IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.

Plaintiffs,

vs.

ARNOLD SCHWARZENEGGER, et al.

Defendants.

No.: C01-1351 T.E.H.

RECEIVER'S SIXTH QUARTERLY REPORT

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I.

INTRODUCTION

A. The Receiver's Reporting Requirements.

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

B. 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.)

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

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

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

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

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

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

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

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

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

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

F. Master Contract Waiver Related Reporting.

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

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

(*Id.* at 12.)

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

G. Introduction Summary.

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

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

II.

PARTICULAR SUCCESSES ACHIEVED BY THE RECEIVER

A. Introduction.

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

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

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

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

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

B. Plan of Action.

1. Introduction.

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

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

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

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

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

2. Plan of Action Update.

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

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

   a. Recruitment and hiring of clinical positions, including physicians, mid-level practitioners, Registered Nurses ("RN"), Licensed Vocational Nurses ("LVN"), and pharmacists. (*See*, Plan of Action Objective A.8).

   b. Recruitment and hiring of executive and management positions including Receiver's Career Executive Assignment staff; regional and statewide medical and nursing directors; Chief Medical Officers ("CMO"); Regional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Nursing initiatives, including the following:

a. Implement a nursing hiring and recruitment executive leadership initiative

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

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

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

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

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

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

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

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

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

3. Plan of Action Focus Groups.

In addition to the above Plan of Action related meetings, for two days in August 2007 and again in September 2007, the Office of the Receiver held focus groups with several dozen State and regional nurse and physician leaders and administrators to review the Receiver's Plan of Action and its implementation. Hosted by Betsy Chang Ha, Chief Nurse Executive, and Dr. Terry Hill, Chief Medical Officer, the groups represented initial steps toward activating a broad clinical leadership cadre who will contribute to and implement the Plan of Action. Their feedback will help clarify, enhance, and improve the next iteration of the Plan of Action, as well as prioritize its elements.

In summary, the focus groups endorsed the need to redesign the medical care delivery system from the ground up, to support the care providers with adequate medical records and IT, and to professionalize the working environment. They also endorsed the need for a vigorous care management system, for a staff education infrastructure, and for leadership and managerial training. There was considerable enthusiasm for holding similar interdisciplinary meetings in the regions to engage local prison leadership in discussion about the Plan of Action's aims and implementation strategies.

4. Plan of Action Metrics.

As set forth in the Receiver's May 2007 Preliminary Plan of Action, the Receiver is currently involved with developing a comprehensive system for measuring the delivery of medical care in California's prisons. Short-term goals regarding metrics include the following:

A) An operational system to objectively measure the basics of *Plata* remedial plan compliance at six pilot prisons;

B) An accurate and objective operational system of mortality reviews; and

C) The submission of metrics and timelines concerning each of the priority programs cited above.

These short-term and additional long-term metrics will be implemented by the Receiver's Office of Evaluation, Measurement and Compliance. The Receiver intends to have this Office

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

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

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

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

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

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

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

(Appointing Order at 5:1-11.)

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

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

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

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

2. Receiver's Motion for Waiver of State Law Re Physician Clinical Competency Determinations.

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

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

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

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

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

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

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

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

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

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

D. Remedial Pilots and Projects.

1. San Quentin State Prison Project.

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

a. Reception Screening Process.

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

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

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

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

b. Primary Care Provider Program.

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

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

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

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

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

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

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

c. Nursing Program.

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

d. Public Health Nursing.

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

e. San Quentin State Prison Health Care Appeals.

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

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

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

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

f. Medical Records.

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

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

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

g. Personnel.

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

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

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

h. Staff Training.

1. Orientation.

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

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

2. Supervisory Training.

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

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

3. Policy Training.

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

i. Department Budgets.

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

j. San Quentin State Prison Specialty Contract Processing.

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

k. Laboratory.

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

l. Environmental Health and Hygiene Services.

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

m. Monthly Reports and Metrics.

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

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

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

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

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

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

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

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

a. Status of Construction of the Central Health Services Building.

