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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO

MARCIANO PLATA, et al.,

Plaintiffs,

v.

EDMUND G. BROWN JR., et al.,

Defendants.

Case No. C01-1351 TEH

RECEIVER'S AND PARTIES' JOINT REPORT AND RESPONSES TO COURT'S JANUARY 17, 2012 ORDER TO MEET AND CONFER RE: POST-RECEIVERSHIP PLANNING

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The parties and Receiver J. Clark Kelso ("Receiver"), by and through their respective counsel, submit this joint response to the Court's January 17, 2012 Order to Meet and Confer Re: Post-Receivership Planning ("Planning Order").

RECEIVER'S SUMMARY OF RELEVANT PROCEDURAL BACKGROUND

Filing of this Action and pre-Receivership remedial efforts.

Plaintiffs filed this action in 2001, alleging that the prison medical health care system was failing to provide constitutionally adequate care to inmates with serious medical needs. The parties thereafter reached agreement on a number of issues intended to address the deficiencies in the system. That agreement was reduced to writing in a Stipulated Injunction which this Court adopted as its order in June 2002 ("2002 Stipulation"). The 2002 Stipulation provided for the development, revision and phased implementation of new medical policies and procedures, specific staffing and administrative requirements for the provision of care, an inmate health care grievance procedure, procedures for monitoring compliance, the appointment of court experts to assist in monitoring and evaluating compliance and the development of an Audit Instrument and auditing process for measuring compliance. Specifically, substantial compliance would be met when a "prison receives a score of 85% or higher on an audit conducted by the Court experts . . . using the Audit instrument. . . . No score less than 85% shall be considered to satisfy this requirement, except that the experts shall have the discretion to find a prison providing adequate medical care in compliance if it achieves a score of no less than 75%. The score shall be calculated by averaging all of the indicators in the audit instrument." 2002 Stipulation at 11. In addition, the experts were tasked with making qualitative judgments regarding the adequacy of the provision of care and that each prison was "conducting minimally adequate death reviews and quality management proceedings." Id. at 12.

The parties thereafter entered into further stipulated orders intended to address continuing deficiencies in the system, including a Stipulated Order Re Quality Of Patient Care And Staffing, entered on September 13, 2004.

Appointment of the Receiver.

Despite the 2002 Stipulation and other orders, the Defendants remained unable to bring the system into compliance with the constitution. In October 2005, after six days of evidentiary hearings, this Court issued comprehensive findings of fact and conclusions of law pursuant to which the Court determined that it would place the prison medical health care system into receivership. Then, on February 14, 2006, this Court appointed Robert Sillen as Receiver. The Order Appointing Receiver ("OAR") relieved the Secretary of CDCR of his authority insofar as the prison medical health care system was concerned and conferred that authority on the Receiver. The Receiver was tasked with providing "leadership and executive management of the California prison medical health care delivery system with the goals of restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care" in the prisons. OAR, ¶ I.A. In particular, the Receiver was charged with developing a Plan of Action, with tasks, metrics and anticipated completion dates for each and with reporting to the Court on a regular basis.

The Receivership "shall remain in place no longer than the conditions which justify it make necessary, and shall cease as soon as the Court is satisfied, and so finds in consultation with the Receiver, that Defendants have the will, capacity, and leadership to maintain a system of providing constitutionally adequate medical heath care services to class members." OAR, ¶ V. To that end, prior to the termination of the Receivership, the Receiver is to develop, and present to the Court for its approval, "a Plan for Post-Receivership Governance of the system, which shall include consideration of its structure, funding, and governmental responsibility for its long-term operation."

Remedial efforts by initial Receiver.

Following his appointment, the Receiver undertook a number of initiatives intended to bring the system into compliance with the constitution, including increased hiring of medical staff, dramatically increasing salaries of medical professionals, modifying the procedures for peer review and discipline to make it easier to remove unqualified doctors, overhauling the

system for prescribing and distributing prescription drugs, and commencing and completing the construction of much needed clinical space. In connection with the Receiver's activities, this Court entered a number of orders waiving state law to permit the Receiver needed flexibility in contracting, construction and hiring and staffing for the prison medical care system. In September 2007, this Court entered an order modifying the 2002 Stipulation and other pre-Receivership orders to account for the changed circumstances wrought by the Receivership.

Appointment of current Receiver and Receiver's Turnaround Plan of Action.

On January 23, 2008, this Court replaced the original Receiver with the current Receiver, J. Clark Kelso. The Receiver has continued to make significant progress in bringing the prison medical care system into constitutional compliance. In June 2008, the Receiver developed and submitted to the Court for its approval a Turnaround Plan of Action ("TPA"), which outlined six basic programmatic goals for remedying the constitutional deficiencies in the system:

- Ensuring timely access to health care services;
- Establishing a prison medical program addressing the full continuum of health care services;
- Recruiting, training and retaining a professional quality medical workforce;
- Implementing a quality assurance and continuous improvement program;
- Establishing a medical support infrastructure; and,
- Providing for necessary, clinical, administrative and housing facilities.

Each such programmatic goal was comprised of multiple subsidiary goals and action items, together with anticipated target dates for completion. The Receiver has regularly reported to the Court on his progress in implementing the TPA. In January 2012, the Receiver filed his 19th Tri-Annual Report, noting that 77% of the action items in the TPA had been completed, and that completion of the remaining items is in sight.

Meanwhile, in 2008, using an audit instrument and scoring system, the Office of Inspector General ("OIG") commenced and completed an audit of each of the 33 California prisons to determine whether, and to what extent, the medical care system was achieving the

overall goal of a constitutional level of care. The OIG found that the system as a whole scored 72%, 24 institutions scored below 75% and nine institutions scored between 75% and 85%. In 2010, OIG commenced a second round of inspections, which was recently completed, and found significant improvement. The system as a whole scored 79.6%, only four institutions scored below 75%, 25 institutions scored between 75% and 85% and four institutions scored above 85%.

Court order for Post-Receivership Planning and the Meet and Confer Process.

In light of the progress achieved by the Receiver, on January 17, 2012, this Court issued the Planning Order which required the parties and the Receiver to meet and confer for the purpose of planning for the transition of the prison medical health care system from the Receivership back to full state control. In the Planning Order, the Court identified six questions or issues intended to guide the discussions. Those issues are as follows:

1. How substantial compliance should be measured, including how the OIG scores should be used and whether the court experts should be involved.

2. Criteria for determining when it is appropriate to move from the Receivership to a less intrusive system of oversight, including factors the court should consider when evaluating Defendants' will, capacity and leadership to maintain a system of providing constitutionally adequate medical care services to class members.

3. Whether the parties agree that the current Receiver can act as a monitor or special master once the Receivership ends and, if not, how the parties propose selecting a monitor or special master.

4. Criteria for ending court oversight and concluding this case, including initial length of the post-Receivership monitoring period and whether the OIG inspection program or other independent process for inspections must be institutionalized before the Court ends its supervision.

5. The parties' view on what the Receiver should include in the Plan for Post-Receivership Governance he must submit to the court.

6. How, if at all, the Court should consider the status of Defendants progress in satisfying the orders of the related three-judge court when determining when to end the Receivership and this case.

The Court ordered that the parties submit a joint report to the Court on April 30, 2012 (subsequently extended by court order to May 7, 2012). The parties and the Receiver met as a group on five occasions. At the first meeting on February 13, 2012, the Receiver provided an

overview of the progress on the TPA and on the goals which remained to be completed. On February 16, plaintiffs' counsel discussed those areas in the system which they believe have yet to see sufficient progress. At the meeting on March 9, the parties began sharing their respective positions on the issues identified by the Court and plaintiffs' counsel articulated their initial position on items 1-4 of the Planning Order. On March 23, Defendants responded to plaintiffs' proposals and the parties and the Receiver agreed that the Defendants, rather than the Receiver, should be primarily responsible for developing a Post-Receivership Governance plan since it will be the Defendants who must implement that plan. On April 16, the Defendants presented the basic outlines of their Post-Receivership Governance plan.

On April 27, the Receiver met with plaintiffs' counsel to determine whether, and to what extent, the Receiver and plaintiffs' positions are in agreement with respect to the issues in the Planning Order and, on April 30, the Receiver met with the Defendants to determine whether, and to what extent, the Receiver and the Defendants are in agreement. The parties and the Receiver agreed to, and did, share with one another their respective responses to the issues in the Planning Order on May 2, 2012.

PARTIES' INTRODUCTORY STATEMENTS

Plaintiffs' Introduction

This Court ordered that the Receivership would end when the defendants demonstrated the "will, capacity, and leadership to maintain a system of providing constitutionally adequate medical heath care services to class members." Order Appointing Receiver, ¶ V. Defendants claim that they currently possess all three necessary characteristics to reassume management of the CDCR's medical delivery system. They are wrong.

A. Defendants' Lack of Will

Defendants have yet to demonstrate that they have developed the will necessary to sustain the programs and systems that the Receivership has developed and implemented to improve the CDCR's medical care delivery system. Defendants show this most vividly by continuing to defy court orders, including orders from the nation's highest court. A year ago, the

U.S. Supreme Court found that overcrowding in the CDCR was the primary cause for the constitutionally inadequate health care system, and upheld the Three Judge Court's order requiring the California Department of Corrections and Rehabilitation to reduce its population to 137.5% of capacity in two years. Defendants have no intention of complying with that order. Last month, defendants unveiled their report, The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight and Improve the Prison System. Defendants below tout this plan as their "comprehensive plan for … ensuring a quality medical care system for years to come" and hold it out as "yet more proof of Defendants' commitment to further improving prison health care." See p. 11, *infra*. Remarkably, defendants fail to acknowledge in this joint report that under this new plan defendants will defy the population cap ordered by the Supreme Court and the Three Judge Court. Defendants have consistently ignored court orders in this action, necessitating first the Patient Care Order and then the Receivership. Now they have developed a plan for the future of the corrections system that intentionally flouts the order designed to remedy the primary cause of the unconstitutional conditions.

Paradoxically, even as they make plans to violate the courts' orders, defendants claim that the population reduction that has occurred in the CDCR demonstrates their will and commitment to improve prisoner health care. As any work on reducing the prisoner population was undertaken only in response to the Three Judge Court's 2009 order, and then only after losing their appeal in the Supreme Court, it is difficult to conceive how defendants' conduct demonstrates defendants' will to address inadequate health care.

B. Defendants' Lack of Capacity

That defendants lack the capacity is evidenced by, among other things, the defendants' failure, after five years, to fund and construct necessary clinical upgrades at prisons throughout the state. As the defendants' Future of California Corrections report acknowledges, defendants' "must address the aging infrastructure and inadequate treatment space" that is hindering defendants' ability to delivery care. "Future of California Corrections" at 35,

http://www.cdcr.ca.gov/2012plan/docs/plan/complete.pdf. Defendants have estimated the cost to upgrade and build the necessary facilities will be approximately $700 million.

Defendants have been aware of these clinical deficiencies for years, yet have failed to fix them, and have even obstructed the Receiver's efforts to address them. After initially working with the Receiver to develop plans for these upgrades in 2007, the defendants then refused to fund the building projects in 2008, forcing the Receiver to move for contempt against the state. Defendants responded by moving to terminate the Receiver and the building plans, and ultimately lost on appeal in 2010. Defendants now cite the new clinical buildings at San Quentin and Avenal, and the conversion of a dormitory at California Medical Facility, to demonstrate their capacity to take on management of the system, yet they are silent regarding their utter failure to address the long-standing clinical space deficiencies at the rest of the state prisons. Defendants' failure to obtain the necessary approval and funding to address the gross clinical deficiencies at the other thirty prisons around the state clearly illustrates the defendants have not yet developed the capacity to take on the management of the health care system

Moreover, some of the vital systemic improvements that the Receiver has implemented, including the physician peer review process, were possible only because the Receiver was able to obtain waivers of state law. Defendants have offered no information as to how the state can sustain these programs once the Receivership ends. Nor have defendants, who have in the past proven incapable of developing and executing complex statewide initiatives, explained how they will be able to carry out and complete the Receiver's multifaceted initiatives to implement an electronic medical record and improve scheduling and tracking. Continuing and completing these projects will be essential to ensure that the Receiver's hard-won improvements to health care do not evaporate.

