

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

5 MARCIANO PLATA, et al.)

6 Plaintiffs,)

7 vs.)

8 ARNOLD SCHWARZENEGGER,)

9 et al.)

10 Defendants.)
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No.: C01-1351 T.E.H.

**RECEIVER'S EIGHTH QUARTERLY
REPORT**

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I.

INTRODUCTION

A. Overview of Quarterly Report.

This is the Eighth Quarterly Report filed by the Receivership, the second submitted by Receiver Clark Kelso.

The Receiver's Turnaround Plan of Action ("Turnaround Plan") was approved by the Court on June 16, 2008. (Exhibit 1). Beginning with the Ninth Quarterly Report, the format of future filings will focus on the agreed upon metrics concerning the initiatives set forth in the Turnaround Plan. This report, however, follows the format of previous Quarterly Reports.

B. The Receiver's Reporting Requirements.

In support of the coordination efforts by the four Federal Courts responsible for the major health care class actions pending against the California Department of Corrections and Rehabilitation ("CDCR"), the Receiver now files his Quarterly Reports in four different Federal Court class action cases. An overview of the Receiver's enhanced reporting responsibilities is set forth below.

C. The Order Appointing Receiver.

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

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

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

1 D. Plata, Coleman, Perez and Armstrong Coordination Reporting Requirements.

2 The Joint Order filed June 28, 2007 in *Coleman v. Schwarzenegger* (mental health
3 care), *Perez v. Tilton* (dental care) and in *Plata v. Schwarzenegger* (medical care) approved
4 various coordination agreements made between the representatives of the three health care
5 class actions. (See, Order Approving Coordination Agreements Attached to Joint May 29,
6 2007 Order, hereinafter "Joint Coordination Order.") These coordination agreements provide
7 for the *Plata* Receiver to assume responsibility for (1) direct oversight of contracting functions
8 for medical, dental, and mental health care; (2) implementation of long-term information
9 technology ("IT") systems to include the medical, dental and mental health programs; and (3)
10 oversight of pharmacy operations serving the medical, dental, and mental health programs.
11 (*Id.* at 2.)

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

19 Additional reporting requirements were subsequently placed on the Receiver following
20 his assumption of the management of certain coordinated functions involving the delivery of
21 Americans With Disability Act ("ADA") related services in California prisons. (See, August
22 24, 2007 *Armstrong v. Schwarzenegger* Order Approving Coordination Statements (hereinafter
23 "*Armstrong* Coordination Order."))

24 On February 26, 2008, the *Plata, Coleman, Perez and Armstrong* Courts issued an
25 additional joint order which provides for the *Plata* Receiver to manage two major prison health
26 care construction projects: (1) upgrades to improve health care delivery at the existing 33
27 CDCR institutions, and (2) the construction, on existing prison sites, of health care facilities for
28 up to 10,000 prisoner/patients (See, Order filed February 26, 2008 hereinafter "Order

1 Approving Construction Agreement”). As with the prior coordination orders, the Receiver was
2 ordered to file quarterly reports in each case “concerning developments pertaining to matters
3 that are the subject of the construction agreement.” (Order Approving Construction Agreement
4 at 3:1-3.)

5 E. Integration of Coordination Related Reporting in This Quarterly Report.

6 Pursuant to the mandates of the coordination orders referenced above, the overhaul of
7 the health care contract function; the implementation of long-term IT systems; the oversight of
8 pharmacy operations for medical, mental health, dental and ADA patient-inmates; and the
9 oversight of health care prison construction projects have been integrated under the Receiver’s
10 remedial umbrella. As such, when this Quarterly Report iterates the progress and challenges
11 facing reform of contracting functions, IT systems, pharmacy operations, and construction, it is
12 referring to mental health, dental, ADA patient-inmates as well as medical health care patient-
13 inmates. Specifically, the Receiver’s Coordination related reporting is set forth in the following
14 sections of this Report: Credentialing and Privileging of Health Care Providers (Section II,
15 Goal 4, Objective 4.2); Contracts (Section II, Goal 2, Objective 2.4); IT Update (Section II,
16 Goal 1, Objective 1.2; Section II, Goal 5, Objective 5.4); Telemedicine Reform (Section II,
17 Goal 5, Objective 5.5); Coordination with Other Lawsuits (Section VI, subsection A); and
18 Construction (Section II, Goal 6).

19 F. Master Contract Waiver Related Reporting

20 On June 4, 2007, the Court approved the Receiver’s Application for a more
21 streamlined, substitute contracting process in lieu of State laws that normally govern State
22 contracts. The substitute contracting process applies to specified project areas identified in the
23 June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders
24 issued since that date. (See Receiver’s Seventh Quarterly Report at Section I(F), “Master
25 Contract Waiver Related Reporting”).

26 As ordered by the Court, a summary of each contract the Receiver has awarded during
27 *this* reporting period is provided including (1) a brief description of each contract, (2) which
28 project the contract pertains to, and (3) the method the Receiver utilized to award the contract

1 (i.e., expedited formal bid, urgent informal bid, sole source.). Vendors were also engaged by
2 the Receiver during this reporting period to assist in the operation of the Receiver's non-profit
3 corporation, the California Prison Health Care Receivership Corporation. Although such
4 contracts are not governed by the Master Contract Waiver, a list of such contracts is also
5 provided as Exhibit 2.

6 G. The Organization of the Eighth Quarterly Report.

7 The Eighth Quarterly Report is organized as follows:

- 8 1. Status reports will be provided concerning the draft Turnaround Plan initiatives,
9 including a discussion of status, metrics, degrees of completion, and anticipated
10 dates of completion. (Section II)
- 11 2. Particular success achieved by the Receiver (Section III).
- 12 3. Particular problems being faced by the Receiver, including any specific obstacles
13 presented by institutions or individuals (Section IV).
- 14 4. An accounting of expenditures for the reporting period. (Section V).
- 15 5. Other matters deemed appropriate for judicial review (Section VI).

16 II.

17 **THE STATUS OF TURNAROUND PLAN INITIATIVES**

18 Significant progress has been made during this reporting period concerning most of the
19 major elements of the Turnaround Plan. Progress is detailed below.

20 **GOAL 1. Ensure Timely Access to Health Care Services**

21 **Objective 1.1. Redesign and Standardize Screening and Assessment Processes at**
22 **Reception/Receiving and Release**

23 The Receiver's Access-to-Care Initiative began on May 21, 2008, as is discussed in
24 more detail under Goal 2, Objective 2.1 below. One element of the access initiative is the
25 reception center redesign effort, which will build on innovations implemented at San Quentin
26 State Prison during 2006 and 2007.

27 Eight core prisons are considered, by the CDCR, as "major" Reception Centers. One of
28 the goals of the access initiative is to implement a new inter-discipline reception model at the

1 core facilities in the next 18 months. Two significant issues, however, may impact on this
2 project. First, CDCR may need to re-evaluate the reception process, including those institutions
3 which should continue to function as reception centers. Second, serious physical space
4 challenges may prohibit an effective integration of all clinical disciplines and may also render
5 impossible the timeliness standards called for by the new reception process. In some cases, the
6 pilots will manage with existing space limitations until the Receiver's "upgrade" construction
7 projects are completed. In the interim, the access initiative team (including correctional and
8 health care staff) will develop temporary space plans to allow the implementation process to
9 move forward.

10 Initial reception center activities include identification of the statewide team leaders,
11 readiness assessments at major reception centers, and consultation on physical plant
12 improvements being planned by Receiver. Inadequacies in physical space and environment
13 will pose the most formidable challenge to progress at all the sites. The local redesign teams
14 and statewide support will need to work creatively to reallocate space and adjust where
15 possible. The first pilot implementation will begin in Summer 2008. Additional reception
16 prisons from the Central Region will begin the six-month implementation process during the
17 latter part of 2008 and early 2009. (Exhibit 3). At the same time, San Quentin State Prison will
18 continue to pilot additional reception center changes, track outcomes, and provide on-site
19 inspections and guidance to peers at other prison facilities in order to share the lessons learned.

20 Process mapping and workflow redesign at the pilot reception sites will lead to a
21 standardized change package. Implementation teams will then partner with local reception
22 center staff to disseminate the redesigned process. Standardization must be implemented *prior*
23 *to* the introduction of electronic record keeping systems. The reception center project will
24 require significant resources throughout 2008 and 2009.

1 **Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each**
2 **Institution**

3 **Preliminary Operational Assessments**

4 Since the Seventh Quarterly Report, Preliminary Correctional Officer Operational
5 Assessments were completed at Valley State Prison for Women, Central California Women's
6 Facility, California State Prison at Corcoran, Pleasant Valley State Prison, and California State
7 Prison - Sacramento. These reviews, which focus on the number of correctional officers
8 necessary to insure prisoner/patients with adequate access to health care services, continue to
9 serve two functions: (1) bridge the site-specific barriers that impede patient-inmate access to
10 care, and (2) leave behind the beginnings of an organizational structure that is consistent with
11 professional standards of custody management dedicated solely to health care operations.

12 By the close of this fiscal year ("FY") (June 30, 2008) all assessments to date will have
13 resulted in (1) the activation of 943.31 correctional officer positions for use as clinic officers,
14 escort officers and transportation officers, and (2) the purchase of 165 transportation vans for
15 use in transporting patient-inmates to off-site hospitals and specialty care appointments.

16 At this time only 3 of the 33 prisons are awaiting operational assessments (Calipatria
17 State Prison, California Correctional Institution, and Chuckawalla Valley State Prison). These
18 remaining assessments will be completed by the end of July 2008. The "re-reviews" of the
19 first eight prisons assessed as mentioned in the Seventh Quarterly Report will begin August 19,
20 2008 and will conclude by December 5, 2008. At that time, operational assessments will
21 conclude, thereby marking the end of the Preliminary Operational Assessments.

22 **Health Care Access Units**

23 During this reporting period, efforts also continued to develop and implement a metrics
24 instrument to formally measure the performance of the Health Care Access Unit at San
25 Quentin State Prison and all prisons statewide. The Custody Support Services Division
26 collaborated with Nursing Executives and Health Care Managers at the prisons in developing
27 one comprehensive method for assimilating the necessary data. To initiate this process, 22 of
28 the prisons which have undergone a Preliminary Operational Assessment have been allocated

1 an Associate Governmental Program Analyst position which will be activated on July 1, 2008.
2 The remainder of the positions will be activated on a rolling basis, as the re-reviews are
3 completed between August and December 2008. The analyst, under the direction of the
4 Associate Warden, Health Care Services, will be (1) responsible for monitoring and collecting
5 data relating to the scheduling and attendance of patient-inmate health care appointments and
6 custody coverage for health care operations, (2) developing corrective action plans, and (3)
7 reviewing proposals for consistency with custody and health care policies and procedures. The
8 data obtained from the analysts will be collected and summarized in a monthly report; the first
9 monthly report will be completed by September 2008 and provided to the Court.

10 San Quentin State Prison, the pilot prison for the Receiver's implementation of an
11 Access Unit for Health Care Operations, successfully established and filled all posts as of April
12 1, 2008. Subsequently, preliminary data from the prison shows an increase in the number of
13 inmates that are now able to access care. (Exhibit 4). For example, during the week of May
14 14, 2008, a priority ducat for either a medical, dental and/or mental health appointment was
15 given to 3,471 inmates or 66% of the total inmate population. Of those inmates, 3,154 inmates
16 or 91% were seen by a clinical provider, 159 inmates or 5% refused services, and 158 inmates
17 or 4% were not seen for reasons such as the clinical provider was not able to see the inmate in
18 time allotted or the inmate paroled prior to the appointment.

19 As clinical construction projects are completed at San Quentin State Prison, additional
20 correctional officer positions and operational procedures will be established to incorporate the
21 additional space. For example, it is anticipated that the Specialty Care Clinics and select health
22 care services will be moved from the Neumiller Building to the new modular Upper Yard
23 Clinic and will be staffed and activated in August 2008. The Receiver will continue to monitor
24 the progress of the Health Care Access Unit and remedy issues as they arise.

25 As mentioned in the Seventh Quarterly Report, the Health Care Access Unit at the
26 California Medical Facility was activated on March 6, 2008. Thus far, it has been successful
27 and is supported by the prisons administrative as well as clinical and custody staff. Custody
28 management, in particular, has a clear vision of an effective Access Unit which translates into

1 an efficient operation. As with San Quentin State Prison, the California Medical Facility has
2 also greatly reduced the number of missed appointments due to a lack of correctional officers
3 or vehicles and increased the ability for more inmates to access care. Formal statistical data
4 and analysis will become available in August 2008 as previously mentioned and will be
5 provided to the Court.

6 The establishment of an Access Unit at Avenal State Prison was initiated on February
7 11, 2008 and remains on schedule for an activation date of July 1, 2008. Upon conclusion of
8 the detailed analysis of custody health care operations, inclusive of the planned construction of
9 new clinical space, the Receiver authorized 96 posts or 134.2 new positions of which 58.16
10 positions or 43.3% are allocated for hospital guarding and 16.46 positions or 12.3% are
11 allocated for transportation. The primary obstacle for the Access Unit at Avenal State Prison
12 currently relates to the lack of on-site medical providers. At the present time, given the high
13 vacancy rate, many inmates are sent off-site for medical services which drives the demand for
14 more transportation officers and more vehicles. This workload continues to be difficult to
15 achieve at this time. The Receiver will continue to monitor the progress of the Access Unit
16 and remedy issues as they arise.

17 The Receiver remains on task to establish complete Health Care Access Units at five
18 additional prisons by June 30, 2009. The Correctional Training Facility is the next prison
19 scheduled, commencing on June 16, 2008 with activation to follow in September 2008.
20 Tentatively, the remaining four prisons scheduled for activation of the Health Care Access
21 Unit are the California Institution for Men, California Rehabilitation Center, California
22 Institution for Men, and Mule Creek State Prison.