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

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

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

b. Funding for the Central Health Services Building.

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

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

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

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

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

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

d. Conclusion.

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

3. Maxor's Pharmacy Management Update.

a. Introduction.

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

Particular successes achieved by the Receiver in accomplishing remedial goals:

b. Pharmaceutical Contracting and Purchasing.

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

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

c. Hiring Pharmacy Administration and Staff.

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

d. Education of Pharmaceutical Staff.

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

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

e. Organization and Management of Pharmacy Staff.

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

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

1. Folsom State Prison.

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

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

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

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

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

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

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

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

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

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

2. Mule Creek State Prison.

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

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

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

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

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

3. Additional Guardian Pilot Prisons.

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

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

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

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

g. Development of a Central Pharmacy.

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

h. Centralization of Clinical Services.

Maxor continues to work with the CDCR P&T Committee to support clinical pharmacy management processes. The official CDCR Formulary was released in June 2007 and reports have been designed to track formulary compliance. During this reporting period, the P&T Committee approved two additional policies and procedures and two new disease medication management guidelines ("DMMG"). A therapeutic interchange program was designed and implemented to help facilitate the transition to the new formulary. Implementation of the new hyperlipidemia[3] DMMG is anticipated to result in an annual cost savings of approximately $7 million dollars by switching patients to the newly preferred formulary agents.

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

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

1. Contracts.

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

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

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

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

2. Pharmacy Software Installation.

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

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

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

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

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

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

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

4. Developments in Recruiting and Hiring.

a. Plata Workforce Development Section.

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

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

1. Progress Made in Clinical Hiring.

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

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

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

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

2. Recruiting Efforts Aimed at Clinical Staff Positions.

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

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

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

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

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

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

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

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

5. Credentialing and Privileging of Health Care Providers.

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

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

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

Particular successes achieved by the Receiver in accomplishing remedial goals:

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

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

Two additional issues require discussion:

a. Credentialing/Privileging Coordination Agreement.

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

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

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

b. Internet-based Credentialing Solution

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

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

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

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

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

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

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

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

6. Specialty Care Contracts Pilot.

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

Particular successes achieved by the Receiver in accomplishing remedial goals:

a. Contracting Functions.

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

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

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

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

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

b. Invoicing and Data Gathering Functions.

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

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

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

c. Administrative Support Unit.

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

d. Independent Assessment of the Pilot.

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

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

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

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

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

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

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

7. Health Care Appeals Update.

a. Health Care Appeals Statewide.

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

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

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

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

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

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

8. Medical Transport Vehicles.

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

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

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

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

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

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

9. Improvements in Nursing Services.

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

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

a. Enhanced Medication Management.

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

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

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

b. Analysis of Policies and Procedures.

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

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

c. Orientation, Continuing Education, and Leadership Training.

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

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

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

d. Staffing.

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

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

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

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

10. Improvements to Physician Services.

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

a. HIV Advisory Committee.

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

b. Quality Improvement in Correctional Medicine ("QICM").

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

c. Training Accomplishments.

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

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

d. The Professional Practice Executive Committee.

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

e. Hiring Successes.

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

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

f. Avenal State Prison.

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

11. Information Technology Update.

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

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

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

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

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

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

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

Particular successes achieved by the Receiver in accomplishing remedial goals:

b. The Health care Information Technology Executive Committee.

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

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

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

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

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

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

c. The Clinical Data Repository Project.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Return-to-Custody Facilities.

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

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

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

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

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

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

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

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

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

1. Receiver's Inspection of the Family Foundation Program.

On July 31, 2007, the Receiver sent an inspection team to conduct an un-announced inspection of the Family Foundation Program ("FFP") in San Diego, which is a community-based program for pregnant and parenting women and their children under the age of six years old. The FFP is a 12-month alternate sentencing program to which pregnant and parenting women are sentenced in lieu of State prison for selective offenses, having a sentence not to exceed 36 months. The FFP has a maximum capacity of 35 female inmates and 40 children.

