable asthma deaths. The failure to do so undercuts the Receiver’s
12 application. Under federal law, he must show that the order permitting a violation of state
13 law is both necessary and that no other relief will correct the problem. 18 U.S.C. section
14 3626(a)(1)(B). The Receiver’s suggested approach shows that he has headed in the
15 wrong direction regarding preventing asthma deaths.

16 Instead of addressing identified deficiencies regarding clinician performance, the
17 application posits questions, and provides for action, regarding a full-fledged practice
18 redesign which should require neither consultants to answer nor two years to implement.
19 Even assuming that answering these questions and implementing actions based thereon
20 somehow is more important than answering the more direct questions and taking more
21 immediate actions as discussed above, outside consultant expertise does not appear
22 necessary, or, if so, that two years is not required to implement “lessons learned.”

23 For example, the Receiver first asserts that while there is no mystery with regard to
24 the need to assess the breathing capacity of asthma patients at each visit, there is no
25 agreement as to “how to do so,” who will do so, and who will document the results.
26 Supplemental Application No. 2 at 8:7-10. However, the published summary of the new
27 updated guidelines promulgated in May by the CDCR/Receiver Pharmacy and
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1 Therapeutics committee in May explicitly sets forth which of the two standard breathing
 2 capacity devices should be used for asthma patients, and when. See Exhibit A hereto at
 3 pages 5 and 6 (indicating when spirometer and/or peak flow meter should be used when
 4 diagnosing and monitoring asthma).¹ Similarly, current CDCR policy provides – and has
 5 for several years – that it is a nurse who should take a peak flow reading at each patient
 6 chronic care visit. See CDCR Inmate Medical Policies and Procedures, Pulmonary
 7 Disease Chronic Care Program, Volume 7, Chapter 7 (June 2003) at page 5 (copy
 8 attached hereto as Exhibit B). It should not require a consultant and two years to make
 9 revisions regarding this matter, even assuming that changes are necessary.

10 The National Commission on Correctional Health Care (NCCHC) states, inter alia,
 11 that “correctional settings tend to house large numbers of patients with asthma” and that
 12 “[a]sthma deaths [are] one of the most common and *preventable* deaths in the correctional
 13 setting” NCCHC Clinical Guideline for Health Care in Correctional Settings:
 14 Asthma, October 2006, available at
 15 http://www.ncchc.org/resources/clinicalguides/Adult_Asthma.pdf, at pages 1 and 7 (copy
 16 attached hereto as Exhibit C). There is also ample, authoritative, and widely available
 17 information regarding asthma care. See e.g., *id.*, and “Expert Panel Report Number 3,
 18 Guidelines for the Management and Treatment of Asthma, Full Report 2007,” National
 19 Institutes of Health, National Heart, Lung, and Blood Institute, available at
 20 <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf> (417 page report).² It is not

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 22 1. For example, the chart summarizing the updated guidelines states that patients
 23 with controlled mild or moderate persistent asthma should have breathing capacity
 24 checked with a peak flow meter every six months, and with a spirometer every one to two
 years. See Exhibit A hereto at page 6 (text in boxes near bottom of page).

25 2. A summary of the report, setting forth key clinical recommendations, including
 26 for adult asthma care, is available at
 27 <http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf> Also, a lengthy National
 28 Institutes of Health report on respiratory therapists and asthma care (the Receiver raises
 the question of what role such therapists should have (see Supplemental Application No.

1 clear, to say the least, why consultants and years are needed when prison asthma care, and
2 asthma care in general, has received so much attention.

3 It is also unclear whether the Receiver, when asking for authorization to engage
4 outside experts for a two year project to improve asthma care, has considered
5 implementing promptly the lessons learned at Pelican Bay, or even at other prisons, where
6 asthma care specifically, or matters related to asthma care (including the challenge of
7 ensuring the adequate flow of patient information), has been less problematic. The
8 Receiver indicates that the ultimate goal for asthma care is a “chronic care model.”
9 Request for Proposal, Asthma Initiative, Exhibit A to Declaration of Terry Hill, filed
10 November 20, 2007 (Docket Number 960 at page 13 of 24). Pelican Bay, per the orders
11 of this Court in the *Madrid* case, has had a chronic care program for many years, and the
12 Special Master in that case to plaintiffs’ knowledge neither required outside consultants
13 (aside from the Court’s own experts Nurse Cotton and Dr. Goldenson) to develop or
14 implement it, and has not identified fundamental flaws in the model itself in the many
15 years that it has been implemented. Presumably, the “lessons learned” at Pelican Bay,
16 including during the period before an electronic medical record was available, could be
17 applied at other prisons. Similarly, it is not clear to what degree, if at all, the Receiver has
18 canvassed existing practices in other CDCR or other state or federal prisons to determine
19 whether there are any patient flow information practices that might be effectively used,
20 even on a interim basis, to improve asthma care.

21 CONCLUSION

22 Given the death review analysis findings pointing to clinician lapses in preventable
23 asthma deaths, and the failure of the Receiver to suggest or even discuss those clinician
24 matters combined with the wide availability of information regarding asthma care in
25 prison and out, Supplemental Application No. 2 should be denied. The Court should

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27 2 at 8:11) is available at
28 http://www.nhlbi.nih.gov/health/prof/lung/asthma/asth_respir.pdf.

1 direct the Receiver to promptly take the remedial actions discussed above herein that
2 respond more directly to the lapses identified in the death review analysis regarding
3 preventable asthma deaths.

4 Dated: December 14, 2007

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6 Respectfully Submitted,

7 PRISON LAW OFFICE
8 Attorneys for Plaintiffs

9 By: /s/ Steven Fama
10 Steven Fama

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