IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA , et al.,

Plaintiffs

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants,

NO. C01-1351-T.E.H.

RECEIVER'S SECOND BI-MONTHLY REPORT

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I.

INTRODUCTION

The Order Appointing Receiver ("Order") filed February 14, 2006 requires that the Receiver file his "Plan of Action" within 180-210 days. In the interim, the Order calls for the Receiver to undertake "immediate and/or short term measures designed to improve medical care and begin the development of a constitutionally adequate medical health care delivery system." Order at page 2-3. In addition, pursuant to page 3, lines 16-22 of the Order, the Receiver must file status reports with the Court on a bi-monthly basis concerning the following issues:

A. 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.

B. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.

C. Particular success achieved by the Receiver.

D. An accounting of expenditures for the reporting period.

E. Other matters deemed appropriate for judicial review.

This is the Receiver's Second Bi-Monthly Report. He addresses herein issues B though E.[1] Before discussing problems, successes, accounting and other matters deemed appropriate for judicial review, however, the Receiver believes it important to place the activities of his Office during the months of July, August, and September 2006 into context. Therefore, in addition to discussing the issues required by the Order, the Receiver will speak to three other issues of importance: (a) the State of the State of California (continued), (b) the waste of taxpayer resources, and (c) on-going efforts to establish the Office of the Receiver.

[1] Given that the Plan of Action is not yet prepared, there will be no status report concerning the plan in this report.

II.

THE STATE OF THE STATE OF CALIFORNIA (CONTINUED)

As indicated in the First Bi-Monthly Report, dysfunction, paralysis, trained incapacity, broken business practices and political machinations of State government are root causes of the devolution of the prison medical care system to its present unconstitutional level. It is, perhaps, axiomatic that unless and until these root causes and "environmental" conditions within which the CDCR medical care system operates are significantly mitigated and ultimately changed, constitutional levels of access to and quality of medical care will not be achieved. As will be detailed below, given the scope and interconnection of the problematic conditions which were created by decades of inaction and mis-management, the challenges ahead are immense, the barriers from the body politic and bureaucracy continue and progress, while already begun, will be measured and must be very carefully managed.

The State's entrenched unwillingness and/or incapability to effectively discuss, let alone act upon, the crisis in California's prisons underscores the critical importance of the Court and the Receivership in its attempts to assure inmate/patients of their constitutional rights. Perhaps no more salient example of State paralysis has been the recently concluded Special Session of the Legislature. On June 26, 2006 the Governor declared the California prison system in crisis and called a special session of the Legislature to deal with the issue of severe overcrowding, the root cause of many of the prison system's ills, including constitutionally inadequate medical care. Instead of the different entities of the State working together, some observers voiced immediate criticism of the Governor's action, calling it "too little, too late." Other critics were cynical regarding the potential for meaningful action when the Governor declared sentencing reform and reform of existing parole violation policies "off the table." Because 2006 is an election year, still others characterized the call for a special session as a "political stunt" armed at applying pressure to the Legislature to take action, affirmative or negative, on various proposals put forward by the Governor in an attempt to, if nothing else, share blame should nothing meaningful eventuate from the session.

Despite dire warnings from CDCR administrators that California's prisons will be out of space by June 2007, despite the fact that population levels are now in excess of 200% of designed capacity, nothing was presented to the Legislature by the Administration that provided for immediate relief for Prison Wardens and Health Care Mangers. Likewise, the Legislature itself offered no realistic proposals to deal with the problems faced within California's prisons in a timely and adequate manner.

The Receiver, however, offered comments and suggestions on the special session in a letter to the Governor and legislative leaders dated July 24, 2006, attached as Exhibit 1.[2] Although not intended for the necessary immediate relief concerning overcrowding, the Receiver's proposal would have both mitigated overcrowding and begun a construction process that is without question one element of a comprehensive plan to raise the health care services in California's prisons to constitutional levels. To the credit of the Governor and Senate, the Receiver's suggestions, as modified during the session, were adopted. For reasons not disclosed, however, the Assembly did not approve the Governor's revised plan to build medical/mental health assets. In the end, nothing productive eventuated from the special session and yet again cynicism proved prophetic and the gubernatorial declaration of a crisis in California's prisons was, effectively, left unaddressed.

This inaction, planned or otherwise, is emblematic of other examples of political paralysis in the State of California. Another recent example of similar State behavior was evidenced in the Receiver's call for salary increases (spoken to later in this report) for clinical personnel. Rather than taking a proactive stance toward such increases, which were well documented by the State itself in its own salary surveys, the State chose to leave it to the Receiver and Court to order such increases, at an attendant additional cost to taxpayers and delay in implementation.

The State's unwillingness and/or inability to take remedial action, and the depth of the problems in the prison medical care system (as detailed in this report) brings to mind

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[2] Exhibits are provided in an Appendix of Exhibits filed concurrently with this Report.

euphemisms and clichés such as "swimming upstream", "walking up the down escalator", "two steps forward, one step back", etc. Suffice it to say, the Receiver will not be as reluctant to effectuate positive change. Despite the barriers imposed by the State, the Office of the Receiver continues to identify problems, seek solutions, implement remedial actions and seek out cadres of employees who are willing and able to undertake the goals and tasks at hand. As explained in the Conclusions set forth at the end of this report, during the next sixty days the Receiver will begin a program to construct up to 5000 beds of dedicated medical facilities to be operational within the next three to five years. Working with CDCR officials he will impose a patient cap and reception center intake limit for San Quentin State Prison. The Receiver will, as well, increase the Office of the Receiver's control over the clinical hiring process and initiate plans to expand certain remedial processes on a pilot regional basis.

III.

THE WASTE OF TAXPAYER RESOURCES

As previously reported by the Receiver, the creation of a constitutional medical care delivery system is entirely consistent with sound fiscal management. Unfortunately, as emphasized by the Receiver in the First Bi-Monthly Report, the California Department of Corrections and Rehabilitation's ("CDCR") failure to deliver constitutionally adequate medical care has been accompanied by extraordinary instances of the waste of taxpayer resources, including the purchase of inappropriate medical equipment, an unnecessarily expensive and poorly managed and dangerous pharmacy system, utilization of acute hospital beds for prisoner/patients who require only sub-acute care, and the use of expensive privately owned clinical registries to fill vacant physician and nurse positions within the prisons.

More evidence of the waste of taxpayer resources was discovered during the months of July, August, and September 2006. First, the San Quentin project, as describe in detail below, has uncovered numerous examples of the waste of taxpayer resources.

Second, on August 2, 2006 Steve Westly, California's State Controller, issued a report concerning the State Controller's fiscal review of the CDCR's inmate health services delivery

system. The State Controller's audit findings are attached as Exhibit 2. As noted by the Controller:

> My office found evidence strongly suggesting that waste, abuse and management deficiencies are rampant in the department's expenditures and oversight of contract health care services. In addition, despite prior audit recommendations by the Office of the Inspector General and Bureau of State Audits the CDCR has not implemented appropriate control measures to provide oversight over contract expenditures.

The Receiver agrees with the findings of the State Controller. And he has commenced, as explained below, a process to remedy the deficiencies found in the report. *See* the Receiver's August 25, 2006 response to the State Controller's audit, attached as Exhibit 3.

After reviewing the findings of the State Controller, discussing findings with his staff, and reviewing the health services contract materials referenced later in this report, the Receiver finds that these audit findings represent another example of the "trained incapacity" noted in the Findings of Fact and Conclusions of Law re Appointment of Receiver ("Findings of Fact and Conclusions of Law") filed October 3, 2005. As stated by the Receiver in the First Bi-Monthly Report:

> "Trained incapacity" is a major cultural obstacle. Furthermore, it is both a vertical and horizontal issue, i.e., it involves not only CDCR but all other State Agencies and Departments whose performance significantly affects CDCR's ability to perform adequately and appropriately. Thus, the Receiver affirms that the inadequacy of medical care in California's prisons is not caused by the CDCR alone. As noted in the Findings of Fact and Conclusions of Law, the problems with CDCR medical care are a product of "[d]ecades of neglecting medical care while vastly expanding the size of the prison system [which] has led to a state of institutional paralysis." The present crisis was created by, and has been tolerated by, both the Executive and Legislative branches of the State of the California. Furthermore, these problems have not been adequately addressed by the State's control agencies, including the Department of Finance ("Finance"), the Department of General Services ("DGS"), and the Department of Personnel Administration ("DPA").

Receiver's First Bi-Monthly Report at page 4.

The crisis in medical services contracting was created by two factors. First, CDCR officials failed to appropriately manage the process for years. This failure includes a series of poor re-organization decisions (including a "Headquarters Operational Assessment Team" process which eliminated some of the administrative staff responsible for health care contracts

during a time period where the workload was increasing), the failure to adequately support the administrative staff responsible for procuring and paying for health care contracts in the prisons, inadequate numbers of contract staff at CDCR Headquarters, and the failure to provide contract personnel with necessary information technology to track and manage contract procurement and payments.

The second factor that created the contract crisis was the failure by California's control agencies to work together with CDCR to solve the growing problem even after the control agencies were informed of the audit findings. There have been, for example, various efforts on the part of Department of Correctional Health Care Services ("DCHCS") personnel to address the audit findings, including attempts to re-organize and modernize the contract process. In every instance, however, these efforts to improve services were thwarted, either by CDCR officials who rejected requests for the additional staff and information technology necessary to improve contract services, or by California's control agencies. For example, in an attempt to effectuate the reforms necessary to address audit findings by the Inspector General and Bureau of State Audits, the CDCR, pursuant to California requirements, prepared a Budget Change Proposal ("BCP") for fiscal year 2005/2006 requesting funding to address the workload requirements created by the decision to obtain, evaluate, and manage the bidding that would be required for previously exempt medical services contracts.[3] This request for funding, however, was denied.

With all said and done, the August 2006 State Controller audit findings serve as yet another example of why the Receivership is essential. Without the authority to remove California's prison medical care from the trained incompetence of the California bureaucracy and the political machinations of the Administration, the systemic improvement needed to pull California's prisons up to constitutional levels will not take place. The Receiver emphasizes the

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[3] *See* Department of General Services Management Memo 04-03, referenced in the *Order re State Contracts and Contract Payments Relating to Service Providers for CDCR Inmate/Patients* filed March 30, 2006.

following: systemic problems with contract processing are not primarily the fault of the employees of DCHCS, nor the employees of CDCR's Office of Business Services, nor the administrative and clinical staff in CDCR's thirty-three prisons who are attempting, under negative conditions, to deliver care to prisoner/patients. Rather, responsibility lies with the entrenched paralysis and dysfunction which exists at all levels of State government.

The Receiver has determined that his stewardship of the prisons' medical delivery calls for additional audits and an enhanced effort to manage the CDCR's medical care operations in a more fiscally sound manner. The steps he intends to take in that direction are set forth in the Conclusions to this report.