The purpose of the inspection was to gather information regarding the medical care operations of the facility and determine what improvements are necessary in order to ensure that medical care needs of the female prisoner/patients are met. In addition, the inspection team evaluated the operational systems in place for meeting the medical care needs of the children and infants that live with their mothers at the FFP. (*See*, FFP Inspection Form, Exhibit 8.)

The inspection team found the care of this high need population was inadequate. They found that there is no medical, mental health or dental review prior to being housed at the FFP. The lack of any health care screening is of significant concern to the Receiver since it places a particularly medically vulnerable population (pregnant women and infants) at significant risk from infectious diseases and potentially subjects children to inappropriate contact with prisoner/patients with severe mental disorders. Furthermore, when the lack of screening results in the inappropriate placement of women at the FFP, it takes extensive work to get them removed from the FFP since there is significant pressure to keep these beds full.

The medical staffing at the FFP generally consists of one LVN who is scheduled five days a week eight hours a day. Clinical competency requirements in the areas of adult medicine, pediatrics, or obstetrics have not been established. Until approximately two weeks ago, this position was filled on a permanent full-time basis. The staff at the FFP indicated that they now try and hire a RN via a local registry until the LVN position can be filled permanently or until the contract is amended to require an RN as the full-time permanent position. On the day of the inspection, the registry RN did not report for work and the registry was not able to back-fill the position for the entire day.

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

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

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

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

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

The inspection team made the following recommendations:

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

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

Establish clinical competency requirements in the areas of adult medicine, pediatrics, and obstetrics. Establish sick-call protocols for adult medicine, pediatrics, and obstetrics. Additionally, the RN must have a primary care provider to confer with when necessary.

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

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

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

6. Consider assigning additional CDCR staff to the FFP.

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

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

d. Multidisciplinary Unit to Assist Community Correctional Facilities.

As a result of what the Office of the Receiver has uncovered over the past several months, it is now clear that additional resources for oversight and management of this previously unknown group of prisoners/patients are required. The Receiver will establish a new division within the Office of the Receiver, to be staffed with a high level administrator, clinical support including physician(s) and nursing, as well as custody and support staff to begin to monitor prisoners/patients housed in CCFs and bring health care for those prisoner/patients up to constitutional levels. Hiring for the unit has commenced. It is anticipated that the unit will be operational in November 2007.

13. Telemedicine Reform.

As called for in the IT coordination agreement, beginning August 2007, the Receiver assumed responsibility for the Office of Telemedicine Services ("OTS"), which includes medical and mental health services. The Receiver's Plan of Action states that CDCR will:

> "Improve and enhance the existing telemedicine program and integrate it into continuum of inmate medical care to provide primary, emergency and specialty care to allow for greater access to inmates while reducing cost of care as well as custody inmate transportation to outside clinical care locations."

(Objective D.6.)

Particular successes achieved by the Receiver in accomplishing remedial goals:

In order to achieve this objective, the Office of the Receiver has instituted several measures to improve the existing telemedicine program.

a. Staffing.

Historically, the OTS was comprised of eight staff members that included: four Registered Nurses, two Staff Services Analysts, one Health Record Technician and one Telecommunications Systems Analyst II. In May 2007, the Office of the Receiver approved the establishment of an additional Health Record Technician (established: August 1, 2007) and an Office Technician position (established: September 1, 2007). These positions will provide scheduling and health records support to the OTS. Both of these positions have been filled. In

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

b. Telemedicine Providers.

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

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

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

c. Equipment.

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

d. Process Mapping and Workload Analysis.

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

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

e. Assistance from the University of Texas Medical Branch.

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

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

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

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

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

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

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

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

14. Health Care Access Units.

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

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

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

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

a. Development of Additional Health Care Access Units.

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

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

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

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

b. Preliminary Reviews of Health Care Access Operations.