Additionally, defendants claim that the latest Office of the Inspector General audit results reflect substantial progress in the delivery of health care, suggesting that the care is now essentially adequate, and defendants would be tasked with maintaining the level of care, as

opposed to improving it. In fact, however, serious health care access issues remain at many prisons.

As defendants point out, the average compliance score for prisons on their second round of OIG audits was 79.6%. However, this overall average score masks significant ongoing access to care problems at prisons across the state. For example, the OIG measures of the timeliness of primary care visits for prisoners enrolled in the Chronic Care Program (i.e., some of the most medically fragile prisoners) show that just one prison achieved a score over 75%, while 12 scored below 50%.[1] For prisoners who are referred to see a primary care provider after being triaged by a nurse, the majority of the prisons scored below 75%, with ten prisons scoring at 50% or below. The scores for delivering medications were likewise dismal. Over two-thirds of the prisons scored below 75% for delivering timely chronic care medications. Twenty-four prisons scored below 75% for timely delivery of medications to patients newly discharged from the hospital, with 13 scoring at 50% or below. These are the types of problems that the CDCR was unable to address six years ago, when this Court ordered the Receivership. Defendants have offered no persuasive evidence that they, lacking the resources of the Receivership, have the capacity to address these ongoing and difficult treatment delivery issues.

[1] The Office of the Inspector General's audit reports for the first and second round audits are posted at http://www.oig.ca.gov/pages/reports/medical-inspections.php, and are the source for the data cited. For example, according to the second round audits, only the California Correctional Center (CCC) achieved an 80% score on the audit question "Was the inmate's most recent chronic care visit within the time frame required by policy?" (Ref. No. 03.076.) California Correctional Center Medical Inspections Results, December 2011, at p. 8. The twelve prisons that scored below 50% are California Rehabilitation Center, 44% (California Rehabilitation Center Medical Inspections Results, April, 2011, at p. 8); Pleasant Valley State Prison, 37.5% (Pleasant Valley State Prison Inspection Results, May, 2011, at p. 8); Central California Women's Facility, 48% (Central California Women's Facility Inspection Results, May, 2011, at p. 8); North Kern State Prison, 43.5% (North Kern State Prison Inspection Results, August, 2011, at p. 8); San Quentin State Prison, 25% (San Quentin State Prison Inspection Results, September, 2011, at p. 8); California Correctional Institution, 40% (California Correctional Institution Inspection Results, September 2011, at p. 8); California Substance Abuse Facility and State Prison at Corcoran, 48% (California Substance Abuse Facility and State Prison at Corcoran Medical Inspection Results, September 2011, at p. 8); Deuel Vocational Institution, 47.8% (Deuel Vocational Institution Medical Inspection Results, October 2011, at p. 8); California State Prison at Corcoran, 40% (California State Prison at Corcoran Inspection Results, December, 2011, at p. 8); California State Prison at Solano, 40% (California State Prison at Solano Inspection Results, January, 2012, at p. 8); Pelican Bay State Prison, 12.5% (Pelican Bay State Prison Inspection Results, January, 2012, at p. 8); Ironwood State Prison, 40.9% (Ironwood State Prison Inspection Results, January, 2012, at p. 8.

C. Defendants' Lack of Leadership

Six years into the Receivership, defendants have yet to develop the leadership within the CDCR that will be necessary to fill the management role that the Receiver has played. When it ordered appointment of a Receiver, the Court concluded, among other things, that defendants "have been unwilling or incapable of breaking out of a deeply entrenched bureaucratic mind-set" (Findings of Fact and Conclusions of Law, Oct. 3, 2005, p. 39:9-12) and had a self-professed inability to take remedial action regarding medical care (see id. at 41:2-4). Defendants' proposal to assume control of the medical delivery system now ignores these circumstances, as would any scheme that fails to require an affirmative showing by defendants that they in fact can adequately manage and sustain the medical delivery system. Just last month California's Legislative Analyst echoed the concern that the Court articulated, stating that "the state has demonstrated that it lacks employees with sufficient expertise to adequately manage a medical care system of the size and complexity of California's prison system . . . ." Legislative Analyst Office, Providing Constitutional and Cost-Effective Inmate Medical Care, April 19, 2012, at page 26.[2] Defendants have offered no evidence to demonstrate that they have groomed the type of managers the state will require to ensure that, once the state takes over medical care delivery, the system does not once again devolve into bureaucratic paralysis.

The Receivership, with its resources and enhanced flexibility, has been able to make substantial strides towards ameliorating the abysmal medical care conditions that existed when defendants managed the system and that were responsible for the death of one prisoner each week. Conditions have improved, and in order for those improvements to meet constitutional standards and be sustainable, the transition back to state control must be thoughtful, with a clear roadmap, adequate management structure, and strong leadership. Defendants have yet to demonstrate the capacity, will or leadership necessary to maintain the Receivership's gains, but, as indicated below, should have the opportunity to develop and strengthen those characteristics over the next 18 months, so that an orderly transition can be effected.

[2] This Report is available at http://lao.ca.gov/reports/2012/crim/inmate-medical-care/inmate-medical-care-041912.pdf

Plaintiffs believe the Receivers' proposals below are generally sound, adequate and appropriate. With the exceptions indicated and discussed below, plaintiffs endorse the Receiver's proposals. Where there are specific differences, plaintiffs set forth the reasons for the differences, and then present the Receiver's proposal with additions indicated by underlined text and deletions indicated by struck out text.

Defendants' Introduction

In the six years that the Receivership has been in place, CDCR's medical care system has been wholly transformed. When the Receiver was installed in 2006, the population in the state's 33 institutions was approaching its all-time high of 162,792 inmates, pushing the prison system above 200 percent of its design bed capacity. In addition, the medical care system was fraught with serious deficiencies in key areas, including staffing, timely access to care, physical treatment and office space, infrastructure, and quality-assurance mechanisms.

Since then, tremendous improvements have been made throughout the system. For example, the Receiver has recruited, trained, and maintained a well-qualified medical care workforce. The system now delivers a continuum of health care services, including chronic and specialty care. Defendants have built or are building new health care facilities, including the San Quentin Central Health Services Facility and the California Health Care Facility in Stockton, and have updated existing facilities to meet the health care needs of the prison population.

Moreover, the population in the state's 33 institutions has dropped by about 40,000 inmates since its peak in 2006, due primarily to recent landmark prison realignment legislation. In the first seven months of realignment, the population has shrunk by more than 21,000 inmates, bringing prison density down to below 155% of design bed capacity. Relieving prison crowding has substantially aided the ability to maintain quality health care throughout the system. But Defendants recognize that further steps must still be taken to preserve and build upon the widespread improvements that have been accomplished to date. Just two weeks ago, CDCR released its comprehensive plan for building upon the opportunities created by realignment, and ensuring a quality medical care system for years to come. This plan has been widely and

consistently praised, and is yet more proof of Defendants' commitment to further improving prison health care. (*See, e.g.*, Declaration of Martin Hoshino, ¶ 5, Ex. 3 [April 29, 2012 Sacramento Bee editorial: "California Can Now Revamp its Prison System at Lower Cost"].)

In its January 17, 2012 order, the Court announced that "it is clear that many of the goals of the Receivership have been accomplished" and that "the end of the Receivership appears to be in sight." Consistent with the Court's order, Defendants have proposed a viable transition plan and are fully prepared to resume control of CDCR's medical care system this year. All of the significant measures Defendants have taken over the past several years, in conjunction with CDCR's newly released plan, abundantly demonstrate that Defendants have the will, capacity, and leadership to complete the few improvement projects that remain.

In the meet-and-confer sessions that took place following the Court's order, Defendants attempted to initiate discussions about a proposal to transition prison medical care back to the state. But little progress was made regarding the timing of the transition. The sustained commitment and capability Defendants have demonstrated time and again over the past several years remain to be acknowledged by either the Receiver or Plaintiffs. Instead, the Receiver proposes here in this document to remain in place for at least another 20 months until 2014. And he has devised no less than seven additional tests Defendants must pass in the future before he will be satisfied. The Receiver's position is unreasonable and would result in federal control over California's prison medical care system longer than is necessary.[3]

A post-receivership plan could easily be structured to prevent backsliding. Under Defendants' proposal, CDCR will successfully complete the remaining projects and maintain a quality prison health care system into the future, and the Court can oversee Defendants' progress by appointing a special master. The time has come to return California's prison medical care system back to California.

[3] Similarly, in their introductory statement Plaintiffs rely exclusively on ancient history set forth in the OAR. Defendants' proposal here explicitly sets forth Defendants' ability to take over and maintain the state's prison medical health care system.

A. Most of the Goals of the Receiver's Turnaround Plan of Action Have Been Accomplished.

On June 6, 2008, the Receiver submitted for approval a Turnaround Plan of Action that was designed to "to correct constitutional deficiencies in California's prison health care system." (*See* The Federal Receiver's Turnaround Plan of Action, June 6, 2008 (Dkt No. 1229) at ii (Turnaround Plan or TPA)). The Turnaround Plan sets six goals, with associated objectives and action items, that collectively "summarize the steps necessary for CDCR's health care program to rise to constitutionally acceptable and sustainable levels." (TPA at iv.)

The six goals in the Turnaround Plan have been substantially completed or are nearly complete. (*See* Nineteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, January 13, 2012 (Dkt. No. 4145-1) (hereafter 19th Report).) The progress made toward each of these goals—and therefore toward the attainment of a sustainable, constitutionally adequate prison medical care system in California—is described in detail below:

1. The Receiver's First Goal—Ensure Timely Access to Health Care Services—Is Substantially Complete.

The Receiver reports that he has completed several of his objectives to ensure that inmate-patients receive timely access to health care services. The Receiver completed all actions necessary to accomplish the following objectives:

- Objective 1.1: "Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release." (TPA at 5; *see also* 19th Report at 4.)
- Objective 1.2: "Establish Staffing and Processes for Ensuring Health Care Access at Each Institution." The Receiver addressed custody interference with access to care by establishing "Health Care Access Units" at every institution—dedicated custody staff whose mission is to facilitate inmate access to health care services. (*Id.*) In November 2011, the number of inmate-patients who were unable to attend their medical appointment due to custody issues represented just 0.5% of the total number of requests. (*Id.*, Appendix 3.)

- Objective 1.4: "Establish a Standardized Utilization Management System." The Receiver has established a centralized Utilization Management system to ensure appropriate access to specialty services, infirmary beds, and hospitalizations, and has opened a long-term care unit at the California Medical Facility. (*See* TPA at 7; 19th Report at 4-5.)

The only remaining action necessary to fully complete this goal is for the Receiver to work with CDCR "to accelerate the development" of an electronic health care scheduling and patient tracking system within CDCR's Strategic Offender Management System. (19th Report at 5.)

2. The Receiver's Second Goal—Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services—Is Substantially Complete.

California Prison Health Care Services (CPHCS), the organization established under the Receivership to serve the health care mission within CDCR, delivers a continuum of health care services to patient-inmates across multiple levels of care and in both outpatient and inpatient settings. The Receiver has improved delivery at all levels of care, and has completed all actions necessary to accomplish the following objectives:

- Objective 2.2: "Improve Chronic Care System to Support Proactive, Planned Care." (19th Report at 6.)
- Objective 2.3: "Improve Emergency Response to Reduce Avoidable Morbidity and Mortality." The Receiver implemented an Emergency Response System policy for all institutions that meets all applicable standards, implements training programs for clinical and custody staff, and requires the acquisition of appropriate emergency response equipment for all institutions. (*Id.*)
- Objective 2.4: "Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality." (*Id.*)

The redesign of the primary care model at all 33 adult institutions has been one of the most important improvements. (19th Report at 12-13.) The Receiver redesigned and

standardized the "sick call" process and is finalizing review and approval of a new Episodic Care Policy and Procedure. (*Id.* at 6.) The new system will be implemented upon approval of the policy and procedure. (*Id.*)

3. The Receiver's Third Goal—Recruit, Train, and Retain a Well-Qualified Medical Care Workforce—Is Complete.

Since the start of the Receivership, there has been significant improvement in the number and quality of the professional health care staff. The Receiver reports that all objectives necessary to complete this goal have been completed, including recruiting physicians and nurses, establishing clinical leadership and management structure, and establishing professional training programs for clinicians. (19th Report at 8.)