IV.

ESTABLISHING AN OFFICE OF THE RECEIVER

A. Introduction.

The process of establishing the Office of the Receiver continues. In that regard, the Receiver reports below concerning new staff, the status of the San Jose office, prison inspections, and communications with the public.

B. New Staff in the Office of the Receiver.

The Receiver appointed several new staff members to positions within the Office of the Receiver since the filing of his last report.

Anastasia Bartle is an Administrative Assistant in the Receiver's Sacramento office. Ms. Bartle has more than ten years combined experience in office administration and legal support services. Most recently, Ms. Bartle was the Administrative Assistant to the Director of the Kylee Lillich Charitable Giving Tree Corporation.

Dave Cameron is a financial consultant to the Receiver, providing accounting and other financial support services to the Office of the Receiver. Among Mr. Cameron's twenty years of financial and accounting experience, he spent 1994 to 1995 as the Chief Financial Officer of the Santa Valley Health and Hospital System (SCVHHS), and from 1988 to 1994 as the SCVHHS Assistant Director of Finance - Controller. Since that time, Mr. Cameron has been the Chief

Financial Officer and General Partner of Professional Club Management Inc. (1995-1999), and the Vice President - Finance and Treasurer of Club One (1999-2005). Mr. Cameron is currently the principal of his own investment company, Cameron Enterprises, LLC.

Kent Imai, M.D., is a medical consultant to the Receiver. Dr. Imai will be assisting the Receiver and the Chief Medical Officer with medical staff matters, medical protocols and standards, process redesign and metrics for access to primary care and system redesign for incident reporting. Dr. Imai has served in multiple leadership positions at the Santa Clara Valley Medical Center (SCVMC), including President of the Medical Staff and Chief of the Department of Medicine Primary Care Division. He remains Associate Chief of the Primary Care Division. Dr. Imai has been on the Stanford clinical faculty since 1975, rising to the rank of Clinical Professor of Medicine. In 1986, Dr. Imai led the creation of Valley Health Plan, an HMO for Santa Clara County employees, and since 1997 he has served as Medical Director of the plan. Since 2004, Dr. Imai has led the development of the SCVMC Cancer Center. Dr. Imai is a fellow in the American College of Physicians.

Kathy Page, R.N., is a nursing consultant to the Receiver. Ms. Page has been a private consultant specializing in correctional health system and emergency management plan review for the past six years. Since 1988, Ms. Page has also served as an auditor for the National Commission on Correctional Health Care, where she assesses adult and juvenile detention facilities' compliance with health service standards. From 1979 to 2000, Ms. Page was the Director of the Multnomah County Corrections Health Division. Ms. Page also served as a reservist in the U.S. Army Nurse Corps for 20 years, retiring at the rank of Colonel in 2004. Ms. Page's initial assignment is as a nurse consultant for the San Quentin Team.

Brett Uhler is a Staff Aide in the Receiver's San Jose Office. Mr. Uhler graduated last spring with a B.A. in Community Studies from the University of California, Santa Cruz. Mr. Uhler's studies focused on health care inequalities, particularly in Native American communities. Mr. Uhler will remain with Office of the Receiver for a limited period while he prepares for further studies in medicine and health policy.

C. The San Jose Office.

On August 1, 2006, the Receiver's Office opened its headquarters location in San Jose. The Receiver and most of his staff are now located in the San Jose office. Several members of the Receiver's staff (including Anastasia Bartle, Linda Buzzini, Lara Hasik and Joseph McGrath) are located in the Receiver's Sacramento office. The Receiver's Chief of Staff, John Hagar, maintains a San Francisco office. Contact information for these offices follow:

San Jose—Headquarters:

California Prison Health Care Receivership Corporation
1731 Technology Drive, Suite 700
San Jose, CA 95110
Phone: (408) 436-6800
Fax: (408) 453-3025

Sacramento:

California Prison Health Care Receivership Corporation
501 J Street, Suite 700
Sacramento, CA 95814
Phone: (916) 323-1221
Fax: (916) 323-1257

San Francisco:

California Prison Health Care Receivership Corporation
450 Golden Gate Avenue
Law Library, 18th Floor
San Francisco, CA 94102
(Phone and Fax) 415 522-4067

D. Communications With the Media and Public.

1. *Introduction.*

The Receiver continues to take proactive steps to ensure that CDCR employees, the prisoner/patients, and the public are informed of his activities and the scope of the remedial effort.

2. *Direct Communication to CDCR Employees and the Public.*

The Receiver circulated his third public letter on July 21, 2006. The Office of the Receiver also distributed press releases concerning his Initial Bi-Monthly Report and Motion to Waive State law relative to clinical salary increases.

3. *Inspections of Prison Operations.*

As stated in the Initial Bimonthly Report, the Receiver plans on visiting at least two prisons every month until he has visited each of the thirty-three adult institutions. To date, the Receiver has visited nine prisons. Since the Receiver's last report he visited Valley State Prison for Women (VSPW), Central California Women's Facility (CCWF), California Medical Facility (CMF), California State Prison, Solano (SOL), Correctional Training Facility (CTF) and Salinas Valley State Prison (SVSP). In September 2006, the Receiver plans to visit California State Prison, Corcoran (CSP-C) and California Substance Abuse Treatment Facility/State Prison (SATF). During each visit the Receiver has engaged in extensive discussions with clinical and correctional personnel.

4. *Media and Public Outreach.*

a. *Newspaper Editorial board meetings with Receiver*:

Vacaville Reporter - August 4, 2006 (for August 11editorial)

Sacramento Bee - August 15, 2006 (for August 20 editorial)

b. *Radio appearances*:

KPCC Radio Los Angeles Air Talk - July 5, 2006

"Insights" program, Capitol Public Radio Sacramento - July 7, 2006

KALW City Visions Radio SF - August 21, 2006

c. *Interviews*:

AP Newsmaker interview with Don Thompson - July 13, 2006

Sacramento Bee interview with columnist Dan Weintraub - July 17, 2006

KGO TV San Francisco, Channel 10 San Diego interview - August 14, 2006

d. *Public Appearances*:

State Controller Steve Westly Press Conference Re: Audit of Prison Medical Care System - August 2, 2006

Centerforce Annual Summit, San Francisco, Luncheon Plenary, September 11, 2006

5. *Editorials Concerning the Receivership*:

Hi-Desert Star - July 9, 2006

San Jose Mercury News - July 9, 2006

Tracy Press - July 9, 2006

Vacaville Reporter - July 9, 2006

ANG newspapers - July 12, 2006

Vacaville Reporter - July 28, 2006

Contra Costa Times - August 7, 2006

Vacaville Reporter - August 11, 2006

Fremont Argus - August 14, 2006

Sacramento Bee - August 20, 2006

6. *Examples of News Coverage*:

San Jose Mercury News July 13, 2006 (AP) re: Receiver Building

San Jose Mercury News July 6, 2006 (AP) re: Receiver's first court report

San Francisco Chronicle July 6, 2006 re: Receiver's first court report

Sacramento Bee July 18, 2006 re: Trained incapacity

Sacramento Bee July 20, 2006 re: San Quentin project

Sacramento Bee July 6, 2006 re: Receiver's first court report

Sacramento Bee July 5, 2006 (AP) re: Receiver's first court report

Riverside Press-Enterprise July 5, 2006 (AP) re: Receiver's first court report

Reuters News Service July 5, 2006 re: Receiver's first court report

Orange County Register July 27, 2006 re: Governor's visit and Receiver

Oakland Tribune July 6, 2006 re: Receiver's first court report

Modern Healthcare July 10, 2006 re: Receiver's first court report

Modern Healthcare July 06, 2006 re: Receiver's first court report

Marin Independent Journal July 7, 2006 re: San Quentin project

Los Angeles Times July 27, 2006 re: Maxor hearing

Los Angeles Times July 6, 2006 re: Receiver's first court report

Los Angeles Daily News July 6, 2006 (AP) re: Receiver's first court report

KESQ News Channel 3, July 5, 2006 re: Receiver's first court report

KCBS Radio July 5, 2006 re: Receiver's first court report

KPCC Radio Los Angeles Air Talk July 5, 2006 re: Receiver's first court report

KPFA Radio Oakland July 5, 2006 re: Receiver's first court report

KQED Radio San Francisco July 5, 2006 re: Receiver's first court report

KQED Radio San Francisco California Report July 6, 2006 re: Prison reform

KTVU Channel 2 Oakland July 5, 2006 re: Receiver's first court report

Inland Valley Daily Bulletin July 25, 2006 re: Prisons ailing medical system

Inland Valley Daily Bulletin July 14, 2006 re: CIM inmate complaint

Vacaville Reporter/ANG Newspapers July 7, 2006 re: Receiver's first report to court

Contra Costa Times July 14, 2006 (AP) re: Receiver recommends building hospitals

CBS 13/UPN 31 Sacramento TV News July 13, 2006 re: Receiver prison hospital

California Progress Report July 6, 2006 re: Receiver's first court report

Capitol Morning Report July 6, 2006 re: Receiver's first court report

San Diego Union Tribune July 6, 2006 (AP) Re: Receiver's first court report

California Progress Report July 31, 2006

California Progress Report July 26, 2006 re: Maxor hearing

Bakersfield Californian July 7, 2006 re: Prison overcrowding

ANG Newspapers July 27, 2006 re: Maxor hearing

American Chronicle July 31, 2006 Cayenne Bird column

ABC 7 News San Francisco July 5, 2006 re: Receiver's first court report

San Jose Mercury News August 18, 2006 (AP) Re: Special Session

San Jose Mercury News August 10, 2006 (AP) re: Aging inmate population

San Jose Mercury News August 3, 2006 re: State Controller audit

San Jose Mercury News August 2, 2006 (AP) re: Special Session

San Diego Union Tribune August 6, 2006 (Copley News Service)

San Diego Union Tribune August 2, 2006 (AP) re: State Controller audit

Sacramento Bee August 15, 2006 Re: re Special Session

Riverside Press-Enterprise August 15, 2006 re: Clinical trials for inmates

Orange County Register August 20, 2006 opinion column

Indy News August 14, 2006 re: Sara Jane Olson

Indy News August 13, 2006 re: Prison overcrowding and health care

Fresno Bee August 10, 2006 re: Special Session

Fremont Argus August 14, 2006 re: prison crisis worsening

Capitol Public Radio Sacramento Insights Program July 12, 2006 re: prison crisis

Contra Costa Times August 6, 2006 re: Special Session

California Progress Report August 2, 2006 re: State Controller audit

San Diego Union Tribune September 2, 2006 re: Special Session

San Jose Mercury News, September 13, 2006 editorial re: Salary increases

Oakland Tribune, September 13, 2006 re: Receiver seeks wage waiver

Sacramento Bee, September 13, 2006 re: Waiver on wages

KCBS Radio News San Francisco September 12, 2006, Receiver interview

7. *Prisoner/Patient Correspondence.*

The Receiver's office has completed implementation of its initial process for receiving and evaluating prisoner/patient complaints and correspondence. These complaints number approximately eighty letters per week, and are steadily increasing as prisoners become aware of the Receivership. The Inmate Patient Relations Manager reads, summarizes, logs, tracks, and forwards an initial response acknowledging every letter received. All patient letters are subject to clinical review by the Chief Medical Officer, who then makes a follow-up and priority determination.