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

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

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

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

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

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

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

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

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

15. Licensure and Operation of Dialysis Clinics.

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

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

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

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

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

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

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

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

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

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

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

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

1. Patient Scheduling System Pilot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Contracts and Fiscal Oversight.

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

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

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

18. Building Upgrades At All Prisons.

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

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

a. Design, Planning, and Construction.

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

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

b. Timetables for Construction Upgrades.

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

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

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

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

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

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

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

a. Conversion of the GACH to an Infirmary.

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

b. Mental Health Crisis Beds at CIM.

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

E. Establishing the Office of the Receiver.

1. New Appointment to the Office of the Receiver.

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

business development, managed care operations, negotiations and strategic planning. She has extensive experience in payor relations, hospital and physician contract negotiations, managed care operations management, marketing and strategic planning. She served as the Strategic and Technical Managed Care Advisor for the University Health Systems Consortium. Prior to joining CCG, she was Director of Health Plan Services for Stanford Health Services, with overall responsibility for providing the strategic direction for Stanford and Lucile Packard Children's Hospitals and the Stanford Faculty Practice Plan. Currently, she provides strategy and business development as well as managed care strategies for many regional and academic medical centers across the country. Ms. Parsons has also worked with a nationally recognized consulting firm as well as with several Academic Medical Centers and a large for profit system as a hospital administrator. Ms. Parsons received her undergraduate degree in government with distinction from Wheaton College in Norton, Massachusetts and a graduate degree in hospital administration from Yale University, School of Epidemiology and Public Health.

2. Determination of Tax Exempt Status by Internal Revenue Service.

On August 1, 2007 the Internal Revenue Service (IRS) notified the Receiver that the application of the California Prison Health Care Receivership Corporation for tax exempt status had been reviewed. In its letter, the IRS reported its determination that the Corporation is a tax exempt organization under 501(c)(3) of the Internal Revenue Code. This confirms that that the Corporation is exempt from Federal income tax, that contributions to the Corporation are deductible under section 170 of the Code, and that the Corporation is qualified to receive tax deductible bequests, devises, transfers or gifts under sections 2055, 2106 or 2522 under the Code. The determination letter is attached as Exhibit 13.

F. Coordination with Other Lawsuits.

The CDCR mental health and dental systems are also under court supervision as a result of two additional inmate heath care class actions: *Coleman v. Schwarzenegger* and *Perez v. Tilton.* To avoid duplication of effort, certain health care initiatives that support the entire health care system are being coordinated by the *Plata*, *Coleman*, and *Perez* Courts. (*See*, Joint

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

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

III.

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

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

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

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

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

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

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

neither of which are acceptable: 1) engage in construction in full compliance with all State laws, regulations, and business practices, including all the attendant additional costs and time delays, regardless of how serious the crisis, or 2) force the Court to go directly into the State General Fund to finance the project on a cash basis – an option that the State should make every effort to avoid. In effect, given this opinion, AB 900 cannot serve as a vehicle for cost-effective, expedited construction providing relief of the constitutional deprivation absent very specific approval by the California Legislature.

The Administration of Governor Schwarzenegger is as concerned and disheartened by this new twist of events as is the Office of the Receiver. Efforts continue to be made by the Administration to seek a resolution concerning this problem. For the present the Receiver is attempting to work with the Administration as the funding of needed prison facilities by the issuance of bonds continues to be the option of choice on the part of California's elected officials as well as the Receiver. The problem, however, provides focus concerning two on-going issues. First, despite promises to the contrary, the State's ever thickening bureaucratic web and planned incompetence continues to hinder efforts by the Receiver to effectuate change within the context of State law. Second, even the best efforts by the Administration continue to be thwarted by politics and bureaucracy as usual.

IV.

ACCOUNTING OF EXPENDITURES FOR THE REPORTING PERIOD

A. Expenses.

The total net operating and capital expenses of the Office of the Receiver for the year ended June 2007 were $11,477,852 and $8,719,171 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Exhibit 14.

