PLAINTIFFS' COMMENTS ON MARCH 11, 2008 DRAFT STRATEGIC PLAN

The March 2008 Draft Strategic Plan (Plan) sets forth the Receiver's major goals, along with objectives for those goals and certain actions to be taken to attain them. Plaintiffs appreciate the Plan's concise and focused presentation. The following comments, we believe, will help the Receiver create a better Plan for establishing a minimally adequate medical care delivery system in California's prisons.

1. The Plan sets forth, in its goals and objectives, certain requirements for a minimally adequate medical delivery system. However, certain requirements are not addressed, and should be added:

Adequate death reviews, as part of quality evaluation: With regard to evaluation and assessment, the Plan calls for peer review (Objective 3.3), measuring and evaluating clinical quality (Objective 4.2), and an annual inspection concerning compliance with policy requirements (Objective 4.2). These objectives do not include a key and required element of quality evaluation: death reviews. See Inmate Medical Policies and Procedures (Medical Policies), Volume 1, chapter 7, *Madrid v. Gomez*, 889 F.Supp. 1146, 1258 (N.D. Cal. 1995).

Local prison self-audit activities, as part of quality evaluation: The Plan's discussion of quality evaluation strongly implies that current efforts and requirements regarding quality and compliance measurements are "virtually non-existent." (Strategic Plan, page 22.) However, there are existing requirements and provisions for various self-audits at the prisons. See, e.g., Medical Policies, Vol. 5, chapter 1 (requiring audits of RN encounters); Vol. 3, chapter 2 (providing for data collection at prisons for quality management purposes). Compliance with these established requirements should be incorporated into the quality evaluation