To date, approximately twenty-percent of letters received were determined to warrant either further investigation (ranging from seeking the appeal records of the patient to ordering a chart review) or some form of timely clinical contact. Due to the steadily increasing volume of complaints about medical services, the complexity of certain cases, difficulty interpreting complaints, and the inherent problem of obtaining prompt and accurate information from an unconstitutional medical delivery system, the Office of the Receiver now faces a difficult decision. On the one hand, the Receiver should not serve as a surrogate for the untimely and inadequate CDCR appeal program. On the other hand, the Office of the Receiver cannot ignore totally individual patient complaints while focusing on systemic reform. Given this dilemma, the Receiver's program to respond to prisoner/patient complaints is under review. Modifying the system will be one of several priorities during the final quarter of 2006. *See* Conclusions below.

V.

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

On June 30, 2006, the Governor signed the 2006 Budget Act into law. *See* Exhibit 4, the Department of Finance letter dated July 27, 2006, which includes, as an attachment, the budget item for the Division of Correctional Health Care Services (DCHCS) and the Office of the Receiver (budget item 5225-002-001, hereafter referred to as "Budget Item"). The Budget Item appropriates approximately $1.5 billion for DCHCS, including CDCR administrative costs related to supporting DCHCS. The Budget Item also specifies that the $1.5 billion is subject to the control of the Receiver. As referenced in Section 1 of the Budget Item, "[t]he Director of Health Services is to administer this item to the extent directed by the receiver."

Among the $1.5 billion appropriated for health care services, "Schedule (5)" of the Budget Item appropriates an unallocated amount of $100 million for those activities of the Receiver not anticipated in the DCHCS budget. The Budget Item states that Schedule (5) is

> . . . for the purpose of funding costs for the Department of Corrections and Rehabilitation, including the operations of the Office of the California Prison Receivership, and any other state agency or department that is involved in the

> provision of health care to California inmates, including the costs of capital projects, resulting from actions by the receiver or the court in *Plata v. Schwarzenegger*.

See Budget Item, § 2. The Department of Finance has assured the Receiver that the funds in Schedule (5) are subject to the exclusive control of the Receiver and the Court, and will not be used as the State might see fit in response to actions by the Receiver. The Department of Finance, in its July 27, 2006 letter, states that:

> . . . the Director of Finance will not unilaterally transfer funds appropriated under Schedule (5) of this budget item. The transfer will occur only in response to specific directions of the Receiver or the court, and only for the purpose of funding costs resulting from actions by the Receiver or the court.

While it appears that the Budget Act provides the Receiver with sufficient *control* over the appropriated funds, it is not clear that the *amount* of appropriated funds will be sufficient. In anticipation of a shortfall of funds for prison medical services, the Receiver's Chief of Staff and Staff Attorney met, on July 28, 2006, with Mark Paxson, General Counsel Office of the State Treasurer, and Rick Chivaro, Chief Counsel, Office of the State Controller to discuss the Receiver's potential recommendation to the Court that the Court issue a writ of execution for the levy of additional State funds. Both Mr. Paxson and Mr. Chivaro expressed their offices' desire to work cooperatively with the Receiver, and further expressed their offices' willingness to honor a writ of execution for the levy of State funds issued by the Court. If the Receiver determines that funding, beyond what has been appropriated by the Legislature, is necessary to appropriately manage the prison medical system, the Receiver will, at that time, present a recommendation to the Court for the issuance of a writ of execution for the levy of additional State funds.

VI.

SUCCESSES ACHIEVED BY THE RECEIVER.

A. Fair and Adequate Compensation for Prison Health Care Personnel.

As noted in the First Bi-Monthly report, the Receiver finds that one of the most serious impediment to improving the delivery of medical care in California's prisons is the inadequate pay currently provided to the health care professionals who work within California's adult

institutions. Without permanent and better qualified clinical personnel the Receiver will be unable to develop and implement the remedial programs necessary to bring prison medical care up to constitutional levels. Without question, prison medical care reform begins with badly needed salary adjustments. Therefore, on September 12, 2006 the Receiver filed with the Court a Motion for Waiver of State Law in order to implement new salary ranges for physicians, mid-level practitioners, registered nurses, licensed vocation nurses, pharmacy employees and other professional positions. The Receiver has requested a September 1, 2006 effective date for these increases.

B. Contracting with Specialty Care and Other Out-of-Prison Providers.

1. *Introduction.*

Another of the most serious systemic impediments to bringing prison medical care up to constitutional standards is the collapse of the CDCR's health care services contract system. To summarize, because the State's system for contracting and paying specialty providers has become entirely dysfunctional, private clinicians who provide essential services to the thirty-three prisons on a contract basis began to refuse to treat prisoner/patients due to the failure to pay invoices dating back for several years.

2. *Background.*

On March 30, 2006 the Court filed its Order re State Contracts and Contract Payments Relating to Service Providers for CDCR Inmate/Patients ("Order re Contracts"), noting:

> another chilling example of the inability of the CDCR to competently perform the basic functions necessary to deliver constitutionally adequate medical health care. In this instance, the abdication not only threatens the health and lives of inmates but also has significant fiscal implications for the State.

Order re Contracts at 1:25-28.

As explained in the Order re Contracts, following findings by the California State Auditor of serious fiscal problems relating to CDCR contracts with outside clinical providers, the Department of General Services ("DGS") established a mandatory policy for obtaining competitive bids for all such contracts, absent certain special circumstances. The State,

however, proved incapable of implementing these new requirements. As found by the Court:

> Instead of approaching these new requirements proactively, the CDCR and the State's control agencies - the Department of Finance, the Department of Personnel, and the DGS - stuck their collective heads in the sand. The administrative processes required by the new DGS requirements are quite time-consuming and complex. Yet the CDCR and the State's control agencies failed to provide the staffing and training necessary to handle the newly heightened obligations and implement effective fiscal controls over the contracting process.

Order re Contracts at 2:27 to 3:6.

Effective April 17, 2006, the Receiver assumed responsibility for overseeing the State's compliance with the provisions of the Order re Contracts, including the Court's mandate (1) that "all current outstanding, valid, and CDCR-approved medical invoices" be paid within 60 days of March 30, 2006. To its credit, but only because of the Court's orders, the State paid outstanding invoices within 60 days in compliance with the Order re Contracts, an effort that demonstrated diligence, organization, appropriate monitoring, and improved coordination between the prisons and CDCR's Central Office.

3. *Development of Health Care Oriented Policies to Govern Contract Management.*

The Order re Contracts also requires that under the direction of the Receiver, the CDCR and State entities responsible for contracts develop and institute health care oriented policies and standards to govern the CDCR medical contract management system considering both the need for timely on-going care and the fiscal concerns of the State. As reported in the First Bi-Monthly Report, the State has addressed this challenge by establishing a Project Team. While primarily involving CDCR staff, the Team also consists of representatives from the State's control agencies.

The restructuring of the CDCR contract management process is monitored by the Receiver's Chief of Staff and Staff Attorney. To date the Project Team has developed modified conceptual bidding, procurement and payment processes that conform, in principle, to the standards mandated by the Receiver. *See* the July 26, 2006 Project Team Report, attached as

Exhibit 5. However, the CDCR has not adequately managed its contracts in the past. Instead, given poor planning, limited staffing, and the lack of information technology, the CDCR's prior efforts focused on procurement and payment only. Therefore, in August, the Project Team was instructed by the Office of the Receiver to develop necessary management elements of an adequate contract processing system. Thus far, the Team has moved forward with this new mandate in a timely and appropriate manner.

4. *The Receiver's Decision to Involve A Consulting Firm With the Contract Re-Structuring Process.*

The CDCR processes over 2,600 medical contracts annually. During Fiscal Year 2005-2006, contract expenditures exceeded $408 million. *See* July 6, 2006, Project Team Report (Exhibit 5) at page 6. Developing a process to manage this staggering number of contracts presents a challenge which will benefit from expert assistance. To assist the State's Project Team, the Receiver made the decision to engage a management consulting firm to assist in the design of an organization structure which establishes the appropriate management controls and eliminates redundancy concerning the contract procurement, management, and accounting process.[4] The Receiver anticipates that this project will be completed by December 2006, at which time the new contract process and new contract administrative unit will begin to function on a pilot basis at four CDCR prisons.

5. *Adequate Health Care Contract Management Requires Information Technology Support.*

In the Order Re Contracts, the Court directed the Project Team, among other requirements, to consider "[e]stablishing an information technology sub-group to evaluate and report on the purchase of a computerized state-wide data base to manage all CDCR medical

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[4] The ability to select and put into place on short notice a consulting contract for the Project Team is an example of why the Receivership is necessary to correct the systemic problems which plague the State's effort to provide adequate medical services in its prisons. Under normal State processing rules, acquiring and funding a consulting contract would have required a Budget Change Proposal ("BCP"), Legislative approval, and the engagement of the State bidding process. Absent assistance by the Office of the Receiver, the process would have taken more than one year.

contracts." *See, Order Re State Contracts* at pg. 6. At the Receiver's direction, the Project Team began to re-structure the contact process with the assumption that additional information technology resources would not be available prior to the "start date" of the new system. As design went forward, however, the Project Team found that the current and complex *paper* based system contributed to contract process delays and irregularities. The Project Team concluded that improvements to the medical contracting system could not reasonably be accomplished without replacing the existing paper based system with an electronic system. *See* July 26, 2006, Project Team Report, pgs. 12, 14, 16 (Exhibit 5). The Receiver concurred with this conclusion and thereafter directed the IT subgroup to proceed with recommending a specific IT system.

Thereafter the Project Team formed such a sub-group, led by CDCR Assistant Secretary Jamie Mangrum to evaluate information technology alternatives. The subgroup has worked diligently toward developing the necessary system, as described below, and has reported its progress to the Project Team and the Receiver's staff every two weeks. Following an evaluation of several potential systems, the IT subgroup, on August 11, 2006, presented a recommended system to the Project Team and the Receiver's staff. Both the Project Team and the Receiver subsequently endorsed the recommended system.