4. The Receiver Has Established a Robust Quality Improvement Program Sufficient to Accomplish his Fourth Goal.

The Receiver has established sustainable quality assessment and patient safety programs. Although the Receiver continues to improve the quality improvement program, the Receiver reports that the following programs are in place:

First, the Receiver developed the Health Care Services Dashboard, a visual display of key performance measures that provides information across all programs for disease management, access to care, utilization management, cost, and human resources. (*See* http://www.cphcs.ca.gov/ docs/special/CCHCS_Dashboard_External.pdf.) The Dashboard is updated monthly and provides detailed aggregate and institution-level performance data on over 100 indicators. (*Id.*; *see also* 19th Report at 9-10.)

Second, the Office of Inspector General (OIG) conducts comprehensive medical inspections under an audit program that was jointly developed by the Receiver, Plaintiffs, and Defendants. The OIG has completed two rounds of inspections at all 33 prisons. (19th Report at 21.) In 2011, the Legislature passed and Governor Brown signed legislation that codified the OIG's ongoing obligation to conduct these medical inspections. (Pen. Code § 6126, subd. (f).)

Third, the Receiver implemented an annual death review process beginning with a review of California inmate deaths in 2006. These death reviews use a standardized, retrospective process that begins with a preparation of a death review summary, prepared by trained reviewers in the Clinical Support Unit. (*See* 2008 Death Reviews at 2.) The summary is presented to a multidisciplinary committee (the Death Review Committee) that makes appropriate referrals to remediate the problems. (*Id.* at 2-3.) The primary purpose of the death reviews is to determine the cause of death, determine whether the death could have been prevented, identify significant departures from the community standard of care attributed to an individual provider, identify significant health care system lapses in care, and make referrals for appropriate action when a situation is identified related to an individual's performance or systemic lapse. (*See* 2008 Death Reviews at 2-3.)

Fourth, the Receiver implemented a Credentialing and Privileging Program. The Credentials Committee is responsible for ensuring that only providers who meet the credentialing requirements, and satisfy the quality of care, professionalism, and practice standards are granted credential approval to provide health care services to inmates. (*See* Eighteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, September 15, 2011 (Dkt. No. 2396) at 21-23 (18th Report).)

Finally, the Receiver established a robust medical peer review and discipline process through the Professional Practices Executive Committee, a clinically-based, peer-review committee whose findings and recommendations are acted upon by the Governing Body. (*Id.* at 26-28; 19th Report at 14.) The Receiver also established the Medical Oversight Unit to control and monitor medical employee investigations. (19th Report at 14.) This program ensures thorough review and investigation of allegations of misconduct related to health care delivery by health care staff. The Medical Oversight Unit commenced operation in January 2008. (*Id.*)

The substantial progress in delivery of care at the prisons is also reflected in the latest OIG inspection results. The OIG medical inspection program encompasses 19 components of medical delivery and includes 138 separate questions. (*See, e.g.,* California Institution for Men

Medical Inspection Results, April 2012, at 3, *available at* http://www.oig.ca.gov/media/reports/MIU/California%20Institution%20for%20Men%20Medical%20Inspection%20Results%20Cycle%202.pdf.) The OIG also developed a weighting system and assigned points to each question based on the medical risk to an inmate-patient. (*Id.*) At the conclusion of the first round of medical inspections of all 33 institutions, the average overall weighted score was 72 percent. (*See* May 2011 OIG Report at 2.) The average overall weighted score in the second round has risen to 79.6 percent, with several institutions showing dramatic improvements of 12 to 15 percentage points. (*See* Declaration of Martin Hoshino, ¶ 2, Ex. 1.)

5. The Receiver Has Completed Many of the Objectives Necessary to Complete His Fifth Goal: Establish Medical Support Infrastructure.

The Receiver has taken several measures to enhance the information technology capabilities of the health care system. The Receiver established a statewide clinical data repository to serve as the platform for custody, disability, pharmacy, and laboratory data needs and programs. The Receiver completed the implementation of an enterprise-wide electronic Unit Health Record (eUHR) with rollout to the men's institutions on July 19, 2011. (18th Report at 37.) The Receiver is developing an Electronic Medical Record system, and issued a Request for Proposal on April 20, 2012. (*See* CPHCS Request for Proposal, Electronic Medical Record Project, *available at* http://www.cphcs.ca.gov/docs/projects/EMR_RFP12-009-ITS-20120420.pdf.)

Pharmacy operations have markedly improved. The Receiver contracted with a nationally-recognized provider of pharmacy services, Maxor National Pharmacy Services Corporation, to assist in establishing a comprehensive, modern pharmacy program throughout CDCR. (TPA at 20.) The Receiver established a drug formulary for the most commonly prescribed medications to standardize and improve quality of care at reduced cost. (19th Report at 16 & Appendix 9.)

And the Receiver established a Central Fill Pharmacy Facility to manage inventory and central distribution. (19th Report at 16.) The Central Pharmacy substantially improves CDCR's

ability to control and cost-effectively manage its drug inventory and utilization through bulk purchasing.

6. The Receiver Has Delegated Authority to Defendants to Complete the Receiver's Sixth Goal: Provide Needed Clinical, Administrative, and Housing Facilities.

The Receiver has delegated authority to Defendants to build new health care facilities and to update existing facilities to meet the health care needs of the prison population.

At San Quentin State Prison, Defendants constructed the San Quentin Central Health Services Facility, a state-of-the-art correctional health care center that was activated on November 19, 2009. Defendants also built new and improved sick call units in facility rotundas, new clinical office space, a new medical supply warehouse, and renovated triage and treatment areas. Defendants also constructed a new health care facility at Avenal State Prison.

At the California Medical Facility, Defendants converted a general population dormitory into a 72-bed Outpatient Housing Unit. The construction added examination rooms, nurses' stations, medication dispensary, and a general storage room. Patient admissions began on August 16, 2010.

Defendants have also completed the following large-scale construction projects and facility upgrades under a long-range mental health bed plan in *Coleman v. Brown*, No. 2:90-cv-00520 LKK (E.D. Cal.):

- at Salinas Valley State Prison, Defendants constructed a 64-bed Intermediate Care Facility (ICF) and additional treatment space;
- at the California Medical Facility, Defendants constructed a 64-bed ICF, which began admitting patients in February 2012. Defendants also constructed a 50-bed Mental Health Crisis Bed (MHCB) Facility and renovated 124 cells for risk mitigation;
- at Avenal State Prison, Defendants built an addition to the clinic and office space;
- at Mule Creek State Prison, Defendants built additional treatment and office space for EOP-general population;

- at the Substance Abuse Treatment Facility in Corcoran, Defendants converted housing to add 88 dual diagnosis beds for EOP/Substance Abuse inmates and 176 beds for EOP inmates with special security needs; and
- at the California Institution for Women, Defendants constructed a 20-bed Psychiatric Services Unit facility, and are constructing a new 45-bed ICF, which is scheduled to open in the next few months.

In addition, the following health care facility projects are presently underway:

- in Stockton, construction is underway for a new 1.2 million square-foot intermediate-level medical and mental health care facility called the California Health Care Facility (CHCF), at a total construction cost of $840 million. The new facility will house 1,722 inmates, will centralize care for inmates with significant health care needs from throughout the prison system, and is expected to be activated in 2013. Defendants are also renovating the DeWitt Nelson Youth Correctional Facility adjacent to CHCF to create a unified Stockton complex that allows efficient transition of the most seriously ill inmate-patients between these two facilities;
- at California Medical Facility, Defendants are constructing additional treatment and office space; and
- at California Men's Colony, Defendants are constructing a 50-bed MHCB unit.

B. Public Safety Realignment.

In April 2011, the Legislature passed historic public safety realignment legislation proposed by the Brown Administration, known as Assembly Bill 109, that went into effect on October 1, 2011. After CDCR's successful implementation, realignment has had an immediate impact on the prison population. Since going into effect on October 1, the population in the state's 33 institutions has decreased by more than 21,000 inmates. (Declaration of Martin Hoshino, ¶ 4.) This population decrease has improved the quality of medical health care, including access to medications and physicians. (*Id.*) As of February 23, 2012, the thousands of

makeshift beds in gymnasiums and dayrooms that CDCR has been forced to use for years are now gone. (*Id.*; http://cdcrtoday.blogspot.com/2012/03/cdcr-announces-final-deactivation-of.html.)

C. On April 23, 2012, The State Released Its Integrated Plan to Effectively And Efficiently Manage CDCR Post Realignment.

Realignment has provided California an historic opportunity to create not just a less-crowded prison system, but one that is safer, less expensive, positioned to continue to provide constitutionally adequate health care to inmate-patients, and better equipped to promote rehabilitation. On April 23, 2012, the state released a plan that builds upon the changes brought by realignment, and delineates, for the first time, a clear and comprehensive blueprint that will enable CDCR to substantially comply with various court mandates and achieve better correctional objectives – all while spending as few taxpayer dollars as possible and necessary in these economically challenging times. (Hoshino Decl., ¶ 5, Ex. 2; *see also* Ex. 3 [April 29, 2012 Sacramento Bee editorial: "California Can Now Revamp its Prison System at Lower Cost"].)

Under the Plan, "The Future of California Corrections," CDCR will improve its inmate classification system, allowing the department to safely shift about 17,000 inmates to less costly housing where they can benefit from more rehabilitative programs. (*Id.*, Ex. 2, at Introduction 7.) These modifications, which will start being implemented within six months, will eliminate the need to build expensive, high-security prisons. (*Id.*)

The plan also calls for the return of out-of-state inmates-inmates who were sent out of state when crowding was at its peak in 2007. (*Id.*) Currently, there are more than 9,500 inmates housed out of state. (*Id.*) CDCR will be able to bring these inmates back as crowding is reduced, changes are implemented in the classification system, and additional rehabilitative housing units are constructed at existing facilities. (*Id.*) Returning these inmates to California will stop the flow of taxpayer dollars to other states, is expected to save the state over $300 million, and will allow inmates to be housed closer to their homes and families. (*Id.*)

The plan also enables CDCR to expand rehabilitative programs, and will place at least 70 percent of CDCR's target population in programs consistent with their academic and rehabilitative needs before being released. (*Id.*) This, in turn, is expected to reduce recidivism by better preparing inmates to be productive members of society. In addition, it will help lower the long-term prison population and save money. (*Id.*)

The state's comprehensive plan also ensures that it will continue to provide constitutionally adequate healthcare to inmate patients by increasing the capacity of the healthcare system. As described above, the California Health Care Facility (CHCF) in Stockton will provide 1,722 beds specially designed to house inmates requiring long-term medical care and intensive mental health care. (*Id.* at ¶ Introduction 8.) Its annex, the soon-to-be renovated DeWitt Correctional Facility, will open in the summer of 2014 to create a unified Stockton complex, allowing both facilities to efficiently transition inmate-patients between the two, while avoiding transportation and security costs as well as the need for expensive services in community hospitals and clinics. (*Id.*) These projects, in addition to the ongoing mental health infill projects and upgrades and improvements to both medical and dental clinics at existing prisons, are key components of the state's plan. (*Id.*) These efforts demonstrate the state's will, capacity and leadership to maintain a constitutionally adequate healthcare delivery system for years to come–both in the near term after the termination of the Receivership, and after all judicial oversight ends.

RECEIVER'S AND PARTIES' RESPONSES TO PLANNING ORDER ISSUES

1. How substantial compliance should be measured, including how the OIG scores should be used and whether the court experts should be involved.