23 **Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System**

24 An automated system for the scheduling and tracking of medical appointments for
25 patient-inmates will be necessary to provide adequate scheduling, tracking, and monitoring of
26 the delivery of medical, mental health, dental, and ADA services. During this reporting period
27 the decision was made to provide patient scheduling via the CDCR's Strategic Offender
28 Management System ("SOMS"), currently in the initial stages of procurement. A Request for

1 Proposals ("RFP") has been drafted to select a system integrator for the project, and
2 Commercial off the Shelf ("COTS") software products have been reviewed. The RFP will be
3 released by CDCR in June 2008 and a contract award is scheduled to be made by the end of
4 2008.

5 The SOMS application will include four components that are critical to the success of
6 the prison health care system: (1) a unique identification number for each inmate; (2) real time
7 location information for each inmate; (3) demographic information on each inmate; and (4) a
8 master schedule and scheduling prioritization system. The COTS offender management
9 products that were reviewed by the Receiver's staff are not sufficiently robust to handle the
10 more complex needs of a health care scheduling system, so the California Prison Health Care
11 Services ("CPHCS") has initiated a project to identify health care scheduling needs, reengineer
12 processes to the extent necessary, and procure or develop software to manage health care
13 scheduling.

14 It is essential that the Health Care Scheduling System ("HCSS") be able to integrate
15 completely with SOMS on a real-time basis. Consequently, CPHCS staff and consultants are
16 closely involved in the SOMS RFP process as evaluators and subject matter experts. CPHCS
17 has recently executed, on a competitive basis, a contract with Gartner, Inc. to define the
18 requirements and parameters, including interfaces with other IT systems, for a system that will
19 encompass prison medical, dental, mental health, and other health care appointment
20 scheduling. Gartner, Inc. will begin working with subject matter experts designated by
21 CPHCS in June 2008, with the objective of drafting, by the end of 2008, an RFP for a COTS
22 HCSS product with necessary modifications and enhancements.

23 It should be noted that an adequate scheduling system must consider critical ancillary
24 scheduling needs, such as notification to custody officers, access to equipment, transportation,
25 special care personnel, prison scheduling, inmate location, and other constraints on patient
26 movement.

1 **Objective 1.4. Establish A Standardized Utilization Management System**

2 **Long-term care unit pilot**

3 California Medical Facility ("CMF") is the proposed site for the new long-term care
4 pilot units. CMF successfully opened new long-term care units in 2005 and 2006, so this pilot
5 will build on that experience. CMF's health care and custody officials have submitted a
6 proposal detailing the staffing needs, equipment needs, and physical plant modifications
7 required to convert 47 Outpatient Housing Unit beds to 41 Correctional Treatment Center beds
8 and to convert 200 General Population beds to 92 Outpatient Housing Unit beds. The
9 conversion would decrease California Medical Facility's total population capacity by 114
10 beds. Increasing the acuity of these units would increase demands on all the requisite support
11 services. The Receiver's staff are currently reviewing the proposal.

12 **Centralized Utilization Management system**

13 Utilization Management ("UM") is an organization-wide, interdisciplinary approach to
14 managing health care costs and quality. The UM program supports clinical processes including
15 specialty service referrals, acute hospitalization, and patient placement by applying specific
16 criteria to requests for services to assure that health care services are medically necessary and
17 cost-effective. The current UM program has been ineffective in containing health care costs
18 and ensuring appropriateness of medical treatment decisions, and as a result, expenditures for
19 contract medical services have steadily risen over the years. Each institution has too much
20 autonomy in managing its health care operations and there is little sharing among institutions
21 and headquarters of best practices or common problems. There are no standardized processes
22 or policies for referral of patient-inmates to specialty care providers or hospitals, and access to
23 care varies from institution to institution. There is no effective system in place for reviewing
24 medical outcomes to determine whether treatment strategies are cost-effective, nor is there a
25 system in place for analyzing health care cost variances on an ongoing basis. Consequently, the
26 department is not able to determine whether the high costs at certain institutions are justified or
27 whether the low costs at other institutions are indications of efficient operations or below-
28 standard operations. Other problems plaguing the current UM program include the following:

1) lack of authority and accountability for UM operations at the regional and headquarters level; 2) failure to adhere to established UM program guidelines at the local level; 3) failure to utilize standardized criteria to support clinical decisions; 4) lack of fiscal accountability for treatment decisions; and 4) inadequate and incomplete documentation of evidenced-based care.

To facilitate access to care and ensure a standardized, functioning, auditable UM system that appropriately manages the use of medical services and costs, a new organizational structure for the UM program is being developed. The new program will include a complementary nursing Care Management program to ensure all patient-inmates' care are coordinated ensuring continuity of care. New positions will be established centrally, serving regional and local institutions to provide oversight and accountability for UM decisions, provide care management for patient-inmates with chronic illness, and monitor health care costs on an ongoing basis. In addition, UM processes will be redesigned to promote operational efficiency, and standardized UM policies, procedures, and forms will be implemented at all 33 institutions. An electronic scheduling and tracking tool will be selected to support clinical referral processes.

It is anticipated that standardized UM and care management processes will be implemented statewide by June 2009. The recruitment of an UM Chief Medical Officer is in progress. A focus group met on June 2, 2008 to begin redesigning current roles and responsibilities and to perform an assessment of the necessary resources for the UM program.

GOAL 2. Establish A Prison Medical Program Addressing The Full Continuum of Health Care Services

Objective 2.1. Redesign and Standardize Access and Medical Processes for Primary Care

On May 21, 2008, the Receiver described his overall plan for clinical redesign in a formal kickoff of the Access-to-Care Initiative, which addresses the heart of his mission: *timely access to safe, effective and efficient medical care*. The Access-to-Care Initiative encompasses four domains:

1. Reception/Receiving and Release (R&R)
2. Sick Call/Primary Care

1 3. Chronic Care

2 4. Specialty, Infirmarv, and Acute Care

3 a. Utilization Management

4 b. Care Management

5 These clinical domains are interdependent. A chronic illness, for example, should be
6 identified and assessed in the reception center process, and that assessment should lead to
7 chronic care follow-up, trigger specialty care as needed, and be available at any sick call
8 appointment. The Access-to-Care Initiative will require coordination across clinical disciplines.
9 Beginning with reception center assessment, medical care processes must be integrated with
10 mental health and dental care. Follow-up of patient needs also requires coordination, so one
11 outcome of the initiative will be development of a sustainable scheduling and tracking
12 information system integrating medical, dental, and mental health care. In addition, all of the
13 Access-to-Care domains are dependent upon custody staff, so these are integrated throughout the
14 Access-to-Care Initiative. Finally, the domains are also dependent upon IT.

15 Successful implementation of the Access-to-Care Initiative will achieve the following
16 goals:

- 17 1. Improve access to care by creating standardized, measurable, and reliable processes
18 that are amenable to implementation across variations in custody levels and physical
19 plants.
 - 20 2. Develop a sustainable integrated scheduling and tracking information system that
21 conforms to best practices; reflects efficient workflows for medical, dental, and
22 mental health care; and integrates with the Receiver's other IT initiatives.
 - 23 3. Develop integrated UM and care management systems to support chronic care,
24 specialty services referral processes, and infirmarv/acute care management.
 - 25 4. Develop system competence in the Model for Improvement (rapid-cycle quality
26 improvement) and use of human factors and reliability science to support additional
27 progress and sustainability post-Receivership.
- 28

Beyond the kickoff, progress to date on the Access-to-Care Initiative includes hiring of the project managers and recruitment of the clinical leaders who will support the clinical redesign efforts of the local teams. Work on the sick call domain will progress in tandem with work on chronic care, discussed below.

Objective 2.2. Improve Chronic Care System to Support Proactive, Planned Care

The May 21, 2008 kickoff of the Access-to-Care Initiative highlighted chronic care redesign and introduced the Model for Improvement as the clinical change methodology for the entire initiative. In April 2008, Health Management Associates (“HMA”) completed its assessment of the statewide chronic care processes, focusing particularly on asthma, and this assessment served as the basis of the chronic care redesign plans. In July 2008, six pilot sites will enroll in an accelerated Chronic Care Learning Collaborative. The collaborative will yield clinical guidelines, policies, documentation tools, and staff education resources and introduce a chronic care team model appropriate for corrections, delineating roles, responsibilities, and measures of team function. Facilitated by Bruce Spurlock, MD, a national leader in health care quality and safety, it will also develop a cadre of leaders who can serve as quality advisors for other clinical initiatives. An intensive skills-based course on quality improvement will be imbedded in the learning sessions.

Objective 2.3 Improve Emergency Response to Reduce Avoidable Morbidity and Mortality

The CDCR currently utilizes a variety of internal medical emergency response systems in its facilities. These procedures are not comparable to services found in the community. As a result, CDCR facilities are often not prepared to handle basic medical emergencies, resulting in deficiencies in care, delayed transport, and poor patient outcomes. The standardized Emergency Medical Response Program (“EMRP”) will provide patient-inmates, staff, and visitors within the California prison system the same level and quality of emergency medical care as in the community. The goal is to improve emergency medical care and response within the prison setting, improve clinical outcomes, and decrease unexpected deaths due to lack of emergency medical care.

1 The standardized EMRP policies, procedures and forms were finalized on May 22,
2 2008. (Exhibit 5). The CDCR plans to implement the program and pilot the policies,
3 procedures and forms at Chuckawalla Valley State Prison for approximately one month
4 beginning June 23, 2008. To facilitate the implementation process, a standardized Emergency
5 Medical Response orientation and training program regarding the new policies, procedures and
6 forms was developed for the nursing and physician staff. Thirty days after implementation of
7 the EMRP at Chuckawalla Valley State Prison, the program will be piloted at Richard J.
8 Donovan Correctional Facility. Approximately two weeks after pilot implementation at
9 Richard J. Donovan Correctional Facility, the Emergency Medical Response team will make
10 any necessary adjustments to the policies, procedures, and forms. During the pilot at
11 Chuckawalla Valley State Prison the implementation team will audit the next scheduled
12 facilities for readiness to implement the EMRP. The roll-out strategy is based on the results of
13 readiness assessments of the medical department and geographic location, and we expect that
14 one prison every two weeks will implement the new program.

15 Within the EMRP, multiple medical skill validation checklists were created as a means
16 to validate clinical competency in basic nursing skills as well as emergency medical
17 procedures. To ensure that all clinical staff possess the requisite skills to provide basic life
18 support in the event of an emergency, staff working in the Triage and Treatment Area ("TTA")
19 will be required to obtain Acute Cardiac Life Support certification within 90 days of hire.

20 In an effort to standardize the emergency medical response equipment in every prison
21 facility, a list of all required emergency medical equipment and supplies for the TTA and
22 standby emergency rooms was developed. To ensure all emergency response bags contain the
23 appropriate and standardized equipment, the Department will purchase new emergency
24 medical response bags for each institution. The total number of bags to be purchased for each
25 institution will be determined during the emergency medical response pre-implementation
26 audit. An emergency medical response bag audit policy and form was developed as a part of
27 the EMRP. The policy will require the institution medical staff to audit the contents of the
28 emergency medical response bags on a regular basis to ensure that the equipment is available

1 and in working order at all times. A statewide audit is currently underway to determine the
2 total number, make and model of Automatic External Defibrillators ("AED") and Defibrillators
3 that are operable and inoperable in each institution. Additionally, a review of the currently
4 commercially available AEDs and defibrillators is in process to determine the appropriate
5 medical equipment that meets the medical needs of patient-inmates and meets community
6 medical standards. The data from these surveys and reviews will be utilized to determine the
7 replacement needs of the emergency equipment and to help with standardizing the emergency
8 equipment from one institution to another statewide.

9 **Objective 2.4. Improve the Provision of Specialty Care and Hospitalization to Reduce**
10 **Avoidable Morbidity and Mortality**

11 Standard UM and care management processes and policies are critical in the provision of
12 specialty care and hospitalizations. This topic is discussed under Goal 1, Objective 1.4 above.

13 **Contracts with specialty care providers and hospitals and invoice processing**

14 *ProdAgio Rollout.*

15 The statewide roll-out of the new contract and invoice processing system (ProdAgio)
16 has continued since the Seventh Quarterly Report with the addition of three institutions. Two
17 of the institutions, Valley State Prison for Women and California State Prison - Sacramento
18 went live on January 28, 2008. Further roll-out was subsequently delayed due to system
19 performance issues affecting invoice processing. Essentially, the system became too slow and
20 unstable to function adequate after the two institutions were added. Modifications to ProdAgio,
21 however, soon stabilized the invoice processing feature, and dramatically improved
22 performance, allowing the roll-out to continue. Statewide implementation was restarted on
23 June 2, 2008 with Folsom State Prison. California State Prison - Solano is anticipated to come
24 on-line on June 23, 2008.

25 A meeting with stakeholders was held on June 3, 2008 to review rollout plans beyond
26 California State Prison - Solano. A draft schedule is under review that will add two institutions
27 each month through August 2008. The draft schedule assumes new institutions by regional area
28 will begin to be added in October 2008 and continue through final implementation in February

1 2009. Initial meetings are currently being held to design the interface for the data transfer from
2 ProdAgio to CDCR's Business Information System ("BIS"), which will begin in early 2009.
3 The final migration to ProdAgio and data transfer to BIS will allow more specialty care
4 providers and hospitals to obtain contracts and payment in a timely manner.