On September 7, 2006, the Receiver issued a Request for Proposal (RFP) for a "System Integrator" to implement the recommended system (Exhibit 6). The contract is being bid and executed by the California Prison Health Care Receivership Corporation (the Receiver's corporate entity), as the State was unable to issue an RFP in the timeframe required by the Receiver.[5]

The Receiver notes that while the State's bureaucracy may make it otherwise unable to respond quickly to the crisis in the prisons (*e.g.*, bid a contract in an appropriate timeframe), certain individuals have been exceptionally cooperative in developing the medical contract IT

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[5] The Project Team estimated that sixteen to twenty-four months were required to obtain approval for the computer system through normal State process, assuming that the requisite funding would be approved by the Legislature. For this reason, the Receiver decided to fund the needed program directly from CPR.

system. The IT subgroup, and in particular Jamie Mangrum, should be commended for their timely and thorough development of the recommended IT system and for the preparation of the statement of work included in the Receiver's RFP. At this point the Receiver anticipates that the IT system project will begin the first week of October 2006 and will be implemented at four pilot sites by December 2006.

C. Pharmacy.

1. *Introduction.*

As explained in the Receiver's First Bi-Monthly Report:

> Even prior to the Receiver's appointment, the Court, at the Receiver's request, took action concerning the pharmacy crisis in California's prisons. The Receiver initiated this action primarily because of concern about patient services; however, it quickly became apparent that the California prison pharmacy system, or more accurately the lack of any system, was also entirely ineffective concerning the contracting, procurement, distribution, and inventory control of necessary patient medications, including controlled substances. Given the massive size of the CDCR pharmacy operation, the lack of centralized controls, the lack of an effective audit program in prisons, and the inherent potential for fraud and theft which exists in the correctional environment, the Receiver made the decision to obtain a timely and independent evaluation of CDCR pharmacy services.

The Receiver retained Maxor, a Texas Corporation with extensive experience in correctional pharmacy management for an up-to-date audit of California's prison pharmacy services. In its comprehensive examination of prison pharmacy services, Maxor reviewed all prior audits, conducted on-site inspections of six California prisons, and initiated its own analysis of pharmacy fiscal controls, examining procurement, inventory control, and distribution and thereafter submitted to the Receiver a written analysis which was attached as Exhibit 1 to the Receiver's initial report. In essence, Maxor confirmed all of the pharmacy deficiencies detailed in prior State audits, including the waste of millions of dollars annually.

2. *The Hearing of July 26, 2006.*

Maxor's audit, titled *An Analysis of the Crisis in the California Prison Pharmacy System Including a Road Map from Despair to Excellence* ("Maxor Audit"), was presented to the Court in a hearing on July 26, 2006. At the hearing, Maxor's representatives testified regarding

existing deficiencies in CDCR's pharmacy system and presented a proposed "Road Map," designed to guide the Receiver in developing a constitutionally adequate pharmacy services delivery system. The primary focus of the Road Map, as explained at the hearing, is implementing a sustainable, patient-centered, and outcome-driven pharmacy process, with the goal of creating a *CDCR* managed and operated "best practice" pharmacy system within three years. At the conclusion of Maxor's testimony, the Receiver set forth his concerns about the existing CDCR pharmacy system to the Court. To summarize, the Receiver finds there is neither adequate central CDCR management of pharmacy services, nor adequate policies and controls concerning pharmacy purchases, management, and distribution. Therefore, the Receiver concluded that a private management firm is needed to control the top level of prison pharmacy services, with the day-to-day operations in the prisons provided by adequately trained and appropriately compensated State pharmacists. Therefore, the Receiver announced a plan to engage a pharmacy management firm to implement the Road Map at the hearing. Plaintiffs, defendants, and the Court approved the Receiver's plan.

3. *The Request for Proposal Concerning Road Map Implementation.*

On August 2, 2006, the Receiver's Chief of Staff and Staff Attorney conducted a phone conference with representatives of DGS to offer the State the opportunity to issue an RFP for the implementation of the Road Map within the following weeks. The State declined the offer, citing its own legal barriers and the difficulty it would face in meeting the Receiver's expedited timeframe. Thus, the Office of the Receiver produced the RFP, issuing it on August 18, 2006 (Exhibit 7). California Prison Receivership will also execute the contract. The RFP responses are due from bidders on September 18, 2006, and the Receiver anticipates awarding the contract in early October 2006. Again, the Receiver's RFP process, approximately two months compared to an approximate sixteen to twenty-four month State process, is another illustration of how the Receiver is able to act quickly and appropriately to address the prison heath care crisis under circumstances where the State is unable to respond in a timely and decisive manner.

D. Provisions for Adequate Medical Supplies and Equipment for Patient Care and Support in California Prisons.

1. *Introduction.*

As explained above, the Receiver has now conducted numerous inspections of prisons, including areas within the prisons that provide health services. In the course of those inspections he interviewed dozens of medical providers and correctional officials. It is apparent from these discussions, and from his staff's evaluation of CDCR Headquarter's policies and operations, that there exists a lack of procurement planning; supply and equipment specifications and requirements; procurement processes; and staffing and training concerning the CDCR's ordering and management of supplies and equipment. In addition, there exists the utter failure of inventory management and a disconnect between the health care needs for supplies and equipment and the corrections-oriented organization responsible for procuring them. Consequently, the Receiver has determined that one of the next priorities which needs to be addressed to bring the prison medical care system up to constitutional levels is a project that addresses medical supplies and equipment.

2. *The Need for Expert Consulting Services.*

There are numerous reasons why clinicians at the prisons are unable to order and receive medical supplies and equipment in a timely manner. Prison personnel blame the "Central Office;" Health Care officials at CDCR Headquarters blame the control agencies; and the control agencies criticize the CDCR's lack of policies, controls, and leadership.

Given this circle of blame, the Receiver made the decision to engage an outside consulting firm to assist in the design and implementation of a new medical supply and equipment procurement system. The consultants will address such issues as planning, forecasting, strategic sourcing and contracting, payment processing, and warehousing.

A presentation which provided an overview of the proposed consulting process was made to the Directors of the Departments of General Services and Finance, the Secretary of Corrections, and Chief Operating Officer from the State Controllers Office on Friday, August 25,

2006 . The Receiver anticipates finalizing this contract within the next 45 days. The project will begin no later than December 2006.

VII.

ACCOUNTING OF EXPENDITURES FOR THE REPORTING PERIOD.

A. Revenues.

The State currently funds the expenses of the Office of the Receiver through Schedule (5) of the CDCR, Correctional Health Care Services Division Budget, as described in section V.(A.) above. On August 11, 2006, the Receiver requested a transfer from Schedule (5) of $1.2 million to cover expenses for the first quarter of Fiscal Year 2006-2007. *See* Exhibit 8. The Receiver also requested that the State establish a routine, quarterly mechanism for replenishing the operating fund of the Office of the Receiver. The State provided a timely transfer of the $1.2 million to the Office of the Receiver, and the Department of Finance and the CDCR have been working cooperatively with the Office of the Receiver to formalize a routine process for the transfer of funds from Schedule (5).

B. Expenses.

The total operating and capital expenses of the Office of the Receiver for the months of July and August, 2006, equaled $728,279.00. A balance sheet and statement of expenses is attached as Exhibit 9.

VIII.

OTHER MATTERS DEEMED APPROPRIATE FOR JUDICIAL REVIEW.

A. The July 2006 San Quentin Project.

1. *Introduction.*

On July 5, 2006 the Office of the Receiver commenced a prison specific corrective action project to improve the medical services provided at San Quentin State Prison. The Project addressed the following elements of prison medical care delivery:

1. Reception Standards and Compliance

2. Outpatient Housing Unit (OHU)

3. Equipment (this element is now titled "Supplies and Equipment")

4. Medical Records (this element is now titled "Health Records")

5. Specialty Services

6. Laboratory (this element is now titled "Laboratory Services")

7. Diagnostic Imaging

8. Patient Complaints/Grievance Process (this element is now titled "Patient Advocacy Process")

9. Clinical Space

10. Facility Maintenance

11. IT, Communications and Power (this element was added to the Project, as explained below)

12. Sanitation/Janitorial

13. Custody & Clinical Relations

14. Organizational Structure

15. Staffing

16. Salaries

17. Internal and External Communications (this element was added to the Project, as explained below)

18. Evaluate *Plata* Remedial Plan Requirements

2. *Project Purpose.*

The purpose of the San Quentin Project is to prepare the Office of the Receiver for the daunting task of restructuring the massive California prison medical delivery system into a constitutionally adequate system. The preparation involves two distinct challenges. First, the Project has begun to deliver timely, necessary relief in the clinical trenches by improving the day-to-day conditions encountered by prisoner/patients and clinical personnel. Second, the Office of the Receiver is utilizing the Project to gain insight and experience concerning the most effective manner to address systemic problems (including, for example, conducting evaluations of how the State's business practices, laws, regulations, and policies serve to inhibit the remedial action that is necessary to bring the San Quentin medical delivery system up to constitutional standards).

3. *Project Status.*

Before providing the Court with an initial appraisal of the Project, the Receiver sets forth below a summary of the status of each Project element. The Project is tracked by the Project Team utilizing a San Quentin Project Task List which is updated no less than once per week.

a. Reception Standards and Compliance

The processes for the San Quentin reception center have been evaluated, the location for conducting physicals was re-located from the first to the third floor of the Neumiller Building for improved privacy and planning has commenced for the construction of a new reception building (selected Team members have begun inspecting the reception and release centers used by large detention systems other than the CDCR). In addition, a project has begun to establish appropriate standards and policies concerning the circumstances under which medical escorts will accompany inmates during transfers. The remedial process for this element of the Program is not, however, at the stage the Team had anticipated it would be for two reasons:

1. Even with the support provided by the Receiver's Team, there are very few individuals at San Quentin with the management skill and energy capable of managing the necessary remedial corrections needed to bring San Quentin's medical services up to constitutional standards. Because the few skilled individuals (for example Chief Medical Officer Karen Saylor and Director of Nursing Jane Robinson) are also charged with managing the prison's day-to-day health care delivery, they have been diverted, throughout the Project period, to correct crisis situations (for example, the failure to provide timely speciality care as explained below).

2. Under current conditions the Reception process at San Quentin may be impossible to manage because of two factors: (a) inadequate space and facilities for receiving, screening, and examining prisoner/patients in a timely manner and the (b) unpredictable and at times excessive flow of newly sentenced prisoners arriving at San Quentin.

The Receiver is in the process of correcting the first problem by retaining additional experienced correctional health care personnel to assign on a temporary basis to San Quentin. He will correct the second issue by working with the CDCR to establish a capacity limit on the

number of newly sentenced prisoners who will be received by San Quentin, as explained in the Conclusions below.

b. Outpatient Housing Unit (OHU)

The San Quentin OHU is an aged cellblock in the Neumiller Building which houses prisoner/patients who require a level of medical and mental health care that cannot be provided in the general population. It is not, however, a licensed treatment facility; for example it is not licensed to provide a level of care similar to that provided in a Correctional Treatment Center ("CTC"). A preliminary assessment of the problems of the OHU has been completed. A new patient-oriented primary care provider/registered nurse treatment program has been implemented throughout San Quentin, including the OHU. At the same time, a mentoring program by physicians from University of California at San Francisco has begun. OHU admission criteria, including the criteria for not admitting a patient to the OHU and referring him to a local hospital, has been determined, as well as a program for appropriate staff coverage and post assignments.