B. Revenues.

On August 8, 2007, the receiver requested a transfer of $12,821,000 from the State to the California Prison Health Care Receivership Corporation ("CPR") to replenish the operating fund of the office of the receiver for the first quarter of the Fiscal Year 2007-2008 and maintain the minimum operating capital on hand to six months. All funds were received in a timely manner.

V.

OTHER MATTERS DEEMED APPROPRIATE FOR JUDICIAL REVIEW

A. Communications with the Media and Public.

1. Press and Public Information.

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

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

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

11. Prison overcrowding.

12. Out-of-State transfers of prisoner/patients.

13. The Receiver's Plan of Action to create a constitutional medical care system.

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

a. Public Information Produced by the Receiver:

Press Release re: Fifth Quarterly Report to the Court – June 20, 2007

"Recommendations for Coccidioidomycosis (Valley Fever) Mitigation in Prisons in the Hyperendemic Areas of California" by Dwight Winslow, M.D., Statewide Medical Director, Report Commissioned by the Receiver — June 2007

"San Quentin Under the Microscope," Multimedia presentation about the San Quentin Project and the new Triage and Treatment Area, posted on Receiver's website – July 27, 2007

Response to the Fresno County Grand Jury's Report on Pleasant Valley State Prison – August 1, 2007

Press release re: "San Quentin Under the Microscope" – August 2, 2007

Methicillin-resistant staphylococcus aureus (MRSA) Fact Sheet – August 2007

b. Receiver's Radio and TV Coverage:

KPCC Southern California Public Radio 89.3 – June 26, 2007, "Federal Court to Consider Population Cap for California Prisons"

KQED Capitol Notes – July 10, 2007, "We'll Do It From Here"

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

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

KQED Capitol Notes – August 27, 2007, "San Quentin Medical $$ Stuck"

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

c. Receiver's Public Appearances:

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

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

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

d. Editorial Coverage:

Sacramento Bee Editorial – June 3, 2007, "Prison reform, for real"

Sacramento Bee Editorial – June 10, 2007, "Prison progress"

The Vacaville Reporter Editorial – June 29, 2007, "No rap on cap: Judges could complement prison plans"

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

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

Whittier Daily News Editorial – August 03, 2007, "No prison for Nelles site"

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

Mountain Democrat Editorial – August 31, 2007, "Prison caper"

e. Examples of News Coverage:

The California Nurses Association/National Nurses Organizing Committee Journal of Patient Advocacy – May 2007, "Inside Job"

Los Angeles Times – June 14, 2007, "Medical care at center spurs lawsuit"

California Progress Report – June 20, 2007, "Federal Court Receiver in Charge of California State Prison Medical System Report to Judge on Progress Being Made"

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Fresno Bee – July 08, 2007, "No More Room: Medical care close to a crisis in the state's crowded women's prisons"

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Sacramento Bee – July 12, 2007, "Medical money for San Quentin: Assembly vote today could shift bond funds to replace prison's crumbling health care center"

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The New Yorker – July 30, 2007, "Dean of Death Row"

Whittier Daily News – July 30, 2007, "Official weighs new use for Nelles: Site could be used as prison hospital"

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Sacramento Bee – August 16, 2007, "Prison report cites Valley Fever risks: Construction may release spores that cause disease, increasing inmates' cases"

Sacramento Bee – August 26, 2007, "Capital man's prison death probed by federal watchdog: Fatalities bring scrutiny of medical care provided to inmates at Avenal facility"

New York Times – August 27, 2007, "Using Muscle to Improve Health Care for Prisoners"

Sacramento Bee – August 28, 2007, "San Quentin hospital loses Senate fund vote"

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Sacramento Bee -- September 7, 2007, "Prison health czar loses bid"

Sacramento Bee -- September 9, 2007, "Disease clouds a prison's future: A deadly outbreak of valley fever is sparking doubts about expanding the Pleasant Valley lockup in Fresno County"

San Jose Mercury News -- Editorial, September 11, 2007, "Time running out on prison reform"

2. Additional Public Outreach Activities.

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

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

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

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

B. Prisoner/Patient Complaints and Correspondence Program.

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

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

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

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

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

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

2. Quarterly Summary (April – June 2007).

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

3. Prison Specific Distribution of Correspondence.

The 818 letters received by the Office of the Receiver included concerns about all of the 33 adult prisons. Mule Creek State Prison is the source of most correspondence, with 87 letters. The next-highest number of complaints came from: Pleasant Valley State Prison (83), Avenal State Prison (76), Salinas Valley State Prison (55) and Corcoran State Prison (49). The number of letters by institution is set forth below:

Avenal State Prison 76
Calipatria State Prison 6
California Correctional Center 8
California Correctional Institution 15
Centinela State Prison 7
Central California Women's Facility 22
California Institution for Men 4
California Institution for Women 15
California Men's Colony 30
California Medical Facility 42
Corcoran State Prison 49
California Rehabilitation Center 5
Correctional Training Facility 47
Chuckawalla Valley State Prison 5
Deuel Vocational Institute 4
Folsom State Prison 14
High Desert State Prison 25
Ironwood State Prison 9
Kern Valley State Prison 20
California State Prison, Los Angeles County 9
Mule Creek State Prison 87
North Kern State Prison 2

Pelican Bay State Prison 14

Pleasant Valley State Prison 83

R.J. Donovan Correctional Facility 14

California State Prison, Sacramento 12

California Substance Abuse Treatment Facility 33

Sierra Conservation Center 18

California State Prison, Solano 46

San Quentin State Prison State Prison 32

Salinas Valley State Prison 55

Valley State Prison for Women 6

Wasco State Prison 4

4. Types of Complaints.

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

The categories of complaints are set forth below:

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

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

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

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

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

Avenal State Prison 30

Calipatria State Prison 2

California Correctional Center 0

California Correctional Institution 3

Centinela State Prison 0

Central California Women's Facility 5

California Institution for Men 0

California Institution for Women 7

California Men's Colony 7

California Medical Facility 14

Corcoran State Prison 25

California Rehabilitation Center 1

Correctional Training Facility 12

Chuckawalla Valley State Prison 2

Deuel Vocational Institute 1

Folsom State Prison 5

High Desert State Prison 9

Ironwood State Prison 3

Kern Valley State Prison 5

California State Prison, Los Angeles County 2

Mule Creek State Prison 32

North Kern State Prison 2

Pelican Bay State Prison 3

Pleasant Valley State Prison 42

R.J. Donovan Correctional Facility 6

California State Prison, Sacramento 3

California Substance Abuse Treatment Facility 11

Sierra Conservation Center 1

California State Prison, Solano 13

San Quentin State Prison 11

Salinas Valley State Prison 25

Valley State Prison for Women 3

Wasco State Prison 1

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

C. Evaluation of Prisoner Deaths During 2006.

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

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

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

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

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

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

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

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

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

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

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

(*Id.*)

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

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

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

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

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

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

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

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

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

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

(*Id.* at 7.)

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

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

(*Id.* at 8.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI.

CONCLUSION

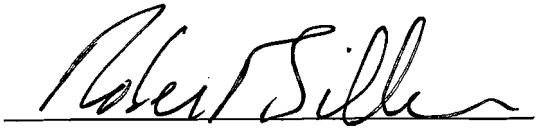
As is apparent from this and prior Quarterly and Bi-monthly reports to the Court, The Office of the Receiver and associated staff in CDCR are deeply involved in attempting to refine our understanding of the problems identified by the court's experts during the several year period leading up to the establishment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

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

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

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

Dated: September 25, 2007



Robert Sillen
Receiver

PROOF OF SERVICE

I, KRISTINA HECTOR, declare:

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

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

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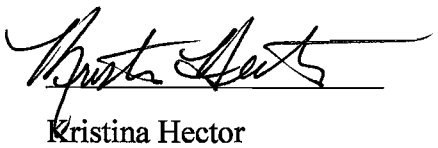
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on September 25, 2007 at Sacramento, California.



Kristina Hector