Receiver's Response

The Receiver proposes that before the prison medical health care system will be considered to be in substantial compliance the Defendants must: (1) with respect to each prison in the system, satisfy compliance criteria substantially similar to the criteria set forth in the 2002 Stipulation, and (2) complete the construction currently proposed by Defendants, including the

California Health Care Facility ("CHCF"), the DeWitt Nelson project and the Health Care Facility Improvement Program ("HCFIP").

With respect to the first factor, an individual prison should be considered in substantial compliance if it receives the requisite OIG score described below and passes an assessment by court appointed medical experts. The following OIG scores would be required for each institution: a score of 80% or higher, or if an institution scores less than 80%, a score of no less than 75% would be sufficient if the medical experts conclude that the institution is providing "adequate medical care." 2002 Stipulation at 10. "The [OIG inspection] score shall be calculated by averaging all of the indicators in the audit instrument." Id. Specific assessment measures should include whether (1) the experts have concluded that there is no "pattern or practice that is likely to result in serious problems" that are not being adequately addressed (id. at 12); (2) CCHCS, statewide and locally as applicable, "is conducting minimally adequate death reviews and quality management proceedings" (id. at 11); and, (3) "the prison generally has tracking, scheduling and medication administration systems adequately in place" (id. at 12).

With respect to the second factor for substantial compliance, the construction of the CHCF is well underway. However, the HCFIP and the DeWitt Nelson project are the principal components of the TPA which remain uncompleted. The Receiver believes that for the system to be considered substantially compliant, the necessary construction, including the CHCF, HCFIP and DeWitt Nelson facility, must be completed.

Plaintiffs' Response

Plaintiffs' agree with the Receiver's proposal, with two modifications. The Receiver's proposal is consistent with the original Stipulation for Injunctive Relief, which similarly provided that each prison's compliance would be measured using a process featuring both objective and subjective components. Specifically, an objective audit instrument, measuring compliance with numerous policy and procedure requirements, would be used by defendants and the Court experts, resulting in an overall score. A score of 85% on the audit instrument was set forth as a measure of substantial compliance, except that the experts were given discretion to find

that a score of 75% was adequate. Additionally, the independent experts would conduct a subjective review at each prison in which they assessed certain essential functions (death review and quality management activities as well as scheduling, tracking and medication processes) that are not easily quantifiable in an objective audit. They also would consider at each prison whether there was any pattern or practice likely to result in serious problems that was not being adequately addressed.

The dual objective and subjective components, including in particular the determination as to whether there is any pattern or practice likely to result in serious problems, are essential to determining the adequacy of a medical care delivery system. The objective components, while permitting standardized review of many policy requirements, can and do mask serious compliance deficiencies when an overall score is used. For example, the OIG's Summary and Analysis of its first cycle of medical inspections, issued in May 2011, reported a statewide average compliance score (i.e., at all 33 prisons) of 72%. Report at 14. However, the OIG reported that the statewide average compliance score for medication management was just 59% with five prisons scoring below 45%. Id. at page 71. Similarly, the OIG reported the statewide average compliance score for access to providers and services was just 65%, with eight prisons scoring below 60%. Id. at page 75.

Similarly, and to use a recent single prison inspection as an example, the OIG in February 2012 published its results of its cycle 2 medical inspection at Avenal State Prison. The prison received an overall compliance score of 86.9%. Avenal Report, February 2012, at page 1. However, Avenal received very low compliance scores with respect to the timeliness of certain primary care provider appointments: only 58.3% of chronic care visits were determined to have been timely, only 64.7% of provider visits were timely after referral by a registered nurse, only 53.8% of provider sick call follow-up appointments were timely, and only 41.7% of provider appointments were timely after a nurse referred a newly-arrived prisoner-patient. Id. at 8 (reference number 03.076), 9 (reference numbers 01.027 and 01.247), and 11 (reference number 02.018). Similarly, compliance with medication requirements was found by the OIG in only

60% of chronic care cases at Avenal, and in only 63% of sick call cases. Id. at 8 (reference number 03.175) and 10 (reference number 01.124).

Given the limits of the overall objective score, there are two alternatives to reliably assess substantial compliance. One approach would require scores equal to or greater than the required overall score for a series of key indicators such as timely access to doctors and medication administration. The other approach would require experts to determine if there was a pattern or practice likely to cause serious problems that was not being adequately addressed; such determinations would plainly consider the impact of such low compliance scores. Either of these approaches are acceptable to plaintiffs; the original Stipulation called for the latter approach.

The Receiver's proposal for measuring substantial compliance, which plaintiffs mostly agree with, embodies objective and subjective components comparable to those set forth in the Stipulation. An objective score, as determined by OIG medical inspections would be obtained and, if sufficient, the experts would then conduct their assessment of each prison, including of key matters (such as death reviews and quality management activities) that are not susceptible to objective review as well as determining if there are any patterns or practices causing serious problems. As explained above, this last determination is one of two acceptable means of reliably determining substantial compliance given the limits of an overall average score that can mask serious deficiencies. Here, plaintiffs defer to the Receiver's choice; the experts, of course, would have to assess each prison in any event, to determine the adequacy of matters not reducible to quantifiable objective measures.

Plaintiffs propose two changes to the Receiver's proposal. First, the compliance measures set forth in the original Stipulation – 85% with a minimum of 75% possible if the experts find adequacy – should be used. The parties previously agreed that those levels are appropriate.

Plaintiffs have also added to the Receiver's proposal by specifying that "peer and physician clinical practice review processes" would be included in the experts' review of quality

management activities. Although peer and clinical practice review are an element of quality management activities, it is prudent to be clear that these matters must be assessed.

Thus, plaintiffs would revise the second paragraph of the Receiver's proposal as follows:

> With respect to the first factor, an individual prison should be considered in substantial compliance if it receives the requisite OIG score described below and passes an assessment by court appointed medical experts. The following OIG scores would be required for each institution: a score of 80% or higher, or if an institution scores less than ~~80~~85%, a score of no less than 75% would be sufficient if the medical experts conclude that the institution is providing "adequate medical care." 2002 Stipulation at 10. "The [OIG inspection] score shall be calculated by averaging all of the indicators in the audit instrument." Id. Specific assessment measures should include whether (1) the experts have concluded that there is no "pattern or practice that is likely to result in serious problems" that are not being adequately addressed, (id. at 12); (2) CCHCS, statewide and locally as applicable, "is conducting minimally adequate death reviews and quality management proceedings" (id. at 11) including peer and physician clinical practice review processes; and, (3) "the prison generally has tracking, scheduling and medication administration systems adequately in place" (id. at 12).

Defendants' Response

This Court's January 17, 2012 order stated that the OIG "scores unquestionably provide some guidance as to whether the care being provided at an individual institution is constitutionally adequate." (Dkt. No. 2417 at 2.) Defendants agree and believe that an overall average score of 75 percent should be considered a strong indication that CDCR is operating a constitutionally adequate medical health care system. (Hoshino Decl., ¶ 3.) As this Court is aware, the OIG developed the inspection program in consultation with the Prison Law Office, the

Receiver's Office, CDCR, and the Court, and the scores have continued to rise. (*Id.* at ¶ 2.)[4] The OIG recently completed inspections and published reports for all 33 prisons during the second inspection cycle. The average score for Cycle Two is 79.6 percent, 29 prisons achieved a score higher than 75 percent, and all 33 prisons scored at least 73 percent. (*Id.* & Ex. 1.)

Because the overall OIG scores measure the state's compliance with medical community standards, they should be used as a key indicator of constitutional compliance signaling when the case should end. (*Id.* at ¶ 3.) Moreover, as discussed in detail in response to the Court's third question, the Court should appoint a Special Master to monitor and report on the state's commitment to provide constitutionally adequate medical health care. (*Id.* at ¶ 12.) Consistent with the 2002 Stipulation, the Special Master may employ experts to evaluate clinical issues specific to whether the state is deliberately indifferent to the serious medical needs of class members to provide assurance that the medical health care system is constitutionally adequate, so long as the overall average score is no less than 75%. (*Id.* at ¶ 13.) Monitoring by the Special Master combined with continued OIG inspections more than adequately measures constitutional compliance, and there is no need for the continued involvement of the previously-appointed court experts or oversight by Plaintiffs' counsel. (*Id.*)

Plaintiffs focus on individual OIG measures related to compliance with strict policy time lines at a single prison. Appendix 3 of the Receiver's 19th Report unequivocally shows that patients are being seen by a doctor, both at Avenal State Prison and system-wide. At Avenal, 92% of patients were seen by their doctor in August 2011, 94% in September 2011, 95% in October 2011, and 93% in November 2011. (19th Report, Appendix 3.) Moreover, during the meet-and-confer, the Receiver stated that 60% of the missed appointments were missed by 5 days or less, and 100% of patients were seen by a doctor. (Hoshino Decl., ¶ 3.) The Receiver also stated that he "commonly found that a patient was actually seen several times before the

[4] The Receiver's reliance on the 2002 Stipulation to define "substantial compliance" is puzzling in light of the substantial changes that have occurred since the stipulation was signed. Neither the Receivership nor the OIG inspection program existed in 2002, and the audit tool used by the OIG is vastly different from the "audit instrument" contemplated by the 2002 Stipulation. Moreover, as the Court stated in its January 17, 2012 order the language the Receiver relies on "was discontinued by the Court following the Receiver's appointment and prior to the development of the OIG inspection instrument." (1/17/12 Order at 2 fn.2; *see also* 9/6/07 Order at 10.)

scheduled appointment by a nurse or physician on other matters. The overall pattern suggests that even when we miss certain deadlines, there is a lot of access to clinicians." (*Id.*) Plaintiffs' complaint is thus neither systemic, nor of constitutional scope.

2. Criteria for determining when it is appropriate to move from the Receivership to a less intrusive system of oversight, including factors the court should consider when evaluating Defendants' will, capacity and leadership to maintain a system of providing constitutionally adequate medical care services to class members.

Receiver's Response

The Receiver proposes that the Receivership should terminate, to be replaced by a Special Master, when four conditions have been satisfied: (1) all action items in the Receiver's TPA have been completed (with the exception of the HCFIP and DeWitt Nelson project); (2) OIG scores system-wide are at or trending toward substantial compliance; (3) a plan for physician staffing at "hard to fill" institutions has been developed; and, (4) the Defendants have demonstrated that they are ready and able to assume control of the system.

With regard to first required condition, the Receiver has completed most of the action items in the TPA and anticipates that the remainder (with the exception of the HCFIP and DeWitt Nelson project) will be completed by January 2014. Completion of the punch list items desired by Plaintiffs would not be required as a condition of ending the Receivership. However, most of the items on the list are likely to be substantially complete by January 2014 (approximately when the Receivership would end). Completion of the HCFIP and the DeWitt Nelson project would be accomplished under the auspices of the Special Master proposed below. The Receiver does not expect the prison medical system to achieve substantial compliance upon the completion of the TPA. It may take a year or more after the implementation of all the TPA's action items for all of the medical programs to mature to the point where the system is substantially compliant. Termination of the Receivership should be viewed, instead, as a step toward substantial compliance. Monitoring by a Special Master is a more appropriate form of court oversight between termination of the Receivership and the point at which substantial compliance is achieved.

The second condition is self-explanatory, but the Receiver cautions that he does not believe that it is necessary for the prisons, individually or system-wide, to achieve any specific OIG score before the Receivership terminates. Nevertheless, it is appropriate to expect that the trend line for the OIG scores points in the direction of improvement.

The third condition is essential since an ongoing problem in the medical health care system has been and continues to be that some prisons, particularly those in more remote areas, have had great difficulty in attracting and keeping high quality medical professionals.

The fourth and final criterion is, ultimately, the most important. This Court stressed in the OAR "[t]he Receivership shall remain in place no longer than the conditions which justify it make necessary, and shall cease as soon as the Court is satisfied, and so finds in consultation with the Receiver, that Defendants have the will, capacity, and leadership to maintain a system of providing constitutionally adequate medical health care services to class members. " OAR, ¶ V.