However, the programs mentioned above have not yet been formalized in policies and procedures because the few competent managers running San Quentin's medical delivery system do not have time to be relieved from their day-to-day responsibilities. In other words, while significant changes and improvements to OHU care have began, these changes are not yet documented and work flow processes have not been formalized.

The OHU element of the Project provides an illustrative example of the complex nature of the remedial effort that will be required from the San Quentin Team. The problems with the delivery of medical care at San Quentin are not the result of a single or even a combination of two or three factors. In reality, everything that can be broken is in fact defective. For example, the following problems work together to adversely impact OHU operations:

A. Inadequate, aged, poorly maintained structure.

B. Non-existent policies and procedures.

C. Inadequate staffing levels.

D. No clearly defined work flow processes.

E. Lack of supervision for registered nurses.

F. Unskilled/inadequately trained primary care providers and registered nurses.

G. Tensions between health care and custody personnel.

H. Conflicts between patient treatment requirements for *Coleman* (mental health) and *Plata* (medical health) relating to staff coverage, nursing responsibilities, and medication dispensation.

I. A systemic shortfall in correctional treatment beds creating situations where OHU inmates who should be housed at other prisons remain too long at San Quentin.

The Team has made progress toward correcting problems B through H (indeed, steps have been taken to clean up the OHU and the inappropriate cell doors in the OHU are now in the process of being replaced). However the seriousness and number of inter-related problems, combined with a culture of neglect as well as decades of bad habits, has rendered the Project's remedial process slower and more difficult than anticipated.

For example, an appropriate remedial plan relative to OHU nursing requires the following: new forms of supervision, establishing expected standards, clarifying day-to-day work processes, clarifying the relationship between nurses and primary care providers, clarifying the relationship between nurses and correctional staff, formalizing and documenting the new work processes, formalizing and establishing new policies and procedures,[6] and developing outcome related metrics and the appropriate follow-up procedures. At this point, the necessary changes are slowly being put into place, however, documentation is non-existent and the culture still resistant.

c. Supplies and Equipment

Significant positive progress has been made concerning medical supplies at San Quentin. An assessment of supply and equipment problem was completed, and a Quality Improvement Team ("QIT") facilitated by the Receiver's Team led to an improved, simplified, and more

[6] The Receiver is engaging a consulting firm to assist San Quentin clinical managers with the preparation of work process charts and formalized policies and procedures.

timely method of ordering and receiving supplies.[7] In practice, access to supplies at San Quentin has improved in many important ways.

Again, however, the Team discovered a wealth of inter-related problems that work together to inhibit the cost-effective and orderly acquisition of necessary supplies. For example, shortly after the Project began the Team discovered that San Quentin had been unable to hire warehouse personnel and supervisors for several *years*. The primary reason for this was a combination of State bureaucracy and mis-management by the CDCR's Support Services Personnel Division. Prior to the beginning of the Project, warehouse candidates were selected by a CDCR created "list" of candidates. However that was not resulting in candidates for San Quentin's vacancies and CDCR Headquarters had not "delegated" testing to San Quentin so that the prison could address its own needs. Also, because of the chronic warehouse personnel shortages, no one at San Quentin was knowledgeable about State Logistics and Materials Management System ("SLAMMS"), the CDCR's somewhat aged warehouse computer inventory system. The Team also discovered that medical supplies were being maintained (without adequate controls) in eight different locations at the prison.

Thus to begin to fix the system the Team first had to instruct CDCR Support Services to delegate warehouse personnel testing to San Quentin so the prison could arrange for local testing and local interviews of applicants. Only after this process was completed, could the processes that will create an adequate supply system at San Quentin begin. In addition, the Team arranged for warehouse training and assistance from Pelican Bay State Prison, one of only a few CDCR institutions which maintains a separate warehouse for medical supplies.

At this point in time the Team, working with some responsive San Quentin personnel, has developed what appears to be an appropriate system to order and maintain supplies. The new system, however, is not yet fully operational in terms of day-to-day practice. Not surprisingly,

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[7] The QIT process involves a facilitator gathering and working with the different professions and employees who, together, are responsible for a particular work function. The purpose of a QIT is to foster understanding and coordination of duty statements, task, problems and better methods of improving work functions.

the full implementation of the new system has been thwarted, to some degree, by the following factors: (1) the need for a warehouse supervisor,[8] (2) the need for a centralized and adequate medical supply warehouse,[9] (3) the need for an adequate supply information technology system to manage inventory; and (4) a culture resulting from years of supply neglect whereby clinical staff (who do not believe the new system will be sustained) continue to order and hoard supplies which were difficult to obtain in the past.

The Team has also examined San Quentin's problems obtaining equipment, and made the determination that given existing structural, power, and computer line problems, remedial projects concerning equipment should be deferred until temporary medical facilities are constructed, as described in section 9 below.

d. Health Records.

Good progress has also been made concerning improving access and control over San Quentin health records. Additional supervision and technical positions have been developed, the first level supervision of the medical records unit has been enhanced, and additional staffing provided. As a result, certain of the unit's chronic problems have been corrected. For example "loose filing" was up to date by early September; the unit is more secure; and medical records staff are available to deliver and pick up health records; and a very fundamental project of auditing medical records has begun.

The Project's purpose is not to fix the health record system at San Quentin. In fact, the Team has discovered that despite hard work and well intentioned efforts by health records personnel, there is a serious lack of technical knowledge concerning the appropriate health records policies, procedures, audit requirements, etc. This shortfall of knowledge is difficult to correct given the lack of resources and technical knowledge in other CDCR facilities and the Central Office. Therefore, the Team is in the process of assessing what sort of technical

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[8] Interviews for this position were taking place the week of September 11, 2006.

[9] The Team is planning to erect a temporary medical supply warehouse in the next ninety days.

assistance will have the most impact on improving the underlying quality of the health records at San Quentin. The Receiver notes that the remedial effort concerning this problem is also aggravated by the long-standing failure on the part of CDCR to conduct a planned systemwide health record assessment and corrective action process.

e. Specialty Services

San Quentin's inability to deliver adequate speciality services provides yet another example of how a wide range of serious and inter-related problems work in conjunction to create unconstitutional medical care that will prove very resistant to corrective action. Within weeks after the Project began, an evaluation of specialty services at the prison had been completed and a QIT was established to improve the process of special care services outside the institution. That process, however, uncovered hundreds of speciality care referrals that, in some instances, had languished for months without action. Summaries of a small sample of these cases are set forth below. The patient's names are not provided for privacy reasons.

Sample of Cardiology Cases:

Case No. 11 involves is a 62 year old man with multiple chronic illnesses, including high blood pressure, high cholesterol, peripheral vascular disease, emphysema, and gastroesophageal reflux disease. His most pressing problem is his coronary artery disease. He complained of substernal chest pain with exertion for several years. A request for urgent cardiology consultation was submitted in December 2005. This request was approved in May 2006, at which time he underwent a stress test that demonstrated significant coronary artery disease. Cardiology follow-up with probable cardiac catheterization was recommended. However, the follow-up was not done. After the Team discovered his case a request for urgent cardiac consultation and angiography was submitted on August 23, 2006.

Case No. 13 involves a 64 year old man with multiple chronic illnesses, including high blood pressure, diabetes mellitus type 2, coronary artery disease, ischemic cardiomyopathy and gastroesophageal reflux disease. He has a history of coronary artery disease and per his recollection, had quadruple bypass surgery in the 1980s. In June 2005 this patient was referred to

cardiology and eventually underwent a myocardial perfusion study in December 2005 that demonstrated severe ischemic cardiomyopathy with possible mild anteroapical and inferolateral ischemia. There is no documentation of further evaluation or treatment for his coronary artery disease until a recent hospitalization. He has been seen several times in clinic since December, 2005 and has complained of persistent chest pain. Urgent referrals for cardiology were submitted on June 23, 2006 and August 10, 2006. The referral from August 10, 2006 was discovered and reviewed on August 15, 2006, and the patient was immediately sent to Marin General Hospital for evaluation. He underwent coronary angiography and had emergent stenting to treat severe coronary artery obstruction.

Case No. 24 involves a 68 year-old man with multiple chronic illnesses, including high blood pressure, high cholesterol, obesity, sleep apnea, chronic kidney disease, and coronary artery disease. He was referred to cardiology in April 2005 for treadmill testing, and ultimately cardiac catheterization and angioplasty. He then paroled. He returned to San Quentin because of a parole violation in June 2006, complaining of stable angina since his angioplasty. After discovery of his file, a referral to cardiology was completed for evaluation of his chest pain and the patient was seen by cardiology on August 10, 2006. Cardiology recommended treadmill stress testing if chest pain worsens or becomes more frequent.

Case No. 26 involves a 41 year-old man who had recurrent signs and symptoms of unstable angina and acute cardiac ischemia in July 2006, which was not appropriately managed until his fourth evaluation in the Triage and Treatment Area. He underwent emergent cardiac catheterization and placement of three coronary artery stents on July 20, 2006. Follow-ups, however, were not completed. After discovery of his file he had a cardiology consultation and stress echocardiogram at Doctors Medical Center of San Pablo on August 17, 2006.

Case No. 30 involves a 59 year-old man who had a porcine aortic value replacement in 2005, secondary to endocarditis related to intravenous drug use. The patient was initially scheduled for a cardiology consult on November 15, 2005, which did not occur until his case was discovered and he was referred for the consult on August 10, 2006.

Case No. 32 involves a 55 year-old man who has multiple chronic conditions including emphysema, diabetes, renal insufficiency, sleep apnea, coronary artery disease, and congestive heart failure who has refused multiple high risk appointments. After his case was discovered, the patient was scheduled for a cardiology consult in late September 2006.

Case No. 36 involves a 66 year-old man with a medical history of hypertension, hyperlipidemia, and coronary artery disease (CAD) who is status- post myocardial infarction and carotid endarterectomy. He went to sick call on April 17, 2006, complaining of chest pain that awoke him from sleep. At that time, he had an EKG that was consistent with acute coronary syndrome. The decision was made not to send the patient offsite for further evaluation. A subsequent troponin was positive, but the test results did not arrive at San Quentin until several weeks later. Thereafter, a stress test was ordered as "urgent" one week after his original complaint, when a high- risk physician finally saw him. At that time, he was no longer complaining of chest pain. The high-risk physician titrated his medications and the patient had no further episodes of chest pain. The case was reviewed by the Team in early August and a stress test was completed on August 15, 2006, which showed a good ejection fraction but fixed wall motion abnormalities consistent with a previous myocardial infarction.