5 *Establishing More Appropriate Payment Rates.*

6 In November 2007 the Navigant Consulting Group provided a report wherein
7 recommendations were provided concerning the appropriate rates for specialty care providers
8 and hospitals. Staff now utilize Navigant's recommendations to negotiate Medicare-based rates
9 with providers. Additionally, the Chancellor Consulting Group, retained by the Receiver in
10 August 2007 to stabilize the Department's hospital network, has been successful in
11 renegotiating rates with several new hospitals and affiliated physicians statewide to a Medicare-
12 based reimbursement structure. Over time, the Receiver anticipates significant taxpayer savings
13 resulting from a more efficient contract process and the utilization of billing standards and
14 methodologies more in line with other State agencies and well managed private health care
15 systems.

16 *Consulting Assessment of the Overall Contract Process.*

17 The Navigant Consulting Inc. submitted a preliminary assessment of the contract and
18 invoice processing functions on April 21, 2008. (Exhibit 6). As part of that assessment,
19 Navigant provided recommendations on follow-up activities regarding staffing structures,
20 modifications to State statutes and regulations, and claims payment/data collection options. At
21 present, contract staff are in the process of finalizing a report that will recommend what options
22 should be pursued.

23 **GOAL 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce**

24 **Objective 3.1. Recruit Physician and Nurses to Fill Ninety Percent of Established**
25 **positions**

26 As of May 31, 2008, approximately 86 percent of nursing positions are filled (note: the
27 percentage is an average of all six State nursing classifications). (Exhibit 7). The goal of
28 filling 90 percent of the Registered Nurse ("RN") positions has been achieved at 22 institutions

1 (70 percent), 15 of these institutions have filled 95 percent to 100 percent of their RN
2 positions. Six institutions (18 percent), have filled 84 to 89 percent of their RN positions. This
3 is within 4 percent of the goal of filling 90 percent of nursing positions by July 2009.

4 To achieve the 90 percent State hire objective at all prisons, including the "difficult to
5 hire clinical staff" desert prisons, the following initiatives are underway: (1) focused
6 recruitment continues statewide for licensed vocational nurses ("LVN") and psychiatric
7 technicians ("PT"); (2) recruiters have been presenting employment opportunities at nursing
8 schools statewide; (3) advertisements are placed statewide in local papers, professional trade
9 magazines, and online; and (4) mass mailers are planned for mid-June for LVNs and mid-July
10 for PTs. Additionally, there has been, and will continue to be, a push at all institutions with
11 nursing vacancies to schedule interviews on a weekly basis and interview all interested
12 applicants expeditiously.

13 As of May 31, 2008, approximately 81 percent of physician positions are filled (note:
14 the percentage is an average of all three State physician classifications). 95 percent of Chief
15 Medical Officer positions are filled, 71 percent of Chief Physician and Surgeon positions are
16 filled and 89 percent of Physician and Surgeon positions are filled. (Exhibit 7). To achieve the
17 90 percent State hire objective at all prisons, including the "difficult to hire clinical staff" desert
18 prisons, the centralized hiring process for physicians continues, a program which can be
19 directly attributed to the success of physician recruitment and hiring thus far.

20 The personalized customer service approach provided by the centralized hire team, and
21 the streamlined hiring process which has resulted (allowing, for example, applicants to
22 interview for multiple locations and different classifications), has been well received by
23 applicants and hiring authorities alike, and has resulted in 147 hires since July 2007. In
24 addition, specialized recruitment efforts continue with advertisements placed in professional
25 periodicals, newspapers, online, direct mailers, and visits to residency programs. Efforts will
26 focus on the central valley prisons during the next reporting for two reasons. First, in many
27 urban areas, every primary care provider position has been filled. Second, the central valley is
28 an area where physician hiring progress has lagged behind other areas of California.

1 **Objective 3.2. Establish Clinical Leadership and Management Structure**

2 Existing plans call for three new clinical executive classifications (Medical Executive,
3 Nurse Executive, and Chief Executive Officer, Health Care) to be implemented at three pilot
4 locations (San Quentin State Prison, Mule Creek State Prison and California State Prison,
5 Sacramento/Folsom State Prison) by approximately September 1, 2008. The exams for these
6 three Receiver Career Executive Assignment ("RCEA") positions are currently being
7 automated by staff at the State Personnel Board ("SPB"), and are set to "go live" in July 2008.
8 Cooperative Personnel Services ("CPS") has indicated the salary surveys for these positions
9 will be completed by late June 2008. Thereafter, salaries will be established either through the
10 Department of Personnel Administration or by Court order and formal recruitment and hiring
11 will commence.

12 A comprehensive media plan has been prepared in preparation for this pilot that will
13 target professional trade publications, online sources, and professional mailers. A hiring
14 program has also been developed in coordination with the CDCR to centrally coordinate the
15 hiring process for these classifications. Finally, a Scope of Work has been developed by CPS
16 to assess the current organizational structure and later evaluate the RCEA pilot organizational
17 structure once implemented.

18 **Regional leadership structure**

19 Following the RCEA pilots at San Quentin State Prison, Mule Creek State Prison and
20 California State Prison, Sacramento/Folsom State Prison, anticipates expanding the RCEA
21 structure to the regional level. Prior to this effort, however, the governance of regions needs to
22 be an issue addressed by the Court representatives of *Plata, Coleman, Perez, and Armstrong*.

23 **Objective 3.3. Establish Professional Training Programs for Clinicians**

24 Staff from the Office of the Receiver and the CDCR developed a standardized health
25 care orientation program for nurses, physicians, and other allied health professionals. This
26 new employee health care orientation will occur regionally on a monthly basis and is a
27 comprehensive orientation for new health care employees and replaces the mandated training
28 required for all new CDCR employees. As of June 2008 all regions have completed a regional

1 health care orientation pilot. Additional health care orientations for all regions are scheduled
2 through November 2008. Following completion of the general orientation, discipline-specific
3 training will commence for each clinical classifications, included physicians and nurses. The
4 registered nurse classification, for example, will be participating in a four week
5 preceptor/proctoring program, following the general health care orientation.

6 Effective June 2, 2008, the *Armstrong* Effective Communication training requirements
7 were integrated into the regional health care orientation. A subject matter expert from the
8 Office of Court Compliance conducted the training. In the event Office of Court Compliance
9 staff are not available to assist with providing training on an ongoing basis, CDCR nurses and
10 physicians will be prepared as trained-trainers to support delivery of the curriculum. A train-
11 the-trainer class is scheduled from June 30 through July 1, 2008.

12 A comprehensive training plan is being developed that describes all training initiatives
13 being undertaken in the next 12 to 18 months by the Receiver. This training plan captures all
14 professional training programs for clinicians, as well as all support services training. The
15 training plan will be finalized by the end of June 2008.

16 **Accreditation for CDCR as a CME provider**

17 In an effort to maintain and enhance the level of clinical competencies with educational
18 programs, the Receiver will establish a Continuing Medical Education (CME) Committee.
19 The primary objective of the CME Committee is to obtain accreditation for CDCR as a CME
20 provider, recognized by the Institute of Medical Quality (IMQ) and the Accreditation Council
21 for Continuing Medical Education. The CME Committee will also oversee the planning of all
22 CME activities.

23 The CME Committee was established and has met three times since February 2008.
24 Committee members and a chairperson have been selected. The Committee membership
25 consists of representatives providing healthcare services within CDCR from each licensed
26 practitioner group, including physician, psychiatrist, nurse, nurse practitioner, psychologist,
27 physician assistant.
28

1 The Interdisciplinary Professional Development ("IPD") Unit within the Clinical
2 Operations Support Branch, Professional Development and Review ("PDR") Section, is
3 providing administrative support for the Committee. The IPD Unit is responsible for
4 conducting the administrative support activities to assist the Committee with developing a
5 charter and maintaining the appropriate functional structure required to meet IMQ
6 accreditation standards. In addition to assisting the Committee in obtaining accreditation, the
7 IPD Unit has responsibility for the operation and administrative aspects of the educational
8 program for all licensed practitioners within CDCR.

9 Prior to submitting an application to the IMQ, the Receiver must ensure compliance
10 with all accreditation requirements. In order to accomplish this objective, CME Committee
11 members and IPD staff attended two IMQ-sponsored conferences, one held in April 2008 and
12 the other in May 2008 on the requirements and process for obtaining accreditation. Prior to
13 submitting the accreditation application, CDCR must plan and present two CME activities,
14 which the CME Committee determined will be focused on pain management and Hepatitis C.
15 The projected completion date for these activities is September 2008. During the May IMQ-
16 sponsored conference, staff met with IMQ executive management to discuss IMQ serving as
17 the "joint sponsor" of these activities and providing a physician liaison to CDCR's CME
18 Committee. CDCR is currently reviewing the proposal submitted by IMQ for joint
19 sponsorship and consulting services.

20 **GOAL 4. Implement Quality Improvement Program**

21 **Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program**

22 The Receiver hired a Chief Medical Officer to lead formation of the new Quality and
23 Safety Branch and has begun recruitment for other positions in the Branch.

24 **Office of the Inspector General Audit Program**

25 The Receiver's staff, representatives from the Prison Law Office, CDCR staff, Office of
26 the Attorney General representatives, and the Special Assistant to the Court have worked
27 closely with the Office of Inspector General ("OIG") to develop an audit instrument which
28 objectively measures compliance with the *Plata* requirements. The current pilot audit

1 instrument is divided into 21 different areas/programs such as Chronic Care, Specialty
2 Services, Preventive Services, etc. Each area/program identifies the separate compliance
3 requirements under the *Plata* Stipulated Agreement and each requirement is weighted
4 according to priority. The OIG has developed the metrics reports, and is currently developing
5 the written report format.

6 The OIG has conducted four pilot audits at Mule Creek State Prison, Valley State Prison
7 for Women, California State Prison, Corcoran and Calipatria State Prison. The fifth pilot audit
8 commenced on June 9, 2008, at California Institution for Men. The OIG has conducted post-
9 audit exit meetings with each institution and the various stakeholders to elicit
10 recommendations and feedback on the audit instrument. After the final pilot audit is
11 completed, the OIG will submit the final draft of the audit instrument and program to the
12 stakeholders for comment, and to the Court for approval. It is anticipated that the Receiver
13 will receive the final draft for comment from the OIG in early fall of 2008.

14 **Objective 4.2. Establish a Quality Improvement Program**

15 As mentioned above, a day-long Access-to-Care Initiative kickoff on May 21, 2008,
16 included training in the Model for Improvement and specifically in rapid-cycle quality
17 improvement. As noted under Goal, 2 Objective 2.2, the pilot Chronic Care Learning
18 Collaborative will include an intensive skills-based course on quality improvement. By the
19 end of the pilot collaborative, an initial cadre of nurse consultants and physicians will be
20 trained as quality advisors capable of facilitating clinical redesign efforts. Additional quality
21 advisors will be trained via the regional collaboratives to follow. In addition, the pilot Chronic
22 Care Learning Collaborative will recruit and train clinical champions from each of the six pilot
23 sites to lead the process redesign teams at the local level. This approach will be replicated in
24 the regional collaboratives and other quality initiatives to follow.

25 Meanwhile, plans are being drafted for the formation of a new Policy Unit. Just as the
26 EMRP will drive improvements in practice and changes in policies and procedures, the
27 Access-to-Care Initiative will drive policy and procedure revisions. The Policy Unit will offer
28

1 support for such revision and will develop reliable systems for dissemination and for regular
2 review.

3 **Credentialing and privileging**

4 A quality-based program to administer the CDCR healthcare credentialing and
5 privileging function has been established. This unit is responsible for implementation of a
6 credentialing software program to facilitate the initial credentialing, and ongoing tracking of
7 required licenses, certification renewals and continuing education for all licensed independent
8 practitioners practicing within the prison system.

9 In January 2008, the Receiver secured and finalized a contract with CredentialSmart to
10 develop a web-based solution to integrate and centralize the credentialing and privileging data
11 for the licensed independent practitioners and designated allied health providers. The contract
12 financing was completed in March 2008. The vendor has begun the training portion of the
13 contract with the Credentialing & Privileging Unit staff on the use of the system. A four-hour
14 web-based training session was conducted on May 29, 2008. During that training, provider
15 files began the transition from hard files to electronic files. Credentialing & Privileging Unit
16 staff is continuing to enter provider data on a daily basis. The additional on-site training will
17 be provided to Credentialing and Privileging Unit staff on June 19 and June 20, 2008.

18 The Credential & Privileging Unit began developing program policies and procedures
19 in August 2007. As of May 2008, five policies have been developed and disseminated, and
20 training on the policies has been conducted. (Exhibit 8). In September 2007 an
21 Interdisciplinary Credentials Committee was established and a committee policy was
22 developed and approved by the Committee and is currently being reviewed for approval by the
23 legal advisors. The remaining policies are in draft form and will require further development
24 once the web-based system has been fully implemented.

25 Completion of the remaining policies will establish the roles and responsibilities of the
26 institutions' credentialing coordinators and the headquarters Credentialing & Privileging Unit.
27 Transferring the centralized credentialing and privileging function to headquarters will be
28 accomplished by transitioning the responsibilities in four phases. Phase I will begin in June

1 2008 with the transfer of credentialing data from the existing systems in headquarters and the
2 regions to the web-based solution and the transfer of the roles and responsibilities to the
3 Credentialing & Privileging Unit. The subsequent three phases will entail transferring the
4 credentialing and privileging function to headquarters from the local Outpatient Housing Units
5 (Phase II); Correctional Treatment Centers (Phase III); and General Acute Care Hospitals
6 (Phase IV).

7 Once Phase I is complete at the end of July 2008, the Credentialing and Privileging
8 Unit anticipates establishing a Credential Hotline to respond to questions and/or concerns from
9 existing staff and potential providers. Information gathered from the Hotline and during the
10 transfer process will be used by the Credentialing and Privileging Unit to develop lists of
11 frequently asked questions. The implementation of this goal is anticipated to be complete by
12 December 2008.