The Receiver believes that Defendants should be deemed to have demonstrated "the will, capacity, and leadership to maintain a system of providing constitutionally adequate medical health care services" when they have satisfied each of the following conditions: (1) achieved the population limits established by the three-judge court; (2) constructed the California Health Care Facility in Stockton, adequately funded its activation and otherwise made adequate provision for full occupancy of the facility (activation is anticipated by July 2013 and full occupancy is estimated by January 2014); (3) obtained Public Works Board, Pooled Money Investment Board, and Department of Finance approval for commencement of construction of the Dewitt Nelson facility in Stockton and all HCFIP projects at Intermediate Care prisons; (4) adequately funded the prison medical system in Fiscal Years 2012-13 and 2013-14; (5) adequately sustained at least two medical system programs (to be selected by agreement between the Receiver and Defendants) under delegation from the Receiver; and, (6) obtained statutory and/or regulatory changes adequate to continue all necessary medical programs and procedures currently possible only through waivers of state law obtained by the Receiver, including the physician peer review process; and, (7) established a healthcare department or division within CDCR as described in

Issue 5, below. Completion of the HCFIP and DeWitt Nelson project would occur under the auspices of the Special Master and, as noted above, would be necessary for a finding of substantial compliance.

Plaintiffs' Response

Again, plaintiffs believe the Receiver's proposal (the actual particulars of which are found in the first and final paragraphs) is sound, but requires modification. First, a flat 75% OIG score threshold should be established as one of the circumstances necessary to end the Receivership. The Court should not adopt the Receiver's suggestion that compliance scores "trending towards substantial compliance" be considered appropriate, if a score at a particular prison is not at least 75%. The term "trending towards substantial compliance" is vague, and would in any event permit transition from the Receiver even if an overall compliance score is very low, so long as it was just marginally higher than a previous score. The Receivership should not end unless prisons are at or very close to substantial compliance. Additionally, should defendants' performance on the OIG audits backslide such that more than eight of the 33 prisons achieve an overall score below 75%, the Receivership should be reinstated.

Plaintiffs also propose that the Receivership not end until an acuity-based medical staffing model is developed and implemented for the prisons, as well as a model for staffing headquarters and regional functions. Over the last several months the Receiver has been developing a medical staffing model by which the number of allocated positions at each prison is based on formulas derived from the acuity of prisoner-patients and other objective factors. The Receiver will use this acuity-based staffing model to replace existing staffing allocations, which are based on sometimes difficult-to-determine historical factors which either did not or did not fully take into account the morbidity of the patient population. Then, after a pilot period and any necessary adjustments, the Receiver intends to implement the acuity-based model so that future medical staffing decisions – including when the Medical Classification system is implemented such that large numbers of prisoners with the most serious conditions are clustered at approximately one dozen prisons – are based on its more objective formulas and ratios.

Implementing the new model, whether seen as part of or an essential ancillary action related to the Turnaround Plan professional staffing goals, is necessary for a adequate medical delivery system, and requires considerable technical and management expertise. The same is true for a model for headquarters and regional medical staff.

Plaintiffs also propose clarifying the language suggested by the Receiver regarding completion of a plan for physician staffing at the hard-to-fill prisons, so that it is understood that completion of a plan means that the vacant positions are actually filled.

It should also be necessary, before the Receivership ends, for key policies and procedures to be revised to reflect current practices. Policies and procedures are key to a minimally adequate medical delivery system, and it is for that reason the Stipulation in this action requires, as a primary matter, that they be followed. See Stipulation at ¶ 4. The policy revisions named by plaintiffs are central to the operation of an adequate medical care delivery system, and in some cases – including regarding death review and with respect to the existence and functions of Healthcare Chief Executive Officers at each prison (established and hired in 2009 and 2010), necessary revisions have been pending for approximately two years. Similarly, revision of the policy and procedure regarding the new healthcare administrative appeals process – a matter which the Stipulation explicitly recognizes is "an integral part of providing essential medical care" (Stipulation at ¶ 7) has been pending for almost a year. In order for an orderly transition to State operation, it should be required that the Receiver complete the specified key policy and procedure revisions.

Finally, plaintiffs believe a court order regarding production to and access by plaintiffs to documents, embodying the matters provided to plaintiffs by the Receiver, should be a necessary condition for defendants to re-assume control. Production and access to documents is part of the monitoring that will continue when the Receivership ends.

Thus, plaintiffs propose the following revisions to the first and final paragraphs of the Receiver's response to Issue 2:

The Receiver proposes that the Receivership should terminate, to be replaced by a Special Master, when ~~four~~ six conditions have been satisfied: (1) all action items in the Receiver's TPA have been completed (with the exception of the HCFIP and DeWitt Nelson project); (2) OIG scores system-wide ~~are at or trending toward substantial compliance~~ must be at least 75%, and if the overall scores at nine or more institutions dip below 75%, the Receivership will be reinstated; (3) the Receiver's acuity-based medical staffing model at the prisons, and formulas for staffing for headquarters and any regional medical care operations are finalized, funded and implemented; (4) a plan for physician staffing at "hard to fill" institutions has been developed such that at least 90% of the positions are filled (5) completion of policy and procedure revisions regarding each of the following: (a) quality management and quality improvement activities including death reviews, the medical oversight program, peer review, and prisoner-patient health care grievances, (b) new health care records processes and (c) the role and functions of Chief Executive Officers, Chief Medical and Nurse Executives and other central and local physician and nurse managers, as well as the functions of headquarters' divisions and committees; and, (6~~4~~) the Defendants have demonstrated that they are ready and able to assume control of the system.

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The Receiver believes that Defendants should be deemed to have demonstrated "the will, capacity, and leadership to maintain a system of providing constitutionally adequate medical health care services" when they have satisfied each of the following conditions: (1) achieved the population limits established by the three-judge court; (2) constructed the California Health Care Facility in Stockton, adequately funded its activation and otherwise made adequate provision

for full occupancy of the facility (activation is anticipated by July 2013 and full occupancy is estimated by January 2014); (3) obtained Public Works Board, Pooled Money Investment Board, and Department of Finance approval for commencement of construction of the Dewitt Nelson facility in Stockton and all HCFIP projects at Intermediate Care prisons; (4) adequately funded the prison medical system in Fiscal Years 2012-13 and 2013-14; (5) adequately sustained at least two medical system programs (to be selected by agreement between the Receiver and Defendants) under delegation from the Receiver; ~~and,~~ (6) obtained statutory and/or regulatory changes adequate to continue all necessary medical programs and procedures currently possible only through waivers of state law obtained by the Receiver, including the physician peer review process; ; (7) established in a Court order a process for production of documents to plaintiffs identical to that in place at the time the Receivership ends; and, (8~~7~~) established a healthcare department or division within CDCR as described in Issue 5, below. Completion of the HCFIP and DeWitt Nelson project would occur under the auspices of the Special Master and, as noted above, would be necessary for a finding of substantial compliance.

Defendants' Response

The imposition of a federal receivership disrupts democratic principles by shifting control away from the state, makes managing prison affairs more difficult, and imposes additional fiscal costs. In 2005, the Court, upon finding that a receivership was necessary, stated that the receivership is a temporary measure that should cease as soon as it is no longer needed:

> It bears emphasizing that establishment of the Receivership, while absolutely necessary, is intended as a temporary, not permanent, measure. The Court looks forward to the day, hopefully sooner rather than later, when responsible officials of the State will assume their legal obligations to run the CDCR in a manner that provides constitutionally adequate health care to all prisoners. As the Supreme Court has instructed, "[a] receivership is only a means to reach some legitimate end sought through the exercise of the power of a court of equity. It is not an end in itself." [*Gordon v. Washington*, 295 U.S. 30, 37 (1935)]. Once the Court is

> confident that defendants have the capacity and will to provide such care, the Court will relinquish control from the Receiver back to the State.

(10/3/05 Findings of Fact and Conclusions of Law, Dkt. No. 371, at 50.) The Order Appointing Receiver (OAR) states that "[t]he Receivership shall remain in place no longer than the conditions which justify it are necessary, and shall cease as soon as the Court is satisfied, and so finds in consultation with the Receiver, that Defendants have the will, capacity, and leadership to maintain a system of providing constitutionally adequate medical health care services to class members." (OAR at 7.) Defendants' actions over the course of the past several years have proven they have the will, capacity, and leadership to retake control of their prison medical care system.

First, last spring the Legislature enacted Governor Brown's Public Safety Realignment legislation that shifts lower-level offenders to county jail. Due to the state's enactment of this landmark legislation, the prison population is in the midst of an historic reduction. The population in the state's 33 institutions dropped by nearly 21,000 since October 2011 when realignment began, and by approximately 40,000 since November 2006 when the three-judge court was convened. (Hoshino Decl., ¶ 4.) Prior to the implementation of realignment, Defendants decreased the institution population by more than 18,000 inmates since January 2010. (1/6/12 Declaration of Jay Atkinson, Dkt No. 4142, ¶ 5.) For example, Senate Bill 18 XXX (enacted January 2010) has reduced the prison population through enhanced sentencing credits, changes to parole rules which resulted in fewer parolees returning to state prison, funding for community-corrections programs to implement and expand evidence-based programs for felony probationers, and by redefining certain crimes so that fewer crimes result in felony convictions and prison sentences. (*Id.*) Defendants have also complied with the three-judge court's population reduction targets to date, and continue to reduce the population. (Hoshino Decl., ¶ 20.)

Second, Defendants have increased spending on mental and dental health care during a time of extensive state-wide budget cuts. (*Id.* at ¶ 6.) Between FY 2006-07 and FY 2011-12, expenditures on prison dental health care increased by 154.13%, from $59.4 million to

$151.1 million. (*Id.*) Defendants increased spending on mental health care by 87.8% between FY 2005-06 and FY 2011-12, from $165.6 million to $311 million. (*Id.*) Defendants have also passed audits to achieve American Correctional Association accreditation, including the medical programs, for three institutions, and are working on achieving accreditation for five additional institutions. (*Id.*)

Third, Defendants have demonstrated success in other health care class actions. On March 21, 2011, this Court terminated *Madrid v. Cate*. (*Id.* at ¶ 7.) Defendants are well on their way to resolving *Perez v. Brown*, which challenged the constitutional adequacy of CDCR's dental care system. (*Id.*, Ex. 2, at p. 51.) To date, 30 of 33 institutions have been reviewed by the dental experts and have satisfied all of the court-ordered mandates, and Defendants anticipate that all prisons will pass the audits by August 2012. (*Id.*) In *Coleman v. Brown*, Defendants have successfully reduced or eliminated the wait lists for high-custody inmates needing inpatient mental health care. On March 16, 2010, the wait list for high-custody inmates needing ICF treatment totaled 542 and on March 15, 2010, the wait list for the inmates needing Acute treatment totaled 97. (*Coleman* Dkt No. 3962-1 at 4.) As of May 3, 2012, there were only 13 inmates who have been accepted by DMH and are pending ICF admission, and just three of those inmates have been waiting more than 30 days, all due to medical holds. Nine inmates were pending Acute admission. (Hoshino Decl., ¶ 7.)

Fourth, last year Governor Brown signed legislation codifying the OIG's medical inspection duties, thereby ensuring continued independent oversight of the medical health care system. (*See* Cal. Penal Code § 6126(f).)

Fifth, Defendants have developed a comprehensive plan to ensure that the state will continue to provide constitutionally adequate healthcare to inmate patients by increasing the capacity of the healthcare system. (*See* Hoshino Decl., Ex. 2.) Defendants are constructing the California Health Care Facility (CHCF) and renovating the DeWitt Correctional Facility in Stockton. These projects, in addition to the ongoing mental health infill projects and upgrades

and improvements to both medical and dental clinics at existing prisons, are key components of the state's plan. (*Id.*)

Finally, the state's Plan for Post-Receivership Governance (attached as Exhibit 4 to the Declaration of Martin Hoshino) demonstrates that Defendants have the will, capacity, and leadership to maintain a sustainable system of providing constitutionally adequate medical health care services to class members.