Sample of Cases Involving Dermatology/Plastic Surgery:

Case No. 1 involves a 37 year-old man with a history of multiple basal cell cancers. The primary care provider made a referral for a dermatology consult and biopsy on June 21, 2006. However, the referral had not taken place when the case was found in August 2006. The patient was seen by a plastic surgeon at Doctors Medical Center on August 21, 2006. That same day, the surgeon performed an excisional biopsy, which showed basal cell cancer with clear margins.

Case No. 6 involves a 27 year-old man who presented to the TTA on June 29, 2006 complaining of a painful, inflamed mole on his left buttock. He was evaluated by the primary care provider on July 20, 2006 who requested an urgent dermatology consult and biopsy because of possible malignant melanoma. His file was discovered in early August and he was seen on August 16, 2006 by a plastic surgeon at Doctors Medical Center in San Pablo who performed an

excisional biopsy on August 21, 2006.

Sample of Oncology Cases:

Case No. 1 involves a 50 year-old man with multiple chronic illnesses including diabetes mellitus type 2, high blood pressure, elevated cholesterol and triglycerides, glaucoma, chronic kidney disease, and possible chronic lymphocytic leukemia (CLL). He has been followed in the high-risk clinic and was first noted to have an elevated white blood count upon his arrival at San Quentin in February 2002. He was seen by the hematologist in April 2002 and given the diagnosis of CLL. He has been followed with complete white blood counts, but he had not had a complete work up to confirm the diagnosis. He has had intermittent hematology follow-up. A referral for hematology consultation was submitted in March 2006 and the patient was apparently seen again by a physician in April 2006. A flow cytometry test was completed in August after the file was discovered by the Team. Complete interpretation of flow cytometry will be performed by hematology at a schedule follow-up visit.

Case No. 2 involves a 60 year-old man who has had a lip ulcer since 2004 and was diagnosed with squamous cell cancer of the lip in 2005. Since 2005, the patient has had a difficult time with the diagnosis and treatment and has refused to see his previous surgeon. Since August 2005, medical providers have requested five different referrals for treatment, which the patient has refused or have not been scheduled. On July 26, 2006, the patient agreed to be evaluated by an oncologist. After the patient's medical file was reviewed, an urgent referral request was completed and the oncologist evaluated the patient on August 9, 2006. After discussion with the oncologist on August 9, 2006 and a physician from University of California, San Francisco on August 30, 2006, the patient is more amenable to treatment.

Case No. 3 involves a 44 year-old man with hypertension, dyslipidemia, renal insufficiency, anemia, a history of an ankle fracture who a monoclonal gammopathy which may progress to multiple myeloma who was evaluated by the oncologist on August 29, 2006.

Case No. 4 involves a 59 year-old man with a long history of coronary artery disease, hypertension and emphysema who was evaluated for chest pain at Marin Hospital on June 7,

2006. During that admission, the patient was noted to have an abnormal chest radiograph and an abnormal CT scan, which showed a mediastinal mass. The patient underwent a biopsy in June 2006, which showed a sarcoma. He was referred for an urgent PET scan on August 4, 2006 to evaluate the presence of metastases. After discovery, the PET was completed on August 22, 2006. In addition to evaluation and management of the sarcoma, the patient underwent coronary angiography and placement of two stents in his left anterior descending artery on June 28, 2006.

Sample of Cases Involving Radiation/Oncology

Case No. 1involves a 45 year-old man recently diagnosed with prostate cancer who arrived at San Quentin in late May 2006. He saw a primary care provider on June 9, 2006 and the Urologist on July 28, 2006. The urologist requested an urgent referral to Radiation Oncology to begin treatment. He was seen by the Oncologist on August 1, 2006 and is awaiting treatment for his cancer.

Case No. 3 involves a 65 year-old man with a history of increasing left shoulder pain which was noted during sick call visits in March and April 2006. The patient had a MRI of the left shoulder on May 1, 2006, which showed a left lung mass. He was referred to the oncologist and underwent a biopsy that showed small cell cancer. Subsequent staging procedures including an MRI scan of the brain revealed metastases. In late August 2006, the patient completed chemotherapy and radiation treatments. He is now being evaluated for hospice care.

Sample of Surgery Cases:

Case No. 1 involves a 39 year-old man with a left inguinal hernia, complicated by occasional incarceration, requiring urgent reduction. The surgeon repaired the hernia on August 18, 2006. The patient tolerated the surgery well and has seen his primary care physician.

Sample of Gastroenterology Cases:

Case No. 4 involves a 52 year-old man with recurrent peri-rectal abscesses since November 2005. He was evaluated by surgery on June 29, 3006 and referred for an urgent Gastroenterology consult and colonscopy to rule out a rectal fistula. After the file was discovered a gastroenterologist evaluated the patient on August 25, 2006 and has recommended

that a colonoscopy be performed, which is being scheduled.

Case No. 11 involves a 58 year-old man infected with Hepatitis C who now has a markedly elevated alpha-feto protein level, which is consistent with hepatocellular carcinoma (liver cancer). After three different referrals to the gastroenterologist, the patient's file was discovered by members of the Project Team and he was finally evaluated on August 29, 2006. In addition, he is undergoing a CT scan and may need a surgery consultation.

Case No. 21 involves a 51 year-old man with liver cirrhosis and esophageal varices. Since December 2005, there have been at least four referrals for gastroenterology consultation and possible endoscopy which were never scheduled. His file was discovered by the Team in August 2006 and the gastroenterologist at Doctors Medical Center Hospital finally evaluated the patient on August 11, 2006. The consultant performed urgent endoscopy with four variceal bandings, which will decrease his risk of esophageal bleeding.

Case No. 32 involves a 52 year-old who was urgently referred in February 2006 to a gastroenterologist for an evaluation of bloody stools. When he was finally evaluated four months later on June 1, 2006, the gastroenterologist recommended an upper endoscopy and colonoscopy. An urgent referral for a colonoscopy and upper endoscopy were ordered on July 6, 2006. After review by the Team the upper endoscopy was performed August 15, 2006, which showed a duodenal ulcer. In addition, the patient has a history of acute coronary syndrome and myocardial infarction requiring an angioplasty and placement of two stents in June 2006.

To summarize, instead of any form of rational process to provide speciality care for San Quentin patients, the Team discovered a "non-system" best characterized as chaos. Concerning access to speciality care, everything possible that could go wrong was going wrong at full speed prior to the start of the Project. The following inter-related problems contributed to the inability of the prison to arrange for timely and appropriate speciality care:

1. Poor performance by San Quentin's primary care providers, including both the over-use of speciality referrals and the failure to follow-up concerning the referrals made.

2. Inadequate utilization management concerning speciality care referrals.

3. Poor training and poor performance by the administrative staff responsible for speciality care referrals and follow-up.

4. The failure by the CDCR to pay private speciality providers (as explained above), resulting in a increasingly limited pool of specialist willing to work for or at San Quentin.

5. Inadequate facilities to provide speciality care at the prison.

6. The lack of vehicles and correctional officer escorts to facilitate the number of outside speciality care visits that are necessary.

7. Poor coordination and the lack of effective policies and procedures that govern the relationships, roles and responsibilities, and duties of clinical and correctional personnel concerning the planning and facilitation of outside speciality care appointments.

8. The lack of an adequate information system to track the status of patient care, aggravated by the prison's failure to develop even the most rudimentary paper controls, a situation that is complicated by the use of a primitive computerized tracking system which because of either programming errors or inappropriate input process continues to "lose" patients with chronic diseases.

9. The CDCR's failure, over many years, to develop fair and cost-effective relationships with hospitals close to San Quentin.

The Receiver notes, however, that the response to the speciality care crisis discovered in August 2006 on the part of both clinical and correctional staff at San Quentin was professional, timely, and in some cases probably life saving. Working closely together and assisted by clinical and correctional experts on the Project Team, San Quentin officials developed and then implemented several weeks of special transportation services to outside speciality providers which, by and large, addressed the needs of the most critical of the urgent care patients awaiting speciality care. Unfortunately, several dozen additional problem cases were discovered (after being lost on the prison's primitive database) the week of September 11, 2006. The Receiver's Team will oversee another emergency effort to refer critical patients during the week of September 18, 2006.

In addition, progress has been made concerning a plan to assign a team of officers to be responsible for providing medical escorts; a QIT concerning the streamlining and coordination of out of prison speciality care is making slow but steady progress; a revised utilization management/review process is proceeding forward with improved results; efforts to establish more positive relationships with speciality providers are underway; and perhaps most important, the primary care provider model of treatment for San Quentin prisoner/patients has been implemented and is being monitored by primary care providers from UCSF. Again, however, finalization of these projects, the documentation of work flow processes, and revised policies and procedures are necessary, these projects, however, strain the existing resources at the prison.

f. Laboratory Services

Laboratory services at San Quentin have improved since the inception of the Project. Vacancies have been filled with contract staff, the backlog of delayed cases has been eliminated, new standards for timeliness imposed (and, for the most part complied with), and plans have been implemented for access to computers. Programs to improve ducating, to reduce "no shows" and ensure better compliance with pre-lab instructions are, however, behind schedule because of other priorities on the part of the Health Care Manager and other key San Quentin personnel.

In summary, the laboratory element of the Project has been successful in terms of providing an immediate fix to what was a serious backlog. However, a long term, more thorough re-building of laboratory services is still needed, including Project goals such as service compliance measurements, improved processing, evaluation of long term staffing needs, and development of a QIT to address prison-wide coordination issues.

g. Diagnostic Imaging

The diagnostic imaging services at San Quentin were in a state of meltdown in July 2006. To provide some background, for many years inmates (trained and licensed years prior) have provided diagnostic imaging services at the prison under the supervision of a licensed State technician. For a number of reasons the decision was made during the Spring of 2006 to remove these inmates from their job positions. The State technician responsible for diagnostic imaging

thereafter failed to manage the process appropriately. As a result, an inspection by plaintiffs' counsel uncovered a very serious backlog of work which had gone unreported by the technician and her supervisor.

Yet again, the problems with diagnostic imaging are indicative of the scope and wide range of combined problems, many systemic, which have rendered quick fixes impossible to implement. For example, in addition to poor work performance and inadequate supervision, the diagnostic imaging equipment at San Quentin is not adequate. Furthermore, the old procedure called for the images to be sent out of the prison to be "read." Thereafter, the readings were returned to San Quentin in the form of tapes to be transcribed. However, for various reasons the transcription unit has not provided timely transcription services. When the Health Care Manager attempted to secure a contract with a transcription company to transcribe the tapes of long delayed casework, she was informed by CDCR Headquarters that the contract would have to be bid, a process that would take several months to effectuate.