13 **Objective 4.3. Establish Medical Peer Review and Discipline Process to Ensure Quality of**
14 **Care**

15 **Peer Review and discipline process**

16 Between March 2008 and May 2008, the Professional Practice Executive Committee
17 ("PPEC") met 10 times and reviewed 152 allegations of clinical misconduct and/or neglect.
18 To protect patient-inmate safety, the PPEC summarily suspended the clinical privileges of 6
19 providers and implemented 13 monitoring plans. The Governing Body issued Notices of
20 Proposed Final Actions to revoke the privileges of 4 providers, and worked with local
21 administrators to develop a remediation plan for a fifth provider. During this reporting period,
22 10 licensed independent practitioners separated from State service following a peer review
23 investigation.

24 On May 23, 2008, the Court granted, in part, the Receiver's Motion for Waiver of State
25 Law Regarding Physician Clinical Competency. The Court further ordered the Receiver to
26 meet and confer with the parties and amici SPB and the Union of Physicians and Dentists
27 ("UAPD") regarding revised policies conforming with the Court's order. The Receiver's
28 attorneys met and conferred with SPB on June 4, 2008, with the expectation that SPB would be

1 prepared to begin administering peer review hearings within 45 days. The Receiver's attorney
2 also met and conferred with UAPD on June 5, 2008. The Receiver's decisions as a result of
3 these meetings will then be discussed when meeting and conferring with the parties before
4 returning a revised policy to the Court, ideally accompanied by a stipulation or statements of
5 non-opposition by the parties and amici.

6 **Objective 4.4. Establish Medical Oversight Unit to Control and Monitor Medical**
7 **Employee Investigations**

8 The Receiver's Medical Oversight Program ("MOP") is a pilot project to conduct
9 clinical investigations in collaboration with Office of Internal Affairs ("OIA"), CDCR;
10 Employee Advocacy Prosecution Team ("EAPT"), Office of Legal Affairs, CDCR; and
11 Bureau of Independent Review ("BIR"), OIG.

12 The MOP has been conducting weekly meetings since November 2007 and performing
13 multi-disciplinary clinical investigations since January 1, 2008. The weekly meetings include
14 a program planning session to refine the operational protocols and a formal case panel intake
15 session to evaluate each individual case. Both meeting sessions include representatives from
16 the OIA, EAPT, BIR, and the Receiver's medical staff.

17 To date, the MOP has conducted a review of 98 unexpected death cases and reviewed 2
18 cases of possible medical harm that did not result in inmate death. These reviews resulted in
19 nine cases being opened for formal investigation. Five referrals were made to PPEC and eight
20 referrals made to the Nursing Professional Practice Executive Committee to address clinical
21 practice related concerns.

22 At the request of the Receiver's Chief of Staff, the MOP team flew to the state of
23 Mississippi to conduct an investigation concerning the unexpected death case of a California
24 prisoner housed at an out-of-state Corrections Corporation of America private prison. Overall,
25 the MOP identified eight different systemic issues during the clinical investigations which
26 have been forwarded to the Receiver for review. See the discussion of this issue under
27 Objective 4.6., below.

1 **Objective 4.5. Establish a Health Care Appeals Process, Correspondence Control and**
2 **Habeas Corpus Petitions Initiative**

3 The Health Care Appeals Task Force ("Task Force") was convened on February 13,
4 2008 to conduct a systemwide analysis of the statewide appeals process. Members of the Task
5 Force include: *Coleman* Court Monitors, Office of Court Compliance (*Armstrong*), *Perez*
6 Court Monitors, Plaintiff's counsel (Prison Law Office and Rosen, Bien, & Galvan), the
7 Receiver's Staff Counsel, the Chief Physician Executive, the Chief of Nursing Operations,
8 CPHCS and Division of Correctional Health Care Services Executive Staff, CDCR Inmate
9 Appeals Branch Chief, CDCR Staff Attorneys, and Litigation Management Unit staff. Four
10 meetings were held to discuss issues, best practices and recommended changes to the statewide
11 health care appeals process. Issues and recommendations were incorporated into a concept
12 paper submitted to the Receiver's Chief of Staff on May 15, 2008. The proposed concept for a
13 new appeal system was approved by the Chief of Staff on May 22, 2008, with the provision
14 that the concept paper be resubmitted to include an initial pilot program for implementation at
15 four CDCR institutions. The pilot program will be implemented in October 2008.

16 To ensure consistent and timely responses, inmate health inquiry functions were
17 consolidated under the Litigation Management Unit, Plata Field Support Division ("PFSD") in
18 October 2007.

19 The sole remaining function under the management of the CDCR Inmate Appeals
20 Branch is the Director's Level responses to health care appeals. Ongoing meetings have been
21 conducted with CDCR executive staff and Inmate Appeals Branch representatives to effectuate
22 the separation of health care appeals from institution appeals. Another meeting is tentatively
23 scheduled for late-June 2008 to discuss appropriate strategies for notifying all patient-inmates,
24 employees and stakeholders of the changes in policy and procedures. The actual bifurcation,
25 whereby the Receiver's staff begins to process Director Level medical appeals is projected to
26 take place on August 1, 2008. To ensure an timely and effective transition, PFSD staff have
27 completed the drafting of policies, procedures and training plans. Recruitment and hiring of
28 staff for the Office of Third Level Health Care Appeals is ongoing and is expected to be

1 completed by July 1, 2008. A statewide training conference for all health care appeals staff is
2 scheduled for July 23 through July 25, 2008.

3 **Objective 4.6. Establish Out-of-State, Community Correctional Facilities and Re-entry**
4 **Facility Oversight Program**

5 The California Out-of-State Correctional Facility ("COCF") Community Correctional
6 Facility ("CCF") and Re-entry Facility Program Oversight Unit ("Program Oversight Unit")
7 has been in operation since November 2007. In April 2008 there was a change in the
8 management structure of the unit, and as a result of this change -- and problems with the
9 COCF in Mississippi -- strategies and resources required to provide oversight of medical care
10 for patient-inmates housed in COCF, CCF, and Re-entry Facilities are being reassessed. The
11 Receiver's staff are confident that the restructuring will result in more efficient strategies and
12 better use of resources.

13 **Out-of-State Facilities**

14 Based on findings of deficiencies in the quality of care provided to two CDCR patient-
15 inmates housed at the Tallahatchie County Correctional Facility in Mississippi, an
16 investigation/review of the care being provided at the facility was conducted by the MOP and
17 members of the Receiver's out of state oversight unit. (Exhibit 9). During the week of May 26,
18 2008, 12 staff, including 7 staff from the MOP, 4 staff from the Program Oversight Unit and 1
19 staff person from CDCR's COCF Program spent four days at the institution investigating the
20 circumstances leading up to the death and questionable care provided to the two inmates. The
21 systemic issues raised concerns regarding the level of health care services provided to the
22 CDCR patient-inmates housed at this facility. From a broad perspective, the following
23 concerns were identified:

- 24 1. Inadequate medical staffing levels and appropriate staff mix for the facility;
- 25 2. Nursing and mid-level practitioners were found to be practicing beyond their scope of
26 training and were not adequately supervised;
- 27
- 28

1 3. The credentialing and peer-review systems for clinicians are inadequate and do not
2 appropriately assess individual skill levels with the expected scope of practice at the
3 facility.

4 A comprehensive report regarding the scope of the investigation and recommendations
5 will be submitted to the Receiver the first week of July 2008. Receiver/CDCR responses to
6 this problem will be described in more detail in the next Quarterly Report

7 **Community Correctional Facilities**

8 During March and April 2008, Program Oversight Unit staff continued with the audits
9 of two additional CCFs, for a total of four audits being completed to date. The decision was
10 made to postpone the two remaining audits scheduled to be completed by May 31, 2008 after
11 numerous discussions with staff assigned to the Program Oversight Unit; reviewing the
12 findings of the four CCF audits previously conducted; and meeting with CCF contract staff,
13 CDCR CCF staff and institution staff. The Program Oversight Unit is reevaluating the audit
14 instrument used and defining the expectations for the contractors as it relates to clinical
15 standards and health care staffing standards.

16 **Re-entry Facilities**

17 As to this date, there are no CDCR re-entry facilities to assess.

18 **GOAL 5. Establish Medical Support Infrastructure**

19 **Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program – Maxor** 20 **Pharmacy Services**

21 Implementation of the Court-adopted *Road Map to Excellence* continues to move
22 forward in a deliberate and timely manner. Implementation activities have been focused upon
23 staffing, implementation of the GuardianRx® pharmacy operating system, maintaining the
24 positive momentum of the Pharmacy and Therapeutics (“P&T”) Committee process, enhancing
25 the CDCR pharmaceutical contracting and procurement processes and developing the
26 centralized pharmacy facility. While there have been some obstacles and challenges
27 encountered in many of the implementation activities, Maxor and the Receiver’s staff have
28

1 addressed each of those directly and have been able to maintain positive momentum towards
2 accomplishing each objective.

3 The collective efforts of the pharmacy improvement program guided by the *Road Map*
4 give priority to achieving improved patient safety and health outcomes, developing an
5 evidence-based pharmacy practice and increasing cost-efficiency. Progress continues to be
6 made in addressing each of these priorities. Monthly and quarterly reports to the Receiver
7 have documented this progress. (Exhibit 10).

8 **Development of the drug formulary**

9 As the enhanced CDCR P&T Committee matures into an effective pharmacy program
10 oversight entity, their collective efforts are showing results. Carefully considered, evidence-
11 based Disease Medication Management Guidelines (“DMMG”) have been developed for
12 Hypertension and Hypertension Urgency, Asthma (acute and chronic), Diabetes (type 1 and
13 type 2), Hyperlipidemia, HIV, Seizure (acute and chronic), Schizophrenia, Gastroesophageal
14 Reflux Disease (GERD), Peptic Ulcer Disease (PUD) and Chronic Obstructive Pulmonary
15 Disease (COPD). Maxor has provided DMMGs for Hepatitis C and Depression which are
16 currently being reviewed by the P&T Committee. These guidelines outline appropriate clinical
17 standards of care for each of these disease states.

18 Formulary review and maintenance is an ongoing process for the P&T Committee.
19 Several formulary decisions were made during the reporting period. The Committee approved
20 the deletion of quetiapine (Seroquel®) (an atypical antipsychotic with well known potential for
21 abuse and misuse) from the formulary along with a transition plan and specific non-formulary
22 criteria for use within the system. An antipsychotic therapeutic category review was
23 conducted in conjunction with the development of the Schizophrenia DMMG. Preferred
24 formulary agents were selected and approved. Announcement and distribution of the DMMG
25 is pending contract approval on selected formulary agents. A category review of the
26 gastrointestinal agents was also conducted. Approved recommendations included selection of
27 a preferred proton pump inhibitor as well as prescribing criteria for use.

1 Access to the formulary was made available to all providers through the *Epocrates* on-
2 line system. This program is a web-based service designed to ensure that the latest formulary
3 and medication related information is readily available to prescribers and pharmacists.

4 The establishment of a viable, active and engaged P&T Committee process; the
5 implementation of a CDCR-specific formulary that is managed on an ongoing basis; and the
6 development of treatment medication guidelines that are evidence-based and focused on
7 patient safety are critical components of achieving improved cost-effectiveness in the system.
8 This integrated approach provides a firm foundation for more effective pharmaceutical
9 contracting. In such a system, good clinical decision-making determines the purchasing needs.
10 By standardizing the clinical pathways, those needs can be targeted through appropriate
11 contracting strategies, including an ability to drive market share. Under the revamped system,
12 each purchase is actively monitored to ensure it is the best relative value. As the pharmacy
13 operating system (GuardianRx®) comes online at each facility, this monitoring moves to a
14 real-time basis. These responsive contract strategies and management continue to provide
15 opportunities for cost avoidance. For example, in the first four months of 2008, Maxor has
16 documented cost avoidance of \$4,834,079 from the use of targeted contracting strategies
17 resulting from P&T Committee decisions (Exhibit 11).

18 Contract, purchase and inventory monitoring efforts also continue to yield results by
19 avoiding unnecessary costs due to out-of-stock orders and ensuring that the correct contracted
20 items are purchased. From January through April 2008, \$652,988 in cost avoidance was
21 realized by working with the wholesaler to ensure the best priced items were sufficiently
22 stocked at the regional distribution centers and another \$640,238 in cost avoidance by directly
23 working with the facilities to ensure the correct contracted items were purchased.

24 Effective February 1, 2008, the Receiver entered into a new wholesaler (also referred to
25 as a Prime Vendor) agreement with Amerisource Bergen tailored specifically to address the
26 pharmaceutical demands of the CDCR health care system. As the *Road Map* implementation
27 proceeded, it became evident that a more responsive wholesaler contract would be beneficial in
28 achieving the *Road Map* goals. The resulting contract leverages CDCR's developing abilities

1 to manage its pharmacy needs and results in a more responsive, cost-effective arrangement for
2 CDCR.