In addition to Defendants' demonstrated ability to operate and maintain the medical health care system, the Receiver's own reports demonstrate that current conditions no longer justify the Receivership. As discussed in Defendants' Statement of the Case and the Receiver's 19th Report, the Receiver's six goals outlined in the Turnaround Plan have been completed or are near completion. The Receiver reports that 77 percent of the Turnaround Plan has been substantially completed, and that adequate systems are in place. (19th Report at 1.) During the meet and confer, the Receiver confirmed that all of the remaining items in the Turnaround Plan have been initiated. (Hoshino Decl., ¶ 9.) Any constitutional deficiencies in California's prison health care system have thus been corrected, and the conditions which justified the Receiver's appointment no longer exist.

"The Receivership's overarching goal should be working itself out of existence once delivery of medical care to California's inmates has been brought up to constitutional standards." (OAR at 4.) The Receiver's proposal ignores the directives in the OAR, and all of the accomplishments by both Defendants and the Receiver to improve the medical health care system. Instead, the Receiver identifies a number of relatively minor tasks to be completed as the criteria for ending the Receivership. As discussed in Defendants' plan, Defendants are prepared to assume responsibility for completing the remaining items in the Turnaround Plan. (Hoshino Decl., ¶ 8 & Ex. 4.) The OIG medical inspection scores improved between Cycle One and Cycle Two, and codification of the medical inspection program ensures that inspections will continue. (*Id.* at ¶ 2 & Cal. Penal Code § 6126(f).) Defendants can work with the Special Master to develop "a plan for physician staffing at 'hard to fill' institutions." (Hoshino Decl., ¶

10.) In addition, many of the criteria used by the Receiver to define "will, capacity, and leadership" are included in Defendants' Plan for Post-Receivership Governance. (*Id.* at Ex. 4.) In short, none of the Receiver's criteria justify continuing the Receivership, particularly if a Special Master continues to provide oversight.

Based on the Receiver's progress on the Turnaround Plan, and Defendants' will and capacity to complete the Turnaround Plan, the Receivership should end and the Court should adopt Defendants' plan for post-Receivership governance. (*Id.* at ¶ 11.) Defendants suggest that the Court enter such an order within thirty days of the filing of this report, allowing CDCR to assume control of the medical health care system upon the entry of the order.

3. Whether the parties agree that the current Receiver can act as a monitor or special master once the Receivership ends and, if not, how the parties propose selecting a monitor or special master.

Receiver's Response

As indicated above, the Receiver believes that a Special Master should be appointed at the termination of the Receivership. Defendants proposed at one point in the meet and confer process that the current Receiver be appointed as Special Master and the Receiver is agreeable to taking on that role. The Receiver believes that the Special Master should be authorized to appoint experts to assist him as needed and as approved by the Court.

Plaintiffs' Response

Plaintiffs believe a Special Master, with a team of experts, is appropriate and necessary. At this point, it is not clear to plaintiffs whether the present Receiver would be the best candidate for this position because, while he is an excellent administrator and has accomplished a great deal, the skills and technical expertise needed as a Special Master are different. Since the Receivership should not end until early 2014, plaintiffs suggest that the selection of the Special Master be deferred until September 2013. Whether or not the Receiver is selected as Special Master, his involvement in the case should continue as a consultant or expert to the Special Master.

Defendants' Response

Upon the Receivership's end, the Court should appoint a Special Master to monitor and report on the state's maintenance of a constitutionally adequate medical health care system. (*See* Hoshino Decl., ¶ 12 & Ex. 4.) Defendants reserve judgment as to whether the current Receiver should be appointed as Special Master. (Id.) The Special Master's duties should be limited as follows:

- Time. The Special Master's compliance monitoring should continue for one year unless the overall system wide average OIG medical inspection score falls below 75%. (*Id.* at ¶ 14 & Ex. 4.)
- Scope. The duties of the Special Master should be to measure progress on completing the unfinished items in the Turnaround Plan, monitor the continuing OIG medical inspection program, provide or secure expert evaluation of clinical issues specific to whether the state is deliberately indifferent to the serious medical needs of class members, and assess the overall effectiveness of the transition of medical health care back to the state. (*Id.* at ¶ 15 & Ex. 4.) To accomplish this monitoring, the Special Master may retain subject matter experts to assess clinical issues specific to whether the state is deliberately indifferent to the serious medical needs of class members. (*Id.*)
- Budget. The Special Master's budget for the one-year monitoring period shall be indexed to the overall size of the Division of Health Care's medical budget and shall not exceed 0.05% of the budget in any given fiscal year ($750,000 in current year dollars). (*Id.* at ¶ 16 & Ex. 4.)

Given the monitoring that will continue under the OIG inspection program and by the Special Master, there is no need for additional monitoring by Plaintiffs during the post-Receivership phase. (*Id.* at ¶ 17.) Plaintiffs will continue to have access to the Receiver's Dashboard, Annual Analysis of Inmate Death Reviews, and Tri-Annual Turnaround Plan of Action Reports. (*Id.* at ¶ 10.)

4. Criteria for ending court oversight and concluding this case, including initial length of the post-Receivership monitoring period and whether the OIG inspection program or other independent process for inspections must be institutionalized before the Court ends its supervision.

Receiver's Response

The Receiver believes that Court oversight and termination of the case should occur when the Defendants have indicated that they are not only willing to provide constitutional care, but capable of providing constitutional care on a sustained basis. The Receiver believes that the Defendants will have demonstrated that capability when all facilities, individually measured, have continually maintained substantial compliance for at least one year following the end of the Receivership. The Receiver proposes that the duration of the OIG inspection program be established by statute or regulation providing for an *annual* review of medical care at each prison. (*See* Cal. Penal Code § 6126(f) ["The Inspector General shall conduct and objective, clinically appropriate, and metric-oriented medical inspection program to periodically review delivery of medical care at each state prison."].)

Plaintiffs' Response

Plaintiffs agree with the Receiver's proposal, with the following modifications. First, plaintiffs propose, for purposes of clarity, that the phrase "as determined by OIG and expert assessment described in Issue 1, above" be added so that there is no confusion regarding the measurement of substantial compliance.

Further, this action should not end until necessary construction is completed. Requiring completion of the specified construction projects here simply makes this section consistent with the language regarding these projects put forth, including by the Receiver, in section 1, above.

With regards to the OIG reviews, as the Receiver sets forth Penal Code section 3126(f) requires the OIG to conduct periodic medical inspections at each prison, but does not require any specific time frames for conducting the inspections. Additionally, the statute does not require that the OIG publish reports regarding those inspections, or specify the form and content of the reports. Plaintiffs' agree that the OIG reviews at each prison must occur at least annually,

and propose that the statute be further amended to require certain content and yearly cumulative summaries.

Finally, plaintiffs propose that the case end only if the policies and procedures governing the medical delivery system are placed into state administrative regulations and the California Department of Corrections' Operation Manual. Currently, the policies and procedures are not set forth in regulations or the manual because they were developed and must be followed as a result of the original Stipulated Injunction in this case. When the case ends, these policies must be adopted in formal regulation and the Operating Manual so that prisoners, staff, and the public can know what defendants must and will do when it operates the prison medical delivery system without a Court order that specially requires the policies and procedures to be followed.

Thus, plaintiffs propose modifying the Receiver's proposal as follows:

> The Receiver believes that Court oversight and termination of the case should occur when the Defendants have indicated that they are not only willing to provide constitutional care, but capable of providing constitutional care on a sustained basis. The Receiver believes that the Defendants will have demonstrated that capability when all facilities, individually measured, have continually maintained substantial compliance for at least one year following the end of the Receivership, and the Dewitt Nelson Facility, and the Health Care Facility Improvement Program at all prisons, have been completed. The Receiver proposes that the duration of the OIG inspection program be established by statute or regulation providing for an *annual* review of medical care at each prison, and a cumulative summary report at the end of each review cycle. (*See* Cal. Penal Code § 6126(f) ["The Inspector General shall conduct and objective, clinically appropriate, and metric-oriented medical inspection program to periodically review delivery of medical care at each state prison."].) All reports shall use the same format and report at least

regarding substantially the same matters as previously issued medical inspection reports. In addition, the medical delivery system policies and procedures would be placed in the California Code of Regulations and the California Department of Corrections and Rehabilitation Department Operations Manual.

Defendants' Response

Post-Receivership monitoring by the Special Master should not exceed one year, subject to the scope and budget discussed above. If the overall average OIG medical inspection score remains above 75% throughout the one-year monitoring period, all court oversight should end and the case should be dismissed at the end of the one-year monitoring period.

In 2011, the OIG's medical inspection duties were codified. (*See* Cal. Penal Code § 6126(f) ["The Inspector General shall conduct an objective, clinically appropriate, and metric-oriented medical inspection program to periodically review delivery of medical care at each state prison."].) The OIG's medical inspection program should continue as codified in current statute, and no further institutionalization of the OIG's inspection program is necessary. (Hoshino Decl., Ex. A.)

5. The parties' view on what the Receiver should include in the Plan for Post-Receivership Governance he must submit to the court.

Receiver's Response

As indicated above, the parties and the Receiver agree that, in the first instance, the Defendants should develop, and propose to the Court, a post-Receivership governance plan. However, the Receiver believes that any plan must include the establishment of an independent department or division of correctional health care services, encompassing all healthcare disciplines, within the CDCR with a director of the department/division who reports directly to the CDCR Secretary. The position of the healthcare organization should not be subordinate to administrative or custody functions within the agency.

Plaintiffs' Response

Plaintiffs agree with the Receiver's response.

Defendants' Response

Defendants' Plan for Post-Receivership Governance is discussed in detail in the attached Declaration of Martin Hoshino. Defendants' plan describes in full the details proving that Defendants have the will, capacity, and leadership to continue providing constitutionally adequate medical health care services to class members. Defendants' plan, which was drafted with input from the Receiver's Office, includes the structure, funding mechanism, and governmental responsibility necessary for Defendants to operate and sustainably maintain the state's prison medical health care system. (Hoshino Decl., Ex. 4.)

As set forth in Defendants' plan, management of prison health care operations will be transferred from the Receivership to the State upon the effective date of an order terminating the Receivership and the appointment of a CDCR Executive Officer of a Division of Health Care. (*Id.* at ¶ 18 & Ex. 4.) The Executive Officer will assume the responsibilities and duties of the former Receiver, be appointed by the Governor, subject to confirmation by the State Senate, report to the CDCR Undersecretary of Administration & Offender Services, and be a member of CDCR's Cabinet. (*Id.*) The Executive Officer will administer a separate and consolidated Division of Health Care to include medical, mental, and dental health care. (*Id.*) All Chief Executive Officers responsible for health care services at each institution will be appointed by and report to the Executive Officer of the Division of Health Care. (*Id.*)

In the first year of transition, the state does not plan to make changes or restructure the support services section of the Receiver's Office. (*Id.* at ¶ 19 & Ex. 4.) The state will seek input from the court-appointed Special Master and recommendations from other clinical experts prior to making any organizational structure or budget adjustments under consideration by the State. (*Id.*) The state will also work with the Special Master to identify any appropriate revisions or additions to state law and regulations, or appropriate revisions of court orders. (*Id.*)

6. How, if at all, the Court should consider the status of Defendants progress in satisfying the orders of the related three-judge court when determining when to end the Receivership and this case.

Receiver's Response

The parties and the Receiver did not discuss this issue in detail during the meet and confer process, although plaintiffs did indicate generally that they believe adequate population reduction is a necessary component of ending the case. The Receiver agrees that compliance with the orders of the three-judge court is a required element in the transition back to control of the system by the Defendants. Thus, as noted under item no. 2, above, the Receiver has proposed that compliance with the population reduction orders of the three-judge court is a necessary element in demonstrating Defendants' "will, capacity, and leadership to maintain a system of providing constitutionally adequate medical health care services."