With assistance by the Office of the Receiver, and through hard work and special efforts by San Quentin officials and CDCR Headquarters personnel, special contracts have been obtained and a make-shift emergency diagnostic imaging system is now in place at the prison whereby necessary testing is conducted in a timely manner. The emergency repair, however, is only a temporary fix. The team has concluded that due to a relatively low volume of referral and the need for more timely responses, contracting our the diagnostic image process should be considered. A consultant has been retained to advise the Receiver concerning this concept.

h. Patient Advocacy Process

The patient advocacy process represents a rejection, by the Receiver, of the CDCR's "form 602" appeal process. In essence, the new patient advocacy process at San Quentin calls for inmate clinical complaints to be directed in a timely manner to a registered nurse. That nurse, the Patient Advocate, provides an immediate triage of all clinical complaints and, if necessary, direct clinical intervention or referral. The purpose of the new process is twofold: (1) to provide prisoner/patients with prompt responses to their concerns about urgent health care matters; and

(2) eventually reduce the number of appeals submitted by patients.

To begin this process registered nurses and office technicians had to be hired and trained for the position, duty statements developed, and prison-wide policies implemented (including notification to patients). These tasks were all completed in a timely manner, and the recently implemented program is functioning in a manner whereby urgent and emergent appeals are being addressed in the appropriate clinical manner on a timely basis.

As with many of the other elements of the San Quentin Project, however, the patient advocacy process is far from being institutionalized because of a number of inter-related problems. For example, the patient advocacy team does not have adequate office space or office equipment to conduct their work, a problem that negatively impacts on all health care disciplines. The advocacy team encountered difficulty obtaining necessary equipment, e.g. computers, filing cabinets and photocopy equipment despite extraordinary efforts on the part of supply and accounting personnel at San Quentin. In addition, the CDCR computer system used for monitoring appeals is too old and cumbersome to effectively track the Patient Advocates' work. The number of complaints combined with suspicion on the part of prisoner/patients concerning the adequacy of medical services has also made the job of the Patient Advocate somewhat stressful, causing one of the two nurses assigned to the position to request a job change.

Despite these temporary set backs the Receiver and the Project Team are convinced that the patient advocacy model is the appropriate method for addressing patient concerns and the Receiver will be considering, as describe in the Conclusion below, how to best expand the program in a careful, time-phased manner.

I. Clinical Space

The lack of space in which to work, not only clinical space but also desperately needed space for services such as telemedicine, for speciality providers, for offices, for meetings, for information technology, for office equipment and for supplies is a major factor driving the inability to provide constitutionally adequate medical care at San Quentin. After ten weeks of intensive study and corrective action, the Project Team and Receiver are forced to conclude that

only a limited number of patients can be provided constitutionally adequate medical care given the limited space, the limited correctional officer staffing, and the old, poorly maintained conditions of confinement at San Quentin State Prison. Therefore, as explained in the Conclusions below, the Receiver will begin working with CDCR officials to establish both a patient population capacity limit and a patient reception limit for the prison. Photographs which depict the space limitations and the extensive facility problems which limit prisoner/patient access to medical care are provided in an Appendix of Photographs filed concurrently with this Report.

The Project Team will be taking steps to maximize the number of prisoner/patients who can be confined at San Quentin under conditions whereby they will be provided with constitutional levels of medical care by commencing a Project element which will have three components:

A. The construction of a permanent licensed San Quentin medical center to replace the aged and entirely inadequate Neumiller Building. Initial plans, which may be subject to modification, call for the new facility to contain at least forty CTC beds, and the appropriate clinical space, administrative space, and offices for both medical and mental health personnel.

B. The construction of a new Reception and Release Center at San Quentin. As mentioned above, the Team is presently inspecting the reception and release facilities of other large California correctional systems.

C. In the interim, while the construction of the permanent facilities proceed, the Project Team will install/construct four interim units for medical services only:

1. Clinics/sick call triage centers outside the rotundas of three of San Quentin's housing units.

2. Additional temporary clinical space inside a centrally located yard at San Quentin.

3. A temporary building for administrative offices, meeting rooms, etc.

4. A permanent medical supply warehouse.

Plans for these projects are proceeding in a steady manner. The interim projects should be finalized by November 2006 with construction/installation scheduled to begin immediately thereafter. Once the maximum amount of clinical space available at the prison is determined, planning can begin to establish a reasonable number of patients who can be served by the facilities that will be available at San Quentin.

j. Facility Maintenance

Steps have been taken to bring about an immediate improvement of clinical areas through the hiring of casual (union) labor to commence repairs, painting, and other simple renovations in the Neumiller Building and other clinical sites. The positive impact of these badly needed repairs cannot be underestimated.

At the same time, however, the Project Team has uncovered facility maintenance problems which, after a complete investigation, may require extensive renovation/repairs at San Quentin to prevent environmental problems found to be so severe that they may adversely affect the health care of prisoner/patients as well as staff (including correctional officers and health care professionals). For example, the HVAC units in North Block presently function in a manner whereby instead of pulling air from the unit, they circulate in reverse, forcing ambient air down into prisoner housing units along with many years accumulation of filth, pigeon droppings, and other noxious particles. Apparently, following a California Court of Appeals reversal of the trial court decision in *Wilson* (which mandated improvements with the air circulation system of North Block), the State abandoned the renovations it had recently constructed, thereby allowing the HVAC system in North Block to return to its present state of abject disrepair. The Receiver and his Project Team have obtained an opinion from a HVAC consultant affirming that the system does not function appropriately, and will be consulting with an environmental hygienist consulting firm relative to the nature of the air particles continually re-circulating throughout North Block.

k. IT, Communications and Power

The Project Team added an information technology, communications and power element

to the Project after determining that the inability of clinicians to communicate with each other, to exchange necessary schedules, and to coordinate in some rational manner with correctional staff about the movement of prisoner/patients was preventing needed remedial activities.

As a result, significant improvements are being made concerning basic services such as installing telephones and personal computers in clinical offices, and providing for beepers for nurses in the housing units. Here again, however, long term systemic problems at San Quentin have created problems affecting all aspects of this Project element. For example, after hiring contract electricians for a project to drop computer lines through the attic of the Neumiller Building (into various clinic locations), asbestos and lead was discovered, rending this manner of wiring the building more difficult. At the same time it was determined that because the Neumiller Building receives electricity through an aged transformer, the electricity needed for computers and other equipment may not be available without an expensive and time-consuming upgrade of the building's power supply. Meanwhile, the primitive CDCR health care services tracking system, and the CDCR's appeals tracking system have proved increasingly unreliable, rendering efforts to coordinate patient appointments and manage appeals difficult to effectuate. Despite all of these problems, slow but steady progress has been made concerning the need to upgrade San Quentin's power, telephones, and computer connectivity.

l. Sanitation/Janitorial

The purpose of the sanitation/janitorial element of the Project is to provide necessary hospital levels of cleanliness and biowaste management for San Quentin clinical areas. After considering numerous options, the Team has concluded that the most effective manner to deliver this service is through a multi-faceted project that will establish an Environmental Services Program at San Quentin. The proposed program will include the following:

1. Specified cleaning schedules with the appropriate equipment and supplies;

2. Full time permanent State employees skilled at supervising hospital levels of sanitation services;

3. The development and implementation of a prisoner vocational/education program

(including an instructor) that will continually train inmate workers on hospital level environment services.

4. Metrics for measuring cleanliness and adequacy of biowaste management.

Progress is being made on all elements of the new program, which is anticipated to begin in November 2006.

m. Custody & Clinical Relations

The purpose of this Project element is to improve relations, coordination, and communication between correctional officers and clinical personnel. The Team has decided to utilize Carol Falherty-Zonis as the instructor for a course entitled "Promoting a Positive Corrections Culture." This course has been well received by many State correctional systems, and has been utilized with success in the CDCR.

The initial training session has been scheduled for off-site, and will be begin with one three-day session, followed by two one-day sessions, all of which will take place during October 2006. Thereafter, the course will be evaluated and the outcomes reported to the Receiver to assist him with the decision of whether to expand, modify, or reject the course.

n. Organizational Structure

One of the goals of the San Quentin Project is to ensure qualified, competent and committed clinical and administrative support personnel are present in adequate numbers for delivery of quality medical care and support activities. A new health care delivery organization structure is critical to their future effectiveness.

Therefore, Mercer Human Resource Consulting was hired by the Receiver to research, conduct a gap analysis, and recommend a customized medical organization structure that can be utilized at San Quentin State Prison as a prototype before expansion statewide. The Mercer Group has in-depth experience in health care management and evaluating and developing appropriate structures for health care operations.

The Mercer Group has completed its analysis of the health care structure at San Quentin and compared it to five (5) well functioning health care organizations. The Mercer project

included identifying gaps in types of personnel available within the San Quentin medical program, and an examination of reporting relationships for all management, supervisory, clinical and support positions and professions. On August 28, 2006, the Receiver decided upon an organizational structure as a result of Mercer's recommendations (Exhibit 10).

The proposed structure is far different than the traditional CDCR method of managing health care at its institutions, providing for both more effective overall management and tighter controls over fiscal matters. The Mercer Group is now in the process of developing job descriptions for top level positions in the organization structure complete with the scope of responsibility, span of control, decision-making authority, education and experience requirements, necessary licenses and certificates, and business and professional skills. These descriptions will form the basis for determining salaries and recruiting qualified individuals to manage the complexities associated with correctional health care.

The Receiver notes that the Mercer findings are entirely consistent with the remedial progress findings of the Project Team. Given the thousands of patients, the extensive turn-over and health care challenges posed by the CDCR reception process, and the serious structural, space, and equipment impediments to providing health care at the aged facility, it is apparent that the existing CDCR health care management is both inadequate and inappropriately organized to meet the challenge of providing constitutional medical care at San Quentin.

o. Staffing

As explained when discussing the elements above, many changes have been made at San Quentin concerning its mix of staff. The Receiver has also approved hiring additional office technicians, health records technicians, property controllers, warehouse workers, staff systems analysts, registered nurses, and primary care providers. The Project Team has engaged in extensive and important work to fill vacancies at San Quentin by arranging for local testing and expediting other aspects of the cumbersome CDCR hiring process. In addition, the Team has worked to develop a plan for establishing posts for critical nursing positions and a plan for staffing and supervising a team of correctional officers responsible for assisting with

prisoner/patient access to the medical delivery system. Overall, this element of the Project is proceeding forward with a wide variety of programs in a timely manner, and at this point in time the Receiver can make two general findings:

A. Final plans for establishing posts and determining the mix of nursing personnel who will be necessary for a constitutionally adequate medical delivery system may take longer than originally anticipated because of the need to restructure the entire medical delivery system at San Quentin to a care management model, a reform that arose out of the Specialty Services QIT and a necessary change that was not part of the original Project.