3 **Pharmacy policies and procedures**

4 The CDCR P&T Committee has continued its work on a complete revision of the
5 Pharmacy policies and procedures, reviewing and updating them to reflect improved practice
6 standards, implement quality control measures and standardize pharmacy processes. Over the
7 first four months of 2008, the P&T Committee has reviewed and updated 11 chapters of the
8 procedures manual (Chapter 2- Pharmacy Licensing Requirements; Chapter 3 – Pharmacy
9 Responsibilities and Scope of Service; Chapter 6 – After-hours Medication Supply; Chapter 9 -
10 Prescription Requirements; Chapter 10 –Automatic Medication Stop Orders; Chapter 12 -
11 Labeling & Storage Requirements; Chapter 13 -Physician Order Forms; Chapter 14 -Rescue
12 Medications; Chapter 17 - Ordering, Receiving, and Stocking of Medications; Chapter 20 –
13 Floor Stock Medications; and Chapter 27 – Medication Errors and Adverse Drug Reaction
14 Reporting). In addition to pharmacy policy revisions, the P&T Committee also reviewed and
15 approved revisions to three related health care policies (Medical Services Chapter 11 –
16 Medication Management; Mental Health Services Delivery System Program Guide Chapter 12
17 – Clozapine; and Dental Services Chapter 5.8 – Dental Emergencies). The Receiver
18 anticipates providing finalized copies of these new policies to counsel within 10 days.

19 Maxor continues to provide support for policy implementation as well as monitoring
20 for adherence to pharmacy policy and procedure. Clinical Pharmacy Specialists provide in-
21 service and implementation support to facility staff as new procedures are released. In
22 addition, Clinical Pharmacy Specialists assistance is provided through in-service training at
23 Regional leadership meetings. A quarterly Pharmacist-In-Charge meeting was held in
24 February 2008, and extensively reviewed policy and procedure implementation issues. Five
25 new policy and procedure training modules were also created and deployed to pharmacy
26 personnel during the reporting period.

27 Standards for measuring pharmacy program performance continue to be refined. The
28 Pharmacy Dashboard, reviewed monthly by the P&T Committee, provides current and

1 historical data on workload, staffing, prescription utilization and cost data for each facility.
2 (Exhibit 10). During this reporting period, stoplight measures were evaluated and added for
3 many Pharmacy Dashboard indicators. Targets were determined after careful evaluation of
4 2007 data and agreement on acceptable measures of performance. The stoplight status will be
5 updated monthly and will help identify facilities that are significantly above or below goal,
6 requiring closer monitoring.

7 The pharmacy inspection process has been well established with documented
8 movement towards compliance across the State. The number of pharmacies with an inspection
9 rating score of pass/problem (not failed) has increased from 21 percent in March 2007 to 67
10 percent in April 2008. Verification and validation of the pharmacy inspections process by the
11 Maxor team has been initiated with the first onsite inspection completed at Avenal State
12 Prison. The purpose of the onsite evaluations is to ensure accurate reporting and to determine
13 whether problems identified in previous inspections have been appropriately addressed.

14 **GuardianRx® implementation**

15 A modified implementation plan was approved by the Receiver to allow for the rapid
16 deployment of GuardianRx® to CDCR facilities over the next 15 months. An intensive process
17 of needs assessment, process review, and gap analysis has been developed and adopted which
18 includes the identification and corrective actions needed to address key infrastructure needs.
19 This process ensures a comprehensive look at each facility's needs and the development of an
20 effective plan to address identified deficiencies. The implementation schedule is highly
21 dependent upon infrastructure, staffing, process improvement and related activities being
22 completed in a timely manner.

23 GuardianRx® implementation has been successfully implemented at six facilities
24 (Folsom State Prison, Mule Creek State Prison, California Men's Colony, California State
25 Prison - Sacramento, California State Prison - Corcoran, and Substance Abuse Treatment
26 Facility). California State Prison - Corcoran and Substance Abuse Treatment Facility represent
27 the first of several scheduled simultaneous dual facility GuardianRx® implementations. A
28 comprehensive schedule for implementation of the GuardianRx® system has been completed

1 and approved by the Receiver. (Exhibit 12). This schedule calls for GuardianRx® conversion
2 to be complete at 23 facilities by the end of 2008 and all facilities by May of 2009. The
3 schedule outlines mandatory training sessions, conversion team schedules and “go-live” dates
4 for each facility.

5 Conversion team meetings began the end of March 2008 for San Quentin State Prison which was
6 expected to go live in May 2008. Unfortunately, facility physical plant delays resulted in the
7 implementation being moved to Summer 2008. Pre-Guardian work continues at several sites
8 with pharmacy computer layout plans completed for California Correctional Center, High Desert
9 State Prison, Chuckawalla Valley State Prison, Ironwood State Prison, California Institution for
10 Women, Valley State Prison for Women, Central California Women’s Facility, Kern Valley
11 State Prison, North Kern State Prison and San Quentin State Prison. In addition, initial
12 medication management assessments have been completed at San Quentin State Prison,
13 Chuckawalla Valley State Prison, Ironwood State Prison, Central California Women’s Facility,
14 Valley State Prison for Women, Kern Valley State Prison, North Kern State Prison, for
15 California Correctional Center, High Desert State Prison and California Institution for Women.
16 Two regional training centers have been established at California State Prison - Sacramento and
17 California State Prison - Corcoran for GuardianRx® pre-training and approval received for
18 additional pharmacy technologist positions at each facility to assist in training. Ironwood State
19 Prison is the first southern region location to go-live and will include four extra technicians to
20 support training needs for the southern region.

21 **Central-Fill Pharmacy Facility**

22 Work continues related to the establishment of a Central Fill Pharmacy Facility for the
23 CDCR. The pre-centralization ambulatory model is being defined and implemented as
24 processes are standardized and validated as part of the GuardianRx® implementation work
25 plan. A comprehensive staffing pattern assessment was completed through February 2008
26 based on workload and related data. Maxor has worked to ensure that the approved staffing
27 levels are communicated to the facilities with support from the Receiver’s Chief of Staff.
28 Revised staffing patterns were approved and instructions given to ensure the approvals were

1 communicated to the facilities. As a result, a letter detailing the approved staffing was sent to
2 all facilities by CDCR Finance in late April 2008.

3 Working with Department of General Services ("DGS"), the Maxor team finalized
4 preliminary site location recommendations for the Central Fill Pharmacy facility, and a
5 document outlining the recommendation was sent to the Office of Receiver for review and
6 approval. Additional inquiries were requested by the Office of the Receiver relating to the
7 flood plain status of proposed locations. Maxor worked with DGS to obtain the requested
8 information which was subsequently provided to the Office of Receiver for consideration. As
9 a result, a determination was made to review additional site locations. Additional site surveys
10 were completed in May 2008 and a selection will be recommended in June 2008. Required
11 State funding documents have been processed and approved. Once a site is approved, the DGS
12 staff, CDCR and Maxor will negotiate final lease and/or purchase terms with the property
13 owner.

14 Concurrently, a detailed RFP document was prepared to address automation needs for
15 the Central Fill Pharmacy facility and was submitted to the Receiver for review and approval.
16 The RFP for pharmacy automation needs must be completed and the automation vendor
17 chosen in order to finalize the floor plans and related specifications for the centralized
18 pharmacy facility. The RFP was released on May 8, 2008 with a June 20, 2008 deadline for
19 receiving responses. A mandatory bidders conference was held on June 3, 2008 to address any
20 questions from prospective bidders. An evaluation team comprised of representatives from
21 CDCR, the Office of the Receiver, and Maxor will review RFP responses and make a
22 recommendation to the Receiver for final approval.

23 **Objective 5.2. Establish Standardized Health Records Practice**

24 On April 4, 2008, the Receiver issued an RFP for professional management services to
25 assist the CPHCS in addressing staffing and organizational issues related to the effective
26 management of inmate health records. The Receiver's Chief Medical Information Officer
27 subsequently conducted a bidder's conference April 25, 2008, at the Health Records Center in
28 Sacramento, California to provide potential bidders with background information regarding the

1 Receivership and its challenges, as well as additional details regarding the current state of health
2 information management in the prisons. The deadline for submission of proposals is Tuesday,
3 June 17, 2008.

4 **Objective 5.3. Establish Effective Radiology and Laboratory Services**

5 **Laboratory services**

6 On June 20, 2007, the Receiver issued an RFP for professional services to perform
7 Enterprise Clinical Laboratory Assessment and Planning to advise the Receiver as to the best
8 approach for improving laboratory services for patient-inmates. The award went to Navigant
9 Consulting. On March 24, 2008, Navigant presented their findings and recommendations
10 which are as follows: (1) laboratory services do not meet health care requirements to patient-
11 inmate; (2) the status quo in laboratory operations is unsafe and prone to adverse patient
12 outcomes; and (3) current laboratory operations are unsustainable.

13 The findings were accepted by the Navigant Steering Committee, which proposed the
14 following courses of action to the Receiver to begin immediately: (1) derive the Clinical
15 Laboratory Governance Council from the existing Navigant Steering Committee; (2) hire a
16 senior lab director and a laboratory pathologist through an interagency agreement with another
17 State agency; (3) rebid reference lab contracts to improve costs, services, and accountability of
18 laboratory services; (4) close laboratories in non-licensed facilities, and if allowable, also close
19 laboratories in licensed facilities (if not allowed by regulation, begin remediation to bring labs
20 up to quality standards); (5) enhance in-house point of care testing to include additional
21 offerings to improve care and reduce reliance on external STAT labs; and (6) work with Plata
22 Personnel Services to redesign duty statements and job classifications to reflect new personnel
23 roles in light of the in-house laboratory closures and other changes.

24 **Radiology services**

25 On September 11, 2007, the Receiver issued an RFP for professional services to
26 perform an Enterprise Imaging and Radiology Assessment and Planning to advise the Receiver
27 as to the best approach for improving radiology services for patient-inmates. The award went
28 to McKenzie Stephenson, Inc. On April 21, 2008, McKenzie Stephenson, Inc. presented their

1 draft assessment which indicated the following: (1) medical diagnostic imaging service is
2 wasteful, inefficient and delinquent in almost every element; (2) imaging services fall far short
3 of any acceptable level of care for this discipline; (3) the combination of deficient work
4 processes, lack of leadership, poor technology decisions and a profound absence of standards
5 may be actively causing harm to patient-inmates and staff. Currently, McKenzie Stephenson,
6 Inc. is developing the final report of findings and recommendations including a strategic
7 roadmap for delivery in late June 2008.

8 Both the laboratory and radiology services programs are awaiting the appropriate
9 leadership. Once the RCEA positions are approved, we can move forward with these
10 initiatives.

11 **Objective 5.4. Establish Clinical Information Systems**

12 In October 2007, the Receiver issued an RFP for a clinical data repository ("CDR") and
13 portal solution. The goal of the CDR project is to store key patient health information, such as
14 current medications, allergies, lab results, encounters, problems, etc., in a standardized manner
15 and make this information available to providers at the point-of-care to support clinical
16 decision making. The Receiver's Chief Medical Information Officer and Director of Health
17 Information Integration conducted a bidders teleconference on October 10, 2007, to provide
18 potential bidders with background information regarding the Receivership and its challenges,
19 as well as additional details regarding the desired solution and corresponding requirements. In
20 the end, 20 vendors submitted proposals in response to the request. The proposals were
21 reviewed over a three week period by a proposal review committee that consisted of members
22 of the Receiver's IT team, a *Coleman* representative, CPHCS staff, and a nationally-recognized
23 expert in health care IT retained by the Receiver to assist during the selection process.

24 The proposal review committee subsequently selected six proposals to evaluate further
25 and invited the respective vendors to interview with the Receiver's staff; the vendors selected
26 were: 3M Health Information Solutions, Accenture, Allscripts Healthcare Solutions, Emergis,
27 IBM, and Medicity. The Receiver's staff conducted in-person interviews from December 12
28 through December 17, 2007, in its San Jose office. The interviews involved meetings with

1 three separate evaluation committees: (1) executive committee consisting of senior
2 management from both the Office of the Receiver and CPHCS, as well as representatives from
3 the *Coleman* and *Perez* cases; (2) clinical user committee consisting of CDCR clinical staff
4 (e.g., physicians, dentists, nurses, psychiatrists, etc.) from a variety of institutions throughout
5 the State; and (3) technical committee consisting of members of the Receiver's IT team, a
6 *Coleman* representative, CPHCS staff, and a nationally-recognized expert in health care IT
7 retained by the Receiver.

8 After the interviews, each of the committees submitted their respective
9 recommendations to the Receiver's IT team. The solution stack proposed by both Accenture
10 and IBM was the first choice of all three committees, followed by 3M and Allscripts. The team
11 subsequently conducted due diligence activities in January and February 2008 by meeting with
12 vendor product teams, performing site visits, interviewing current and former product
13 managers, etc. On February 28, 2008, the Receiver issued a notification of award to IBM,
14 indicating that it had been selected to deliver the clinical data repository and portal solution,
15 pending the successful completion of contract negotiations. From March through May 2008,
16 the Office of the Receiver has been in contract negotiations with both IBM and the principal
17 subcontractors (Initiate Systems, Oracle, and Orion Health). Negotiations recently concluded,
18 and the contracts are awaiting final review and signature.

19 **Objective 5.5. Expand and Improve Telemedicine Capabilities**

20 As reported in the Seventh Quarterly Report, the University of Texas, Medical Branch
21 ("UTMB") submitted its assessment and telemedicine roadmap to the Receiver. A majority of
22 the recommendations contained in the report are difficult to implement until such time as the
23 Health Care Information Network has been rolled out to all 33 institutions.

24 In the interim, the Office of Telemedicine Services ("OTS") is addressing some of the
25 issues contained in UTMB's report to improve efficiency and increase services to the patient-
26 inmate population. Management has embarked on an analysis of current processes within the
27 OTS and is in the process of implementing changes to improve the efficiency of staff. OTS is
28 also working collaborative with Mental Health staff to increase services to a number of

1 institutions. To increase the network of telemedicine providers, a meeting has been scheduled
2 with the Contracts Branch and the Healthcare Invoice, Data and Provider Services Branch to
3 discuss issues and the development of additional telemedicine provider contracts.