Plaintiffs' Response

Plaintiffs believe that the defendants must comply with the Three Judge Court's order regarding population reduction before the Receivership ends.

Defendants' Response

Defendants timely achieved the three-judge court's first benchmark, which required a reduction to 167% of design bed capacity. (*See* 1/6/12 Report, Dkt. No. 2411.) Defendants achieved the three-judge court's second benchmark, which required a reduction to 155% of design bed capacity, by April 25, 2012, more than two months ahead of the date set by the court. (*See* Hoshino Decl., ¶ 20.) Defendants' compliance to date, and their efforts since 2006 to reduce the population in the state's 33 institutions by approximately 40,000 inmates, support terminating the Receivership.

Defendants' compliance with the final benchmark should not dictate when the Receivership should end. (*Id.* at ¶ 21.) The Receiver can transition control of the health care system back to CDCR, and Defendants can implement their Plan for Post-Receivership Governance, while the three-judge court continues to monitor the historic prison population reduction. (*Id.*)

Similarly, the court should enter an order to show cause why the entire case should not be terminated once Defendants assume responsibility for prison health care and the overall average OIG score remains above 75% throughout the one-year monitoring period, regardless of what the population number is at that time.

7. Any other issues the parties or the receiver deem relevant.

Receiver's Response

Defendants suggest below that the coordination orders be terminated. The Receiver believes that addressing this issue is premature. Whether, and to what extent, the coordination orders should be continued or modified following termination of the Receivership and prior to conclusion of the case need not be addressed until the Receivership is, in fact, terminated and the scope of responsibilities of any Special Master has been determined.

Defendants' Response

Defendants request that the Court address the following issues necessary for efficient post-Receivership governance:

1. Termination of Orders Approving Coordination Agreements.

Following transition, Defendants will assume control for many functions previously operated by the Receiver and coordinated with the Special Master in *Coleman v. Brown*, No. 2:90-cv-00520 LKK (E.D. Cal.), and the Court Experts in *Perez v. Cate*, No. 05-05241 JSW (N.D. Cal.) and *Armstrong v. Brown*, No. C94 2307 CW (N.D. Cal.). Under these court-approved agreements, the Receiver has been responsible for (1) implementation of a long-term information technology program to include the medical, dental, disability, and mental health programs, including Electronic Medical Records and the Mental Health Tracking System; (2) telemedicine serving the medical, dental, mental health, and disability programs; (3) oversight of pharmacy operations serving the medical, dental, and mental health programs, including all medication management; (4) the hiring of all medical, mental health, and dental personnel and running the Chief Executive Officer program; (5) credentialing and privileging for the medical, mental health and dental programs; (6) space coordination; (7) the construction of new health

care facilities and upgrade projects; (8) direct oversight of contracting functions for medical, dental, and mental health; and (9) the statewide appeals program.

Once the Receivership ceases to exist, Defendants request that the Court terminate its orders requiring coordination among the *Plata* Receiver, *Coleman* Special Master, and *Perez* and *Armstrong* court representatives, including all reporting requirements and associated meetings. (*See* Dkt. Nos. 603 (January 26, 2007), 691 (May 29, 2007), 737 (June 28, 2007), 1107 (February 26, 2008), 1123 (March 10, 2008), 1151 (April 1, 2008), 1545 (October 7, 2008), and 1830 (November 19, 2008). Terminating these orders is consistent with the transfer of responsibility for these functions to Defendants, will promote efficiency, and eliminate unnecessary expense caused by duplication of effort by the *Coleman* Special Master and *Perez* and *Armstrong* Court Experts. (Hoshino Decl., ¶ 22.)

2. Termination of Orders for Injunctive Relief.

Defendants request that all previous orders for injunctive relief be discharged, including the June 13, 2002 Stipulation for Injunctive Relief (Dkt No. 68) and the September 17, 2004 Patient Care Order (Dkt No. 229.) The substance of these orders has been addressed in the Turnaround Plan of Action.

Dated: May 7, 2012

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Dated: May 7, 2012

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

EDMUND G. BROWN JR., et al.,

Defendants.

C01-1351 TEH

DECLARATION OF MARTIN HOSHINO IN SUPPORT OF JOINT REPORT IN RESPONSE TO THE COURT'S JANUARY 17, 2012 ORDER TO MEET AND CONFER RE: POST-RECEIVERSHIP PLANNING

I, Martin Hoshino, declare as follows:

1. I am the Undersecretary of Administration and Offender Services for the California Department of Corrections and Rehabilitation (CDCR). I have been employed in this position since January 2011. I am the chief negotiator for Defendants in the meet-and-confer to respond to the Court's January 17, 2012 order, and have been involved in developing Defendants' Plan for Post-Receivership Governance. I am competent to testify to the matters set forth in this declaration, and if called upon to do so, I would and could so testify. I submit this declaration in support of the parties' Joint Report in Response to the Court's January 17, 2012 Order to Meet and Confer re: Post-Receivership Planning.

2. The medical inspection scores by the Office of Inspector General (OIG) objectively demonstrate the medical health care improvements in California's prisons. The OIG developed the inspection program in consultation with the Prison Law Office, the Receiver's Office, CDCR, and the Court. Attached as Exhibit 1 is a true and correct copy of a summary of the overall scores of the OIG's inspections of medical health care services at the state's prisons. At the conclusion of the first round of medical inspections of all 33 institutions, the average overall weighted score was 72 percent. (*See* May 2011 OIG Report at 2.) The average overall weighted score in the second round has risen to 79.6%, 29 prisons achieved a score higher than 75%, and all 33 prisons scored at least 73%. Several institutions also showed dramatic improvements of 12 to 15 percentage points.

3. The overall OIG scores should guide the parties and the Court as to whether the care being provided is constitutionally adequate. Defendants' position is that an overall average score of 75 percent should be used as a key indicator of constitutional compliance signaling when the case should end. Plaintiffs misplace focus on individual OIG measures related to compliance with strict policy time lines at a single prison. During the meet-and-confer, the Receiver stated that 60% of the missed appointments were missed by 5 days or less, and 100% of patients were seen by a doctor. The Receiver also stated that he "commonly found that a patient was actually seen several times before the scheduled appointment by a nurse or physician on other matters.

The overall pattern suggests that even when we miss certain deadlines, there is a lot of access to clinicians."

4. In April 2011, the Legislature passed historic public safety realignment legislation proposed by the Brown Administration, known as Assembly Bill 109, that went into effect on October 1, 2011. After CDCR's successful implementation, realignment has had an immediate impact on the prison population. Since going into effect on October 1, the population in the state's 33 institutions has decreased by more than 21,000 inmates. Overall, the population has decreased by 39,505 inmates since November 2006 when Plaintiffs moved to convene the three-judge court. This population decrease has improved the quality of medical health care, including access to medications and physicians. As of February 23, 2012, the thousands of makeshift beds in gymnasiums and dayrooms that CDCR has been forced to use for years are now gone.

5. Realignment has provided California an historic opportunity to create not just a less-crowded prison system, but one that is safer, less expensive, positioned to continue to provide constitutionally adequate health care to inmate-patients, and better equipped to promote rehabilitation. On April 23, 2012, the state released a plan that builds upon the changes brought by realignment, and delineates, for the first time, a clear and comprehensive blueprint that will enable CDCR to substantially comply with various court mandates and achieve better correctional objectives – all while spending as little taxpayer dollars as possible and necessary in these economically challenging times. A true and correct copy of the state's Plan, entitled "The Future of California Corrections," is attached as Exhibit 2. Reaction to the state's plan has been favorable, as shown by the April 29, 2012 Sacramento Bee editorial entitled "California Can Now Revamp its Prison System at Lower Cost," a true and correct copy of which is attached as Exhibit 3.

6. Defendants have increased spending on mental and dental health care during a time of state-wide budget cuts. Between FY 2006-07 and FY 2011-12, expenditures on prison dental health care increased by 154.13%, from $59.4 million to $151.1 million. Defendants increased spending on mental health care by 87.8% between FY 2005-06 and FY 2011-12, from $165.6 million to $311 million. Defendants have also passed audits to achieve American Correctional

Association accreditation, including the medical programs, for three institutions, and are working on achieving accreditation for five additional institutions.

7. Defendants have also demonstrated recent success in other health care class actions. On March 21, 2011, this Court terminated *Madrid v. Cate*. As discussed in the state's "The Future of California Corrections" plan, Defendants are also well on their way to resolving *Perez v. Brown*, No. 05-05421 JSW (N.D. Cal.). In *Coleman v. Brown*, Defendants have successfully reduced or eliminated the wait lists for high-custody inmates needing inpatient mental health care. On March 16, 2010, the wait list for high-custody inmates needing ICF treatment totaled 542 and on March 15, 2010, the wait list for the inmates needing Acute treatment totaled 97. (*Coleman* Dkt No. 3962-1 at 4.) As of May 3, 2012, there were only 13 inmates who have been accepted by DMH and are pending ICF admission, and just three of those inmates have been waiting more than 30 days, all due to medical holds. Nine inmates were pending Acute admission.

8. Attached as Exhibit 4 is a true and correct copy of CDCR's Plan for Post-Receivership Governance, which demonstrates that Defendants have the will, capacity, and leadership to maintain a sustainable system of providing constitutionally adequate medical health care services to class members.

9. In his Nineteenth Tri-Annual Report, the Receiver reports that 77% of the Turnaround Plan has been substantially completed. Similarly, during the meet and confer, the Receiver confirmed that adequate systems were in place for the completed items in the Turnaround Plan, and that all of the remaining items in the Turnaround Plan have been initiated. As discussed in Defendants' plan, Defendants are prepared to assume responsibility for completing the remaining items in the Turnaround Plan under the oversight of a court-appointed special master.

10. Defendants will also continue to prepare the Receiver's established quality controls and reports, including the Dashboard, Annual Analysis of Inmate Death Reviews, and Tri-Annual Turnaround Plan of Action Reports. Defendants are also prepared to work with the special master to develop a staffing plan for "hard to fill" institutions.

11. Based on the Receiver's progress on the Turnaround Plan, and Defendants' will and capacity to complete the unfinished items in the Turnaround Plan, the Receivership should end immediately upon entry of an order from the court terminating the Receivership and adopting Defendants' plan for post-Receivership governance.

12. As reflected in CDCR's plan, upon the end of the Receivership, the Court should appoint a Special Master to monitor and report on the state's commitment to provide constitutionally adequate medical health care. Defendants reserve judgment as to whether the current receiver should be appointed as Special Master.

13. Monitoring by the Special Master (including evaluation of clinical issues specific to whether the state is deliberately indifferent to the serious medical needs of class member by experts hired by the Special Master) combined with continued OIG inspections more than adequately measure constitutional compliance. There is thus no need for the continued involvement of the previously-appointed court experts or by Plaintiffs' counsel.

14. The Special Master's compliance monitoring should continue for one year unless the overall system wide average OIG medical inspection score falls below 75%.

15. The duties of the Special Master should be to measure progress on completing the unfinished items in the Turnaround Plan, monitor the continuing OIG medical inspection program, provide or secure expert evaluation of clinical issues specific to whether the state is deliberately indifferent to the serious medical needs of class members, and assess the overall effectiveness of the transition of medical health care back to the state. To accomplish this monitoring, the Special Master should be authorized to retain subject matter experts to assess clinical issues specific to whether the state is deliberately indifferent to the serious medical needs of class members. The Special Master's monitoring of construction projects should also continue until all required approvals of the construction plan in the state's plan have occurred.

16. Defendants propose that the Special Master's budget for the one-year monitoring period shall be indexed to the overall size of the Division of Health Care's medical budget and shall not exceed 0.05% of the budget in any given fiscal year, an amount that is equal to $750,000 in current year dollars.

17. Given the monitoring that will continue under the OIG inspection program and by the Special Master, there is no need for additional monitoring by Plaintiffs during the post-Receivership phase.