B. While additional support and administrative personnel have been needed, whether more or less nurses will be necessary cannot, at this point, be determined. It is apparent, however, that MTAs and Registered Nurses at San Quentin were not managed in an effective manner prior to the implementation of the Project. Improvement concerning nursing care will be primarily driven by improved supervision, policies and process and not necessarily by adding more nursing staff.

p. Salaries

Salaries for San Quentin clinical personnel were addressed in the Receiver's Motion for Waiver of State Law filed September 12, 2006 and are currently pending before the Court.

q. Internal and External Communications

The Receiver has continued his efforts to communicate to staff, prisoner/patients, and the public about the importance of the San Quentin Project in the following manner: issuing an initial announcement about the project to the public, San Quentin staff and inmates; providing two written updates to San Quentin staff; providing one written update to inmates; arranging for a professional photographer to shoot "before" pictures depicting the conditions; arranging for preparation of a video B-Roll shoot by CDCR communications staff; responding to multiple press inquiries; requesting that his staff orchestrate media access to San Quentin and create talking points for San Quentin's Prison Information Officer ("PIO"); and meeting with the Inmate Men's Advisory Council to obtain their input concerning San Quentin's medical

conditions and efforts to change them.

r. Evaluate *Plata* Remedial Plan Requirements

The Team's evaluation concerning the Project's remedial efforts and *Plata* Remedial Plan implications will be addressed after the conclusion of the Project.

4. *The Receiver's Initial Appraisal of the San Quentin Project.*

a. Introduction.

The San Quentin Project has been successful concerning both of its objectives: (a) bringing relief to clinical staff working in the trenches at the prison and (2) educating the Receiver and his staff concerning the major problems to be encountered when attempting to implement remedial programs in California's prisons. The Receiver would be remiss, however, if he did not also state clearly that the Project has not proceeded with the development and implementation of certain specific remedial programs in as prompt a fashion as the Team envisioned. This too has been a valuable lesson.

b. Findings.

Based on the first ten weeks of the Project, the Receiver finds as follows:

1. No one factor is responsible for the utter breakdown of medical services at San Quentin. Every problem which has been encountered, including the untimely and inadequate reception center processes, the use of the OHU as a care center, the inability to obtain and manage supplies, poorly organized and incomplete health records, the failure to provide timely speciality care, the failure to manage laboratory services, the breakdown of diagnostic imaging services, an untimely and ineffective patient appeal process, the lack of adequate clinical and administrative space, the lack of facility maintenance, an absence of information technology, lack of office equipment and even telephones and electrical power, the failure to clean clinical areas, adversarial staff relationships, inappropriate health services organization, and inadequate and poorly trained supervisors stem from a wide variety of long term and entrenched systemic shortfalls which have complicated and in some cases delayed the Team's corrective actions. The Receiver and his staff initially determined that the Project should take place over a ninety day

period (with certain elements continuing longer) and followed by continuous monitoring and re-calibration concerning certain corrective actions. The schedule now requires adjustment.

2. It will be impossible, given the serious staffing shortfalls and structural impediments which exist at San Quentin, to provide adequate medical care until and unless the patient population is limited to the services that will be available after the construction of additional clinics, a supply warehouse, a new reception center, and badly needed administrative office space.

3. The Warden at San Quentin has proven to be an essential component of the San Quentin Program. Without the full time assistance of Acting Warden Robert Ayers, the Project would not have accomplished many of the results which have been achieved. One of the major lessons of the Project is the absolutely critical role which CDCR Wardens must play in the State's effort to work with the Receiver to bring the medical care in California's prisons up to constitutional standard. Warden Ayers has provided a model for what the Receiver and his Office will expect from other wardens as the remedial process expands to other institutions.

4. The CDCR structure for managing medical care in California's prisons (e.g. Physician Chief Medical Office, Physician Chief Physician and Surgeon, Registered Nurse III's and II's) is entirely inadequate given the number prisoner/patients and the complex health care problems which afflict a significant percentage of the California prisoner population. The Project demonstrates that it is unreasonable to expect that even a diligent Health Care Manager such as Dr. Karen Saylor and very competent Nursing Director such as Jane Robinson to manage both the day-to-day operation of a prison in crisis and, at the same time, implement with the detail necessary an improved medical delivery system (even with the assistance of the Office of the Receiver). Therefore the first step toward improving health care in the prisons must involve a complete re-organization of the management and supervisory structure along the lines proposed by the Mercer consultants (Exhibit 10). The need to re-structure the management at the prison, combined with mid-management instability, incompetence, and turnover at San Quentin after July 5, 2006 will delay the full implementation of the Reception Process, OHU, Organizational

Structure, and Speciality Services elements of the Project.

5. Potentially very serious environmental problems which may adversely impact on the health of prisoners (and staff) will require the Receiver to become involved with facility problems the Team did not anticipate at the beginning of the Project.

6. The need to entirely reconstruct the San Quentin nursing function and take steps not anticipated to develop an appropriate model of medical delivery will delay the full implementation of several aspects of the Staffing element of the Project.

7. The degree to which the CDCR self-imposes unnecessary redundancies in its processes (e.g. procurement), and the reluctance on the part of CDCR Headquarters to delegate functions that are best performed at the local level, combined with Headquarters' underestimation of capabilities of the administrative staff at San Quentin (including staff in San Quentin's Personnel Office and the San Quentin Business Manager) has delayed various remedial Project elements. However, this issue appears to have been worked through between the Office of the Receiver and the CDCR and should not further delay the Project.

8. The Project Team has encountered a high level of cooperation, dedication, and willingness the part of many employees at San Quentin who have worked diligently with the Receiver's staff to affect change and make constructive progress. While it is always problematic to cite specific examples because of the inherent danger of neglecting other employees who have worked well with the Team, the Project Team has identified Dr. Karen Saylor, Jane Robinson, Acting Warden Robert Ayers, Captain John Day, Don Meier, Dr. Renee Kanan, Margaret Stokes, Kelly Mitchell, Tracy McCracy, Felicia Brown, Jeanina Dominie, Shalona Van Hook, Booker Welsh and Rahsaan Raimey as being especially helpful in this regard.

IX.

CONCLUSION

As explained above, the Office of the Receiver has developed and implemented numerous immediate and/or short term measures designed to improve medical care and begun the development of a constitutionally adequate medical health care delivery system during the

past sixty days. These efforts include a new clinician salary structure, the continuation of a project designed to improve health care services contracting, the beginning of a system-wide medical supply and equipment procurement improvement project, completion of an RFP for contracting for a pharmacy management firm, and the implementation of numerous and important changes to the medical delivery system at San Quentin State Prison.

During the next sixty days the Receiver will focus his Office's efforts on the following issues:

1. To ensure the timely recruitment, hiring, and improve retention of clinical personnel, the Office of the Receiver will develop and begin to implement a new hiring program for clinical job applicants. Given the poor performance and inaccurate reporting by CDCR's Support Services Division personnel unit, the Receiver is convinced that absent direct intervention by his Office concerning the hiring process many of the benefits which may be achieved through the proposed clinical salary increases will be lost due to CDCR bureaucratic delay and Support Services incompetence.

2. The Office of the Receiver will commence planning for 5000 multi-purpose medical beds to be operational within the next three-to-five years. This construction, which began with a meeting with State officials on Friday September 15, 2006, will initially encompass four inter-related projects:

A. A survey of prisoner/patient medical needs to be conducted by a private consulting firm.

B. A project (assigned to the Receiver's Chief of Staff) to identify and secure five hundred CTC or CTC replacement beds within the next one-hundred-and-eighty days. Two factors mandate an immediate increase in CTC or CTC replacement beds. First, there is a serious need for more in-patient and step-down beds, an existing problem which will not be addressed in a timely manner through the proposed 5000 beds previously mentioned. Second, the CDCR has implemented a practice whereby prisoner/patients in contract acute beds remain in those expensive beds because the CDCR's health care

system does not have alternative step-down facilities or adequate numbers of CTC beds in which to house the patients. In addition to being wasteful, this practice has created a crisis shortage of contract acute beds.

C. Coordination with the Coleman Special Master concerning whether the proposed three-to-five year construction project should be expanded to 10,000 medical and mental health beds.

D. The development and timely implementation of the three to five year medical prison project.

3. The Receiver will modify the San Quentin Project as follows:

A. The Project's term will continue for one additional month, to Friday November 5, 2006.

B. The Receiver and the Project Team will meet and confer with CDCR officials to establish a patient capacity and a daily and weekly patient reception center processing capacity for San Quentin State Prison.

4. The Office of the Receiver will take additional steps to identify and stop wasteful health care processes within the CDCR's Central Office. Two specific actions will begin within the next 60 days.

A. Following a request by the Receiver, the State Auditor has agreed to commence an audit of CDCR health care related contracts, focusing on registry contracts. The audit is expected to begin in October 2006 and continue through March 2007.

B. The Office of the Receiver will begin a process to identify and stop Central Office medical care projects, and to eliminate unneeded positions and pending BCP requests that will not be necessary given the Receiver's plans to reorganize the medical care delivery system.

5. The Receiver will consider the implementation of carefully selected programs designed to re-organize components of the entire CDCR medical care delivery system. Concerning this effort, two potential projects have been identified for early consideration:

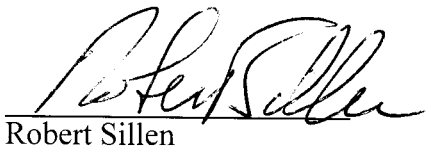
A. Establishing pilot regional office limited to four prisons. The pilot region will focus its initial efforts on establishing a registered nurse driven medical care system relative to the following issues: (1) developing and implementing the primary care provider model of in-prison medical services; (2) implementing adequate controls over the delivery of speciality care services; and (3) implementing the San Quentin model of patient advocacy to supplement the existing CDCR inmate appeal system.

B. Moving the responsibility for the overall direction and management of CDCR nursing personnel into the Office of the Receiver.

While both projects are subject to additional review and discussion, modification of the duties and obligations of Health Care Headquarters operation will become, over time, an increasingly important element of the Receiver's plans for improving prison medical care.

6. The Office of the Receiver will develop and begin to implement a program that will survey, prioritize, catagorize and begin to plan for the construction of additional clinical and administrative space at selected CDCR prisons.

Dated: September 19, 2006



Robert Sillen
Receiver

PROOF OF SERVICE BY MAIL

I, Kristina Hector, declare:

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

On September 19, 2006 I arranged for the service of a copy of the attached documents described as RECEIVER'S SECOND BI-MONTHLY REPORT on the parties of record in said cause by sending a true and correct copy thereof by pdf and by United States Mail and addressed as follows:

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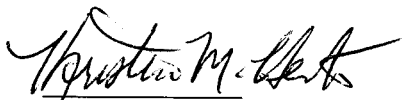
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on September 19, 2006 at San Francisco, California.



Kristina Hector