4 Additionally, OTS has been asked to engage in a series of pilots to expand its off-site
5 specialty provider network to medical centers more closely affiliated with specific prisons to
6 facilitate telemedicine augmentation of procedure-based care. To adequately pursue these
7 pilots, a project manager has recently been assigned to work with the providers to develop
8 detailed proposals and sound implementation plans which include clear guidelines, processes
9 and responsibilities, in addition to measurable outcomes. The expectations for these pilot
10 telemedicine programs include improved access to care, expedited patient access to specialty
11 physicians, improved patient outcomes, reduced necessity for transporting inmates out of the
12 institution for initial and follow-up appointments, and ultimately establishing telemedicine as a
13 standard resource for addressing access to care for routine and follow-up appointments.

14 **GOAL 6. Construct Necessary Clinical, Administrative and Housing Facilities**

15 **Objective 6.1. Upgrade administrative and clinical facilities at each of CDCR's 33 prison**
16 **locations to provide patient-inmates with appropriate access to care**

17 **Assessment and planning efforts**

18 The assessments and planning to renovate or build new clinical space at each of the 33
19 prisons continues. The Facility Master Plans for the Correctional Training Facility, California
20 Rehabilitation Center and Mule Creek State Prison (the second, third, and fourth prison
21 respectively to undergo the planning process) were reviewed by an architectural consultant and
22 approved by the Receiver. At present, a motion is pending before the Court concerning these
23 upgrade proposals.

24 The Site Planning Committee began assessing clinical space at the California
25 Institution for Women on February 8, 2008 and the California Institution for Men on February
26 11, 2008. Similar to the previous assessments, an analysis of existing facility space was
27 completed at both prisons, and multiple coordination meetings (which included *Coleman* and
28 *Perez* representatives and CDCR's Facilities Management) were held to review concepts and

1 coordinate needs specific to each prison. The Facility Master Plans were completed and
2 agreed upon by the respective Warden; Associate Warden, Health Care Services; Chief
3 Medical Officer; and Director of Nursing as well as a member of CDCR's Facilities
4 Management on March 28, 2008 for the California Institution for Women and on April 14,
5 2008 for the California Institution for Men. The Master Plans have been reviewed by an
6 architectural consultant and are awaiting approval by the Receiver. The Master Plan for the
7 California Institution for Women includes seven construction projects such as additions and
8 renovations to existing buildings for more clinic space, (inclusive of pharmacy, mental health,
9 and dental); new modular clinics, one for the Reception Center and one for the Administrative
10 Segregation Unit; and a medical supply warehouse. The Master Plan for the California
11 Institution for Men includes ten construction projects such as additions and renovations to
12 existing buildings for more clinic space, (inclusive of pharmacy, mental health, and dental); a
13 new modular clinic for the North and South Minimum Security Facilities, West Reception
14 Center, Receiving and Release area, and Administrative Segregation Unit; and a medical
15 supply warehouse. The approximate cost and timeframe for these Master Plans are not yet
16 known but will be provided in the Receiver's next quarterly report to the Court.

17 Consistent with the robust schedule as outlined in the Seventh Quarterly Report, the
18 Site Planning Committee is in the process of conducting assessments at three prisons
19 simultaneously with staggered start dates earlier than originally planned. Planning for Richard
20 J. Donovan Correctional Facility started on April 1, 2008, Folsom State Prison on April 22,
21 2008, followed by California State Prison – Sacramento on June 3, 2008. On June 17, 2008
22 planning for High Desert State Prison and California Correctional Center (co-located in
23 Susanville) California is scheduled to begin. It is anticipated the assessments and preliminary
24 planning for these five prisons will conclude approximately eight weeks after the respective
25 start date. By August 2008, the Master Plans for all five prisons will be completed.

26 Looking ahead, the Master Schedule for planning and assessments of the remaining
27 prisons is currently undergoing revision. The Site Planning Committee is attempting to group
28 the rest of the prisons geographically where possible in order to incorporate the three-team

1 approach and provide efficiency in planning and travel. Once the approach is agreed upon, a
2 revised Master Schedule will be formalized and provided to the Court. As planned, the
3 Receiver continues to complete a Master Plan for each prison by January 2010.

4 In addition to the Master Schedule, a special planning project was initiated May 13,
5 2008 at Salinas Valley State Prison. The Salinas Valley Psychiatric Program (Intermediate
6 Care Facility) opened in 2006 without adequate treatment space. The project includes
7 providing group and treatment rooms within the housing and yard facility. The Master Plan
8 for this project will be completed on June 13, 2008 and funded by the CDCR.

9 **Avenal State Prison construction**

10 Presently, Avenal State Prison is the only prison in the implementation phase of
11 construction. As a result of the Receiver's recent tour of the prison, additional projects were
12 added to the Avenal State Prison Facility Master Plan. In addition, some projects were
13 combined for bid purpose. So for purposes of this and future reports, the projects are now as
14 follows: Project Three, Modifications of Building #390 - Infirmary, is combined with Project
15 Seven, Infirmary Conversion & Pharmacy Relocation. Project Four, Temporary Conversion of
16 Isolation Rooms, was removed. Project Six, Modular Health Services Administration
17 Building, was combined with Project Five, Complex Yard Clinics, and the scope was increased
18 to incorporate space for medical records, the newly formed Custody Health Care Access Unit
19 and newly hired medical staff. (These elements have been incorporated in all subsequent
20 assessments.) Finally, Project Eight, the Facility Pill Room Expansion, was combined with
21 Project Nine, the Administrative Segregation Clinics, and the scope and location changed to
22 include a free-standing clinic west of the Administrative Segregation Unit. The Master Plan
23 Addendum will be completed on June 12, 2008 and provided to the Court in the next Quarterly
24 Report.

25 Despite the modifications to the design, the implementation phase of construction has
26 continued. Based on the recommendations of the County Department of Public Health, an
27 occupational health and safety consultant was hired to assist with finalizing the Valley Fever
28 mitigation plan. It is anticipated the report will be finished by the end of July 2008 with

1 concurrence by CPHCS staff, the Receiver, and county health officials soon thereafter.
2 Consultants were contracted for the topographical survey and geotechnical services. Once the
3 reports are received the bid documents for the medical supply warehouse, health services
4 building and complex clinics will then be finalized and the projects opened for bid. Five of the
5 six additional mobile clinics as required in project one were delivered. The manufacturer of
6 the clinics delivered the sixth mobile clinic on June 10, 2008. Plumbing work to connect the
7 mobile clinics is underway and electrical work is preparing to start. The design draft for
8 modifications to the infirmary and pharmacy relocation is complete, and the project is out to
9 bid with a bid date of June 18, 2008. Contracts are expected to be awarded and construction to
10 begin within two weeks of the bid date. The schedule is designed to parallel the planned roll-
11 out of the GuardianRX® by Maxor. The anticipated date of completion remains July 2009.

12 **Objective 6.2. Construct administrative, clinical and housing facilities to serve up to 10,000**
13 **patient-inmates with medical and/or mental health needs**

14 The Receiver has defined plans for seven new facilities of 1,400 to 1,700 patient-
15 inmates each, for a total of 10,000 beds. Each California Health Care Facility will
16 accommodate roughly equal numbers of medical and mental health patient-inmates with
17 centralized clinical, administrative and support service spaces. Two facilities (one north and
18 one south) will accommodate women in separate but equal accommodations. A "Facility
19 Program Statement," describing each project in detail, will be completed by URS Bovis Lend
20 Lease Joint Venture ("URS-BLL") in June 2008, for approval by the Receiver by July 15, 2008.
21 Site evaluations are underway at eight existing CDCR locations:

22 **Northern California**

- 23 • California Medical Facility/California State Prison – Solano
- 24 • Deuel Vocational Institution – Tracy
- 25 • California State Prison – Sacramento/Folsom State Prison
- 26 • Northern California Youth Correctional Center – Stockton

1 Southern California

- 2 • Richard J. Donovan Correctional Facility – San Diego
- 3 • Ventura Youth Correctional Facility – Camarillo
- 4 • California Institution for Men – Chino
- 5 • Nelles Youth Facility – Whittier

6 Environmental analysis and infrastructure engineering investigations are proceeding at
7 seven of the locations to identify the three best candidates for the earliest environmental impact
8 reports, and mitigations, as well as to determine the least challenging infrastructure
9 engineering problems, in anticipation of environmental certification of one site by January
10 2009, and two others by April 2009 and July 2009. The current “first/fastest” candidate sites
11 based on this criteria include Northern California Youth Correctional Center, Richard J.
12 Donovan Correctional Facility, and Ventura Youth Correctional Facility. A community
13 outreach program is being implemented at each location to advise elected officials, business
14 and community leaders, and the local press of the upcoming projects, to identify concerns, and
15 to define reasonable mitigations for the projects to move forward.

16 The selection process is underway for the Integrated Project Delivery (“IPD”) teams for
17 building design and construction of the first three facilities. Design-build contract awards are
18 targeted for January, April, and July of 2009. The selection process is underway for separate
19 design-build teams for site and infrastructure “enabling projects” at the first three sites,
20 intended to start demolition, remediation, utility work, and site grading while building design
21 is underway. Enabling projects design-build agreements are to be awarded in an October 2008
22 to December 2008 timeframe, and are expected to start site preparation construction as soon as
23 the Environmental Impact Reports (“EIR”) are certified.

24 It should be noted that this program may be vulnerable to delay as the result of funding
25 delays, EIR approval delays, including community impact issues, and to decision-making
26 delays for issues expected to be highly political, technically complex, or impacted by CDCR,
27 counsel, or the other Courts involved in construction. The Receiver’s team is developing
28 strategies to mitigate potential delays.

1 **Objective 6.3. Complete Construction at San Quentin State Prison**

2 The construction projects of new and/or renovated clinical space at San Quentin State
3 Prison continue to progress with the involvement of San Quentin State Prison personnel, the
4 Receiver's custody subject matter experts, *Coleman, Perez* and *Armstrong* representatives, and
5 the Department of Finance.

6 Prior to the Seventh Quarterly Report, three of the eight projects in Construction
7 Package One were completed: Project Two, Replacement Parking Spaces; Project Five, the
8 Triage and Treatment Area Renovation; and Project Eight, Addition of Re-locatable Office
9 Space Trailer. During this reporting period, Project Three, Relocation of Individual Exercise
10 Yards, was completed on April 28, 2008. Unfortunately due to delays in the bidding and
11 contract approval process, two of the four remaining projects will not be completed by the
12 anticipated date of December 2008 as set forth in the Receiver's Turnaround Plan. The new
13 anticipated date of completion for all projects in this package is February 2009.

14 The following are updates for each of the four remaining projects:

- 15 1. Project One, the Personnel Offices, was authorized by the Receiver on March
16 24, 2008 and the contract was signed. The builder was given a Notice to
17 Proceed with construction on March 26, 2008 and construction began March 27,
18 2008. The anticipated date of completion is now September 22, 2008.
19 Recently, this project encountered an issue when the soil was discovered to
20 have nickel content that was slightly above hazardous level. As a result, the
21 project was delayed by about two weeks as tests were done and the issue
22 resolved. At this point the extent of the delay and its effect on the completion
23 date has not yet been determined. The building pad is now ready and
24 foundation excavation is beginning. It is expected that framing of the building
25 will be complete and exterior closure will be ongoing in the next three months.
- 26 2. Project Four, Medical Supply Warehouse, was opened for bid on March 31,
27 2008. Bids were received and the Selection Panel chose a builder, although due
28 to delays in the contract approval process construction did not begin on May 1,

1 2008. The new commencement date is June 23, 2008 and the new anticipated
2 completion date is February 2009. The contractor will conduct additional
3 geotechnical investigations and begin the design process once the Notice to
4 Proceed is issued. The design should be completed and approved and it is likely
5 that some site demolition and preparation will begin within the next three
6 months.

- 7 3. Project Six, Expansion of the East and West Block Rotundas, commenced
8 construction on March 17, 2008 and is currently running approximately 70 days
9 behind schedule. The new electrical panels have not arrived and have caused
10 several tasks to be delayed such as the relocation of the transformers and the
11 construction of the building pad. Due to the delays the project will not meet the
12 November 12, 2008 completion date. The contractor is in the process of re-
13 sequencing the work, and if able to do so, the project could be completed by
14 December 2008. If not, the new date could be as late as February 2009. Intense
15 discussions are ongoing with the contractor and the electrical subcontractor to
16 mitigate the delays. In the next three months, the transformers will be relocated
17 and the building foundations will be complete. The masonry walls will be
18 ongoing.

- 19 4. Project Seven, Upgrade to Adjustment Center Clinic, North Segregation Clinic,
20 and Gym Clinic, may increase in scope from the original plan to provide heated
21 ventilation. These proposed modifications are being evaluated and priced by
22 the construction management team and submitted to the Receiver for approval.
23 The heating project received three quotes and a recommendation is being
24 forwarded to the Office of the Receiver. The heating project remains on task to
25 be completed by September 15, 2008 pending contract approval. Completion
26 time for the balance of the work will be developed upon approval of the budget.

27 As explained in the Seventh Quarterly Report, two of three projects in Construction
28 Package Two are complete. The remaining project, Project One, Primary/Specialty Care

1 Modular, received design approval on March 10, 2008. Site work began on May 8, 2008 and
2 the modular fabrication was delivered and set on the foundation the week of May 19, 2008.
3 The furniture, equipment, and telecommunication packages are being finalized for
4 procurement. Although the schedule is currently tight, the project remains on task to be
5 completed by August 15, 2008.

6 Construction Package Three, the Central Health Services Facility, is progressing well.
7 The working drawings were submitted on March 21, 2008 and approved, the demolition of
8 Building 22 is complete, the retaining wall reinforcement is complete, and construction of the
9 foundation commenced on April 15, 2008. Foundation work will continue, steel erection will
10 start in mid-June and substantial progress is expected in the next three months. This project
11 remains on task to be completed by April 2010.