18. As set forth in Defendants' plan, management of prison health care operations will be transferred from the Receivership to the State upon the effective date of an order terminating the Receivership and the appointment of a CDCR Executive Officer of a Division of Health Care. The Executive Officer will assume the responsibilities and duties of the former Receiver, be appointed by the Governor, subject to confirmation by the State Senate, report to the CDCR Undersecretary of Administration & Offender Services, and be a member of CDCR's Cabinet. The Executive Officer will administer a separate and consolidated Division of Health Care to include medical, mental, and dental health care. All Chief Executive Officers responsible for health care services at each institution will be appointed by and report to the Executive Officer of the Division of Health Care.

19. In the first year of transition, the state does not plan to make changes or restructure the support services section of the Receiver's Office. The state will seek input from the court-appointed Special Master and recommendations from other clinical experts prior to making any organizational structure or budget adjustments under consideration by the State. The state will also work with the Special Master to identify any appropriate revisions or additions to state law and regulations, or appropriate revisions of court orders.

20. Defendants timely achieved the three-judge court's first benchmark, which required a reduction to 167% of design bed capacity. On April 25, 2012, the institution population totaled 123,287 inmates, or 154.8% of design bed capacity. Defendants thus achieved the three-judge court's second benchmark, which required a reduction to 155% of design bed capacity, more than two months ahead of the date set by the court.

21. Defendants' compliance with the three-judge court's final benchmark should not dictate when the Receivership should end. The Receiver can transition control of the health care system back to CDCR, and Defendants can implement their Plan for Post-Receivership

Governance, while the three-judge court continues to monitor the historic prison population reduction.

22. Once the Receivership ceases to exist, Defendants request that the Court terminate its orders requiring coordination among the Receiver, the Special Master in *Coleman v. Brown*, No. 2:90-cv-00520 LKK (E.D. Cal.), and the Court Experts in *Perez v. Brown* and *Armstrong v. Brown*, No. C94 2307 CW (N.D. Cal.). Terminating these orders is consistent with the transfer of responsibility for the functions governed by the coordination orders to Defendants, will promote efficiency, and eliminate unnecessary expense caused by duplication of effort by the *Coleman* Special Master and the *Perez* and *Armstrong* Court Experts.

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed in Sacramento, California on May 7, 2012.

Martin Hoshino

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EXHIBIT 1

Summary of the Office of the Inspector General's Medical Inspections - Overall Results

(Organized by highest current score – Updated April 26, 2012)

Institution	Cycle 1 Score	Report Date	Cycle 2 Score	Report Date	Change
CCC	73.4%	Jan. 2010	89.5%	Dec. 2011	+16.1%
FSP	83.2%	Mar. 2010	89.1%	Nov. 2011	+5.9%
SCC	76.1%	June 2009	87.5%	June 2011	+11.4%
ASP	70.4%	Nov. 2009	86.9%	Feb. 2012	+16.5%
CIM	81.4%	Oct. 2010	84.8%	April 2012	+3.4%
WSP	75.9%	Nov. 2010	84.3%	Mar. 2012	+8.4
CAL	76.6%	July 2010	83.0%	Mar. 2012	+6.4%
PBSP	81.0%	Nov. 2010	82.8%	Jan. 2012	+1.8%
VSPW	80.0%	May 2010	82.2%	Sept. 2011	+2.2%
CVSP	69.4%	July 2010	82.2%	Mar. 2012	+12.8
SQ	68.2%	Dec. 2009	81.5%	Sept. 2011	+13.3%
CMC	71.3%	May 2009	80.0%	June 2011	+8.7%
CCI	64.3%	Sept. 2009	79.8%	Sept. 2011	+15.5%
MCSP	74.5%	Sept. 2010	79.8%	Feb. 2012	+5.3%
NKSP	72.2%	Mar. 2010	79.3%	Aug. 2011	+7.1%
CMF	72.4%	Jan. 2009	79.0%	Mar. 2011	+6.6%
ISP	68.3%	June 2010	78.6%	Jan. 2012	+10.3%
LAC	71.7%	Jul. 2009	78.4%	Sept. 2011	+6.7%
SVSP	74.1%	Oct. 2010	78.0%	Jan. 2012	+3.9%
HDSP	62.4%	Dec. 2009	77.8%	Oct. 2011	+15.4%
CCWF	77.9%	May 2009	77.5%	May 2011	-0.4%
CIW	69.6%	Nov. 2009	77.5%	Mar. 2011	+7.9%
SOL	67.1%	Apr. 2010	76.7%	Jan. 2012	+9.6%
SAC	65%	Nov. 2008	76.3%	Feb. 2011	+11.1%
COR	68.9%	July 2010	76.2%	Dec. 2011	+7.3%
KVSP	64.0%	Mar. 2010	76.1%	Sept. 2011	+12.1%
CRC	74.3%	Oct. 2009	75.9%	Apr. 2011	+1.6%
SATF	68.1%	May 2010	75.7%	Sept. 2011	+7.6%
DVI	72.6%	Mar. 2009	75.4%	Oct. 2011	+2.8%
CEN	74.4%	Feb. 2009	74.7%	May 2011	+0.3%
CTF	72.0%	Aug. 2010	74.5%	Dec. 2011	+2.5%
PVSP	64.5%	Aug. 2009	73.3%	May 2011	+8.8%
RJD	68.0%	Feb. 2009	73.0%	Apr. 2011	+5.0%

EXHIBIT 3

THE SACRAMENTO BEE sacbee.com

Editorial: California can now revamp its prison system at lower cost

Published Sunday, Apr. 29, 2012

The one-year anniversary of the U.S. Supreme Court decision affirming that California would have to lower the number of inmates in its overcrowded 33-prison system comes in May.

So where are we? Prison population has dropped dramatically by 22,000 inmates. The triple bunks in gymnasiums, day rooms and other areas are gone. Most prisons are noticeably quieter and less violent.

The finality of the U.S. Supreme Court decision provided focus for all parties to get on with the task of reducing the state's prison population.

Gov. Jerry Brown proposed and the Legislature passed "realignment," where certain individuals convicted of low-level felony offenses are now sentenced to county jails instead of to state prisons. Since it took effect last October, that shift has gone as expected. Counties have not been overwhelmed. In fact, the number of offenders released from county jails due to lack of space actually declined in the first three months.

And now the California Department of Corrections and Rehabilitation has come out with a new plan that would adjust the whole state prison system based on lower inmate numbers and a close look at the remaining population.

This realistic, feasible blueprint provides the much-needed next steps beyond realignment.

Lower inmate numbers mean the state prison system can make significant reductions in reception center beds and lower-security beds. The need for higher-security beds will stay about the same.

The system will be left with higher-level offenders, who will be older. A decade ago, the state prison system had 6,000 inmates age 55 and older. Now it's 14,100. In five years, it will be 20,000. Many of these older inmates can be housed at lower security levels. CDCR estimates that about 17,000 inmates can be shifted to less costly, lower-security housing.

The number of correctional officers and other staff can be reduced – by 5,500 in 2012-2013, CDCR estimates; ultimately, by 6,400. The department has set new uniform staffing standards for each prison based on its design, inmate classification levels, perimeter security and daily timelines (such as feeding, medication distribution and education programming). This is long overdue.

The state will be able to close the old, dilapidated, expensive California Rehabilitation Center and bring home 9,500 inmates from expensive out-of-state prisons in Arizona, Mississippi and Oklahoma.

In the end, it looks as if the state may have to build only one separate facility for the most seriously ill, mentally ill, aged and disabled prisoners. A new prison health care facility in Stockton is expected to add 1,722 beds by June 2013. With renovation of the old, closed juvenile DeWitt Nelson facility in Stockton, the state would add another 1,133 beds by June 2014 for inmates with a temporary crisis (such as a psychotic episode). This unified Stockton complex would avoid the cost of transporting prisoners to expensive care at community hospitals.

The state also plans to catch up on updating clinics at each prison – some so primitive they have no sinks or hot water. The Joint Legislative Budget Committee should take action to accelerate this so it gets done in two or three years – not five or six.

The federal court ordered state officials, inmate lawyers and the receiver to meet and issue a report by April 30 on how to get beyond the federal takeover to a "post-receivership phase" and plan a "period of oversight" to "sustain the progress" that has been achieved. That has been pushed back to May 7.

But, make no mistake, California finally seems on the right path to get its state prison population and management under control.

EXHIBIT 4

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
POST-RECEIVERSHIP GOVERNANCE
APRIL 16, 2012

I. TRANSITION OF AUTHORITY, STRUCTURE AND RESPONSIBILITY

A. LEADERSHIP

1. Upon the effective date of an order terminating the Receivership and the appointment of a California Department of Corrections and Rehabilitation's (CDCR) Executive Officer of a Division of Health Care, management and responsibility for prison health care operations should be transferred from the Receivership to the State.

2. The Executive Officer will assume the responsibilities and duties of the former federally-appointed Receiver, be appointed by the Governor, subject to confirmation by the State Senate, report to the Undersecretary of Administration & Offender Services, and be a member of CDCR's Cabinet.

3. The Executive Officer will administer a separate and consolidated Division of Health Care to include medical, mental, and dental health care. All Chief Executive Officers responsible for the health care services at each institution will be appointed by and report to the Executive Officer of the Division of Health Care.

B. PROGRAM

1. In the first year of transition, no changes or restructuring to the Receiver's Office support services would be anticipated. The State will seek input from the court-appointed Special Master and recommendations from other clinical experts prior to making any organizational structure or budget adjustments under consideration by the State.

C. TURNAROUND PLAN OF ACTION

1. The Receiver reports that 77% of the Turnaround Plan of Action (TPA) has been substantially completed, and that adequate systems are in place. Of the 23% remaining TPA items, according to the Receiver, all items have been initiated. The State will complete the 23% remaining TPA items.

2. The State plans to complete construction of new beds and health care facility improvement plans as detailed in the State's "Post-Realignment Implementation Plan." Full completion of construction items does not preclude the conclusion of this case.

D. REPORTING AND QUALITY ASSURANCE

1. CDCR will continue with the Receiver's established quality controls and reports including the Dashboard, Annual Analysis of Inmate Death Reviews, and Monthly and Tri-Annual TPA Reports.

II. JUDICIAL OVERSIGHT AND ASSURANCE

A. SPECIAL MASTER AND COURT EXPERTS

1. Upon the end of the Receivership, the Court should appoint a Special Master to monitor and report on the State's commitment to provide an adequate constitutional level of care, its construction plans and structural organizational transition.

2. The duties of the Special Master should be to measure progress on unfinished TPA items including construction, monitor the continuing Office of Inspector General (OIG) medical inspection program, provide or secure expert evaluation of clinical issues specific to whether the State is deliberately indifferent to the serious medical needs of class members to provide assurance that the medical health care system is constitutionally adequate, and assess the overall effectiveness of the transition back to the State's responsibility.

3. Additional clinical experts may be deployed at the discretion of the Special Master to provide or secure expert evaluation of clinical issues specific to whether the State is deliberately indifferent to the serious medical needs of class members.

4. The Special Master's compliance monitoring should continue for one year, at which point the case should be dismissed unless the overall average OIG medical inspection score falls below 75%.

5. The Special Master's construction monitoring will continue until all required approvals of the construction plans contained in the State's "Post-Realignment Implementation Plan" have occurred.

B. LEGISLATION AND REGULATIONS

1. The State will work with the Special Master to identify any appropriate revisions or additions to State law and regulations, or revisions of Orders, such that the Court may modify or cease its Orders. Examples include:

    a. Codifying or adopting the established Executive Officer and Division of Health Care;

    b. Appointing authority for California Health Care Facility;

    c. Inmate Medical Services' policies and procedures into CDCR's Department Operations Manual.

C. OIG INSPECTION PROGRAM

1. The OIG's medical inspection program will continue as codified in current statute. The OIG developed the inspection program in consultation with the Prison Law Office, the Receiver's Office, CDCR, and the Court. The OIG has completed inspections and published reports for all 33 prisons during the second inspection cycle. The average score to date is 79.6%, 29 prisons achieved a score higher than 75%, and all 33 prisons scored at least 73%.