12 III.

13 PARTICULAR SUCCESSES ACHIEVED BY THE RECEIVER

14 The Receiver's successes concerning the medical initiatives are included in the "Status
15 of Turnaround Plan Initiatives" above. The following additional achievements should be
16 reported:

- 17 A. As mentioned above, the Receiver's Turnaround Plan was approved by the
18 Court.
- 19 B. The Receiver has completed the shut-down of the San Jose office, resulting in
20 significant reduction in overhead and operational expenses.
- 21 C. The Receiver has hired a new Chief Information Officer and Public Information
22 Officer.

23 Overview of the Receiver's Project Management Office.

24 Shortly after his appointment, the Receiver's Chief Information Officer, Jamie
25 Mangrum, established the Receiver's Project Management Office ("PMO"). The PMO is the
26 first necessary step toward improving the project, program and portfolio management within
27 the Office of the Receiver, and will provide for greater organization and accountability related
28 to Turnaround Plan initiatives.

1 To jump start this program, in April 2008 the Receiver hired a consultant to serve as the
2 project manager for building and deploying the PMO. The responsibility of the consultant is to
3 develop the PMO processes and library of templates, deploy an appropriate electronic Project
4 and Portfolio Management (ePPM) system and help identify project management needs
5 throughout the organization and staff for those needs.

6 As of the close of the reporting period, the PMO has developed and deployed a library
7 of PMO materials and templates (e.g. project plan templates, project charter templates and
8 workflow diagrams) for all project managers to utilize, and purchased an "ePPM" system. The
9 ePPM will assist project managers deliver projects within scope, schedule and budget and
10 provide needed tracking tools for the PMO to manage its procedures and controls for collecting
11 information, performing data analysis, optimize decision making and strengthen controls. The
12 system will also give the Office of the Receiver the ability to track and report on all projects
13 and align them with the goals and objectives laid out in the Receiver's Turnaround Plan.

14 One of the first challenges for the PMO was to hire needed project managers for all
15 Office of Receiver projects. As of the end of the reporting period the PMO has employed nine
16 project managers, and is working to add eight additional project managers by the end of June
17 2008. Additionally the PMO, in cooperation with Plata Human Resources, has developed the
18 duty statements for two new project management classifications within California State civil
19 service. These classifications are project manager and senior project manager. Both
20 classification packages have been submitted to SPB and the Department of Personnel
21 Administration for review and approval. The intent is that once the classifications are approved
22 we would then conduct exams, create permanent civil service positions and recruit for those
23 newly established positions.

1 IV.

2 PROBLEMS BEING FACED BY THE RECEIVER, INCLUDING ANY SPECIFIC
3 OBSTACLES PRESENTED BY INSTITUTIONS OR INDIVIDUALS

4 A. Introduction.

5 Before the Receiver is able to provide the long-term medical care required by
6 approximately six percent of the CDCR's population, before the *Coleman* remedial plan can
7 provide adequate mental health treatment to those CDCR prisoner/patients with serious mental
8 health problems, and before the members of the *Armstrong* class can be provided with
9 adequate treatment and the appropriate housing required by their disabilities, adequate health
10 care facilities must be constructed. Carefully calibrated studies by expert consultants have
11 identified the need for medical and mental health treatment facilities for 10,000
12 prisoner/patients. No one seriously disagrees with these projections. Indeed, the scope of the
13 existing shortfall in treatment facilities provides yet another example of the seriousness of the
14 State's long-term failure to provide constitutionally adequate medical and mental health
15 facilities for its prisoners.

16 Simply stated, before constitutionally adequate health care can be delivered in
17 California's prisons, there needs to be *constitutionally adequate treatment facilities to provide*
18 *such care*. Unless and until these facilities are constructed, the major health care class action
19 cases will continue indefinitely. Likewise, prisoners will continue to die unnecessarily.

20 In the Receiver's March 11, 2008, draft of the Turnaround Plan, and in other
21 documentation available on the Receiver's website, the Receiver presented the State with the
22 details of its facilities planning, which included the upgrade program described in Objective
23 6.1, the 10,000-patient expansion program described in Objective 6.2, and the San Quentin
24 program described in Objective 6.3. Funding for the San Quentin construction program has
25 been previously secured. The Receiver needs the State's commitment to fund the upgrade
26 program in the amount of \$1 billion and to fund the expansion program in the amount of \$6
27 billion. Notwithstanding our best efforts this spring, the State has refused to commit itself to
28

1 providing *any* of the funding necessary for either the upgrade program or the expansion
2 program.

3 B. Avoidable Prisoner Deaths That Continue to Take Place Because of the Lack of
4 Access to Long-Term Health Care Facilities.

5 If the consequences of the State's willful obstruction were not so serious and so
6 immediate, the State's behavior might be excusable. But the hard truth is that men and women
7 continue on a daily, weekly and monthly basis to suffer and die unnecessarily in California
8 prisons as a direct result of the unconstitutional health care conditions for which the State and
9 its leaders are responsible. Every moments delay in implementing the Receiver's Turnaround
10 Plan results in avoidable suffering and death. Without question, one of the primary factors
11 creating unnecessary prisoner deaths has been the State's refusal to construct adequate
12 treatment facilities for California's prisoners.

13 Three recent examples of avoidable prisoner deaths illustrate the human cost of the
14 State's failure to provide adequate funding for needed health care treatment facilities:

- 15 1. Patient A was a 44 year old male diagnosed with Ankylosing Spondylitis, a chronic
16 inflammatory disease affecting primarily the back, neck and hips. The term
17 "ankylosing" means "joining together;" the term "spondylitis" means inflammation
18 of the vertebrae. Based on available X-rays, Patient A's chart indicated as follows:
19 "AP cervical spine, AP thoracic spine and AP lumbar spine all show Ankylosing
20 Spondylitis with back completely fused. The hips are completely gone both right
21 and left." The condition can be extremely painful and, given other common related
22 problems (e.g. abscesses), very difficult to manage. Patient A should have been
23 treated in a long-term medical facility which provides the interdisciplinary
24 treatment necessary; however, adequate facilities for long-term medical problems
25 do not exist in CDCR. Instead, Patient A was housed in a Correctional Treatment
26 Facility ("CTC") in a remote prison. While licensed, a CTC without specialized
27 services is entirely unsuitable for long-term care. In late January 2008, after more
28 than a year of CTC confinement, Patient A's condition deteriorated rapidly. He

1 was unresponsive to pain management efforts and died suddenly on February 12,
2 2008.

- 3 2. At present, there exist serious shortages of mental health inpatient beds (including a
4 waiting list of 162 for long-term intermediate care hospitalization). At present,
5 CDCR simply does not have anything near adequate mental health treatment
6 facilities for prisoners with serious mental health problems. Patient B was a 36 year
7 old male diagnosed with Hepatitis C antibody positive, paranoid schizophrenia,
8 history of head trauma, borderline intellectual functioning, antisocial personality
9 disorder, and history of substance abuse. Incarcerated continually since 1994,
10 Patient B has been, in the past, admitted to both mental health crisis housing and
11 administrative segregation housing. These placements were for safety concerns.
12 Because of his mental health problem, Patient B was vulnerable to victimization
13 when housed in "general population." He was last housed in general population,
14 however, and also double-celled. On November 26, 2007 Patient B was found in
15 his cell unresponsive with multiple wounds about the head, weak pulse, agonal
16 breathing and fixed dilated pupils. He was transferred to a local hospital,
17 determined to be brain dead, and care subsequently withdrawn. According to
18 CDCR officials, Patient B had been beaten to death by his cellmate.
- 19 3. At present, the CDCR does not have any housing units designed to adequately
20 provide for the needs of developmentally disabled prisoners. Patient C was a 36
21 year old prisoner with the functional IQ of a nine-year old, and documented seizure
22 disorders. An adaptive evaluation dated July 14, 2005 required "close supervision"
23 in order to remind Patient C to take his medications. However, instead of being
24 placed in a medical sheltered living unit (no such facilities exist in CDCR), Patient
25 C was confined to an overcrowded dormitory in one of California's most
26 deteriorated prisons. In late 2007, Patient C began to encounter problems with
27 medication management and his behavior. On November 9, 2007, as the result of
28 an alleged battery, Patient C was transferred (without his medical records) to a

1 nearby high security prison administrative segregation unit. Thereafter, between
2 November 9, 2007 and January 4, 2008 Patient C “missed” four medical
3 appointments (the exact causes for the “missed” appointments is currently under
4 investigation). On January 17, 2008 Patient C returned to dormitory housing;
5 however, there is no indication that the necessary close supervision to remind him
6 to take his medications was provided. Indeed, given the age and structure of the
7 dormitory, and the limited staffing at this facility, it does not appear reasonable to
8 expect minimally adequate care for developmentally disabled prisoners to be
9 delivered at the prison where he had been housed. On January 27, 2008 another
10 prisoner in the dormitory reported to correctional officers that Patient C was having
11 a seizure. Prisoner C died the same day.

12 C. The Receiver’s Efforts to Work with State Officials to Fund Necessary Long-Term
13 Health Care Facilities.

14 Within two weeks after his appointment on January 23, 2008, the Receiver, after
15 conferring with officials in the Governor’s Office and the Department of Finance, had decided
16 upon the appropriate strategy for securing the necessary \$7 billion in funding for the upgrade
17 and expansion programs. The Receiver decided to find an experienced author to carry a single
18 bill that would contain lease-revenue bond financing for the entire construction program. This
19 choice was dictated by several factors:

- 20 • Consistent with the Court’s orders requiring the Receiver to resort to ordinary State
21 processes before turning to the Court for more intrusive relief, the Receiver decided
22 to seek legislative authorization for the construction program.
- 23 • Given the speed with which the Receiver intends to build, and the construction
24 management approach (which requires full funding for a building to be available
25 up front before construction commences), the Receiver needs the State to commit
26 to funding approximately \$3.5 billion during FY 2008-2009, \$2.0 billion during FY
27 2009-2010, and \$1.5 billion during FY 2010-2011.

- In light of the difficulty of securing legislative approvals, the Receiver did not want to piece-meal the funding of the construction program. That approach would subject the Receiver to a significant risk of legislative meddling in subsequent years.
- Given the State's serious budget and cash management problems, bond financing appears to be the only sensible fiscal alternative. Although bond financing substantially increases the overall costs of a construction program compared to a "pay-as-you-go" approach, bond financing substantially reduces the annual costs and delays the impact on the State's General Fund until each building is completed and occupied. This would give the State three years to plan for how it would pay the on-going lease payments to repay the bond.
- Because of the substantial difficulties that have plagued the implementation of AB 900 and the fact that AB 900 did not contain nearly enough funds for the construction of necessary health-care-related facilities (less than \$1 billion had been allocated in AB 900 to health care facilities, and the parties who negotiated AB 900 had all agreed last year that this sum was simply a "placeholder" until the Receiver had fully estimated its construction costs), the Receiver decided to seek a "clean bill" to fund the Receiver's entire construction effort without any ties to AB 900.

The Receiver approached Senator Michael Machado (D-Linden) to author the bond bill. Senator Machado is the Chair of the Senate Budget Sub-Committee with authority over the Department of Corrections and Rehabilitation and has almost fifteen years experience in the California Legislature, both in the Assembly and the Senate. He introduced the bond bill, Senate Bill ("SB") 1665, on February 22, 2008.

The Receiver secured the services of Mr. Ray Le Bov to represent the Receiver in legislative discussions regarding SB 1665. Mr. Le Bov has almost three decades of experience in the State Capitol. He served for over ten years during the 1990s and early 2000s as the head

1 of the Office of Governmental Affairs for the California Administrative Office of the Courts.
2 His integrity and knowledge of legislative processes is unsurpassed.

3 The Receiver and Mr. Le Bov met with all members of the relevant Senate policy and
4 appropriations committees before SB 1665 was heard, and held other meetings with key Senate
5 and Assembly budget staff and members. The Receiver supplied comprehensive
6 documentation regarding the need for, the scope of and the plans for the upgrade and
7 expansions programs. SB 1665 was passed by the Senate Public Safety Committee on April
8 29, 2008, by a 4-1 vote. It was passed by the Senate Appropriations Committee on May 8,
9 2008, by a 9-1 vote.

10 Based on discussions with legislators and feedback from legislative staff and Senator
11 Machado's office, it appeared that we had the necessary two-thirds vote to clear the Senate (a
12 two-thirds vote was required because the bill contained an appropriation and urgency clause so
13 the bill would become law immediately upon enactment). In particular, the Receiver believes
14 that four or five Republican Senators were prepared to vote for the measure, more than enough
15 to clear the Senate.

16 We had planned to have the bill taken up on the Senate floor on May 15, 2008. Late on
17 May 14, 2008, Senator Machado's office received a call from staff from the Legislative
18 Analyst's Office ("LAO") indicating that they were planning on issuing a report the following
19 week on SB 1665 that, among other things, would indicate that the bill contained some major
20 legal conflict with provisions in the Prison Litigation Reform Act. We could not schedule a
21 meeting with the LAO before the Senate floor vote on May 15, 2008 to determine more
22 precisely what legal conflict supposedly existed. Faced with the prospect of taking a floor vote
23 with a subsequent LAO report that might identify a major legal conflict, Senator Machado
24 decided, with the Receiver's concurrence, to delay the vote.

25 When we met the LAO staff on the afternoon of May 15, 2008 we learned that staff was
26 asserting that 28 U.S.C. § 3626(a)(1)(C) might legally bar the Receiver and/or the Court from
27 ordering the State to make expenditures to improve and/or expand healthcare-related facilities
28 for use by inmate-patients. LAO staff admitted during this meeting that they had identified

1 this provision *during the discussions surrounding AB 900 in 2007* as establishing a potential
2 problem. LAO staff had not raised the issue at all with the Receiver during the consideration of
3 SB 1665 until the night before the bill was scheduled for a vote on the Senate floor, when LAO
4 informed Senator Machado's staff of the potential problem. The timing of the phone call to
5 Senator Machado on May 14 leaves one with the clear impression that the timing was designed
6 to forestall SB 1665's successful passage out of the Senate.

7 On the merits, LAO's argument does not hold water. Section 3626(a)(1)(C) was written
8 to ensure that the *limitations* placed on equitable relief contained in Section 3626(a)(1)(A)
9 were not creatively transformed into an *independent source of power* to order the construction
10 of prisons or the raising of taxes (that is the purpose of the "nothing in this section" language at
11 the beginning of Section 3626(a)(1)(C)). Section 3626(a)(1)(C) by its plain language and
12 ordinary construction does not place any new or additional limitation on the Court's equitable
13 powers to order appropriate relief for constitutional violations.

14 Nevertheless, LAO had successfully put off the Senate vote in order to give itself the
15 additional time it needed to issue a report on SB 1665 the following week. (Exhibit 13). In
16 addition to repeating its argument regarding 28 U.S.C. § 3626(a)(1)(C), the LAO report
17 contained a series of statements and criticisms that fly in the face of this Court's findings and
18 orders, and the findings and orders in *Coleman*. For example, the LAO report asserts:

- 19 • *Need for 10,000 New Beds Uncertain. The Receiver proposes that 5,000 beds at*
20 *the stand-alone facilities be developed for chronically ill inmates with medical*
21 *needs, while another 5,000 beds would be for inmates who primarily have mental*
22 *health needs. However, our analysis indicates that the number of new prison beds*
23 *proposed to be built in the Receiver's medical facilities has not been fully justified.*

24 This statement is false. The LAO was provided with more than ample documentation of
25 bed needs, including prior Court orders and the Abt Associates, Inc. and Navigant Consulting,
26 Inc. bed studies.

- 27 • *Notably, the prison population has dropped over the last year, and the most*
28 *recently adopted prison inmate population projections, which have not been taken*
into account in the Receiver's planning assumptions, indicate that the inmate
population will decline modestly over the next five years. The Receiver has partly
justified his plans on the assumption of significant inmate population increases, but
the most recent projections by the California Department of Corrections and
Rehabilitation (CDCR) show actual numbers in 2012 will be 22,000 lower than
what was projected when the Receiver developed his plan last year. While it is not

1 *clear to us that these new projections will prove to be accurate, this significant*
2 *reduction in the projections means that the assumption that 10,000 beds will be*
3 *needed should be reevaluated.*

4 The above statement is misleading. There is no evidence that low security population
5 cuts will impact the long-term need for medical and mental health beds. Furthermore, the
6 Receiver has repeatedly stated that he intends to re-evaluate clinical bed needs every six
7 months.

- 8 • *The number of new beds proposed specifically for seriously mentally ill inmates*
9 *appears to exceed the orders of the federal court in another case, known as the*
10 *Coleman case. A bed plan approved by the Coleman court ordered the*
11 *development of about 4,000 new beds at various levels of care, while the Receiver's*
12 *plan identifies about 5,000 beds for such purposes. The Receiver's plan also does*
13 *not appear to take into account a series of construction projects that the Coleman*
14 *court has already authorized that would provide hundreds of additional beds for*
15 *mentally ill inmates. We asked the Receiver's office to reconcile the number of*
16 *beds for this purpose to its proposal with the Coleman court plans, but it did not do*
17 *so in its written responses to our questions.*

18 The above statement is misleading, and ignores the fact that the LAO and the
19 Legislature have failed over the course of many years to fund beds required by Coleman. The
20 LAO's assertion that the Receiver failed to reconcile the 10,000 beds project with Coleman
21 needs is false.

- 22 • *The Receiver has asserted that concentrating chronically ill inmates in seven new*
23 *facilities would be more efficient than attempting to provide an improved level of*
24 *care for this same population in existing prisons. However, the Receiver's office*
25 *was unable to provide us with any estimates comparing the costs, on a per patient*
26 *basis, of operating the proposed seven new medical facilities compared to the cost,*
27 *on a per patient basis, of providing them care in existing prisons.*

28 The above statement is false. The Receiver informed the LAO that it is not relevant to
compare the cost of a future correctional operation to existing unconstitutional services.
Indeed, this LOA request is an example of how the LAO works to subvert the Federal Court,
demanding that the Receiver engage in meaningless cost comparisons, and then
misrepresenting the facts to the Legislature.

- *The Receiver has retained his own experts on security in his facility planning, but it*
does not appear that CDCR has formally reviewed and commented on these issues.
This is an important consideration for two reasons. First, the estimates of costs
and square footage assumed for these projects appear to depend heavily on the
assumption that they will largely be constructed as dormitories. Second, given that
the department will eventually be responsible for managing the facilities once the

1 *Receivership ends, it is important that it be in concurrence with the security plans*
2 *and classification systems developed for these facilities.*

3 This above statement is false. The Receiver's staff and CDCR have discussed
4 classification issues. Furthermore, CDCR will not manage the new health care facilities; they
5 will be managed by the Receiver. Finally, while the prison health care system will, eventually,
6 be returned to the State, LAO's assumption that CDCR will manage the system is premature.

7 In broad summary, LAO's report asserts that the Legislature actually has various
8 alternatives it can and should be considering to the Receiver's construction plan,
9 notwithstanding the fact that the Receiver's plan is supported by multiple federal court orders,
10 and that the Receiver has been authorized by four Federal Judges to construct facilities to
11 satisfy the needs of four separate class actions. Stripped to its basics, the LAO recommends
12 "business as usual," contemptuous of the existing *Plata*, *Coleman*, and *Armstrong* orders.

13 When SB 1665 was initially scheduled to come up for a vote on May 15, the Senate
14 Republicans – after hearing a presentation by the Receiver – had decided *not* to take a caucus
15 position, which is why the Receiver believed he had the necessary Republican votes to secure
16 SB 1665's passage. However, on May 19, 2008, reports started surfacing regarding a possible
17 settlement agreement in the three judge court proceeding – an agreement that might lead to
18 tens of thousands of persons avoiding prison or being released from prison. These reports,
19 combined with the LAO's inaccurate report, galvanized Senate Republicans into taking a
20 caucus position against SB 1665.

21 The Receiver met several times with the Republican caucus to determine what their
22 concerns were and to offer additional reasons why SB 1665 should continue moving.
23 Essentially, the caucus determined that SB 1665 would not pass out of the Senate unless it was
24 part of a comprehensive deal involving both Assembly Bill ("AB") 900 and the three judge
25 court. The Receiver explained that none of the funds in AB 900 were going to be used by the
26 Receiver and that AB 900 was therefore irrelevant to the consideration of SB 1665. The
27 Receiver also explained that, in light of the Separation of Powers and principles of federalism,
28 the Legislature could not possibly have an opportunity to strike a deal with the three judge

1 court. The Receiver explained that the best the California Legislature could do to influence the
2 Federal Courts was to enact SB 1665 as quickly as possible to demonstrate the State's full,
3 unqualified endorsement of the Receiver's Turnaround Plan and construction program.

4 The Republican caucus did not change their position, and SB 1665 was twice rejected
5 by the Senate, once on May 27 and again on May 29. Under applicable parliamentary rules, SB
6 1665 is now dead.

7 The Receiver has now turned his attention to discussions with the responsible
8 constitutional officers – the Governor, the Controller and the Treasurer – to determine whether
9 there are other options for funding the Receiver's construction program without securing
10 immediate legislative concurrence and without resorting to more intrusive Federal Court
11 orders. Those discussions so far have not produced any breakthroughs, and the Receiver is now
12 forced to take certain actions in Federal Court preparatory to a direct order securing funds.

13 D. The Structure of the Legislation Necessary to Fund Long-Term Health Care
14 Facilities.

15 The Receiver continues to hope that the California Legislature will act quickly and
16 responsibly to authorize funding for the upgrade and expansion programs. To this end, the
17 Receiver and his staff stand willing to assist with drafting of adequate legislative language.
18 There is still time for the Legislature to do the right thing.

19 The Receiver's experience this Spring with SB 1665, however, reinforces his initial
20 conclusions that all the funding – the full \$7 billion – needs to be authorized up front and that
21 *the Receiver cannot be required to come back to the Legislature or the LAO for any further*
22 *approvals.* The Receiver is of course willing to consult with the Legislature or appropriate
23 legislative committees as the construction program moves forward – e.g., to consult with the
24 Joint Legislative Budget Committee – but the experience this Spring demonstrates that
25 legislative decision-making processes are too uncertain, and too fraught with the potential for
26 misdirection (e.g., the LAO's involvement), to be relied upon by the Receiver or the Federal
27 Courts.

1 E. Summary.

2 The State's failure to make this necessary financial commitment puts the Receiver's
3 entire remedial program at risk since the various pieces of the program are so intertwined and
4 interconnected that failure to fund and implement one major element undermines all of the
5 other elements. Unfortunately, the State's failure to make the necessary financial commitment
6 is not a result of inadvertent neglect or mere incompetence (trained or otherwise). Instead, it is
7 a result of conscious, deliberate obstruction by key decision-makers and decision-influencers
8 resulting in a willful failure by the State to live up to its constitutional and court-ordered
9 obligations. This is not a charge that the Receiver makes lightly; he has spent the last fifteen
10 years working within State government processes to improve government operations. The
11 State has now crossed that line and, in so doing, demonstrates a lack of remorse and an
12 unwillingness to accept accountability for its own constitutional violations. The State's failure
13 to express its unequivocal commitment to the Receiver's necessary construction program
14 should be taken into account by this Court in subsequent proceedings, and by the *Coleman*,
15 *Armstrong*, and *Perez* Courts.

16 V.

17 **ACCOUNTING OF EXPENDITURES FOR THE REPORTING PERIOD**

18 A. Expenses.

19 The total net operating and capital expenses of the Office of the Receiver for the eleven
20 months ending May 31, 2008 were \$19,319,316 and \$20,628,857 respectively. A balance sheet
21 and statement of activity and brief discussion and analysis is attached as Exhibit 14.

22 B. Revenues.

23 On January 11, 2008 the Receiver requested a transfer of \$28.3 million from the State
24 to the California Prison Health Care Receivership Corporation ("CPR") to replenish the
25 operating fund of the Office of the Receiver for the third quarter of FY 2007-2008 and
26 maintain the minimum operating capital on hand to six months. This brought the total funds
27 received from the State of California in this fiscal year to \$41.1 million.
28

1 VI.

2 **OTHER MATTERS DEEMED APPROPRIATE FOR JUDICIAL REVIEW**

3 A. Coordination with Other Lawsuits.

4 During the reporting period, regular meetings between the Receiver and the monitors of
5 the *Coleman, Perez, and Armstrong* ("Coordination Group") class actions have continued. The
6 last Coordination Group meeting for this reporting period was held on May 13, 2008. The next
7 meeting will take place on June 24, 2008. Steady progress has continued during this reporting
8 period.

9 For example, as reported in the Receiver's Seventh Quarterly Report, the Coordination
10 Group agreed on the design of a governance model for managing health care in the prison
11 system. The Chief Executive Officer, Health Care class specification for the governance
12 model was adopted by the State Personnel Board at their meeting of March 4, 2008. The
13 governance agreement was approved by the Court on April 1, 2008. As with prior orders
14 pertaining to coordination efforts between the health care class actions, the Receiver was also
15 ordered to file quarterly reports in each of the cases. (*See, Order Approving Chief Executive*
16 *Officer Pilot Program Coordination Agreement.*) California State Prison-Sacramento/Folsom
17 State Prison, Mule Creek State Prison and San Quentin State Prison have been chosen as pilot
18 sites for the governance model.

19 Other areas of agreement reached during this reporting period include, the Receiver's
20 assumption of the following: responsibility for personnel work at San Quentin including
21 mental health and dental, responsibility on behalf of all disciplines to manage the transition and
22 opening of new health care facilities and responsibility for the health care appeals policy,
23 which is being modified to accept third-level appeals.

VII.

CONCLUSION

As demonstrated above, the Receiver has made significant progress during the reporting period. However, the State's obstruction threatens the Receiver's ability to resolve prison medical problems in a timely and cost effective manner.

Clark Kelso (JK)

Clark Kelso

Receiver

FUTTERMAN & DUPREE LLP
MARTIN H. DODD (104363)
160 Sansome Street, 17th Floor
San Francisco, California 94104
Telephone: (415) 399-3840
Facsimile: (415) 399-3838
martin@fdlaw.com

Attorneys for Receiver
J. Clark Kelso

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND FOR THE NORTHERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,
Defendants.

Case No. CIV S-90-0520 LKK JFM P

CARLOS PEREZ, et al.,
Plaintiffs,

v.

JAMES TILTON, et al.,
Defendants.

Case No. C 05-05241 JSW

JOHN ARMSTRONG, et al.,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,
Defendants.

Case No. C 94-2307 CW

**NOTICE OF FILING OF RECEIVER'S
EIGHTH QUARTERLY REPORT**

PLEASE TAKE NOTICE that the Receiver in *Plata v. Schwarzenegger*, Case No. C01-1351 TEH has filed herewith his Eighth Quarterly Report.

Dated: June 17, 2008

FUTTERMAN & DUPREE LLP

By: /s/ Martin H. Dodd
Martin H. Dodd
Attorneys for Receiver J. Clark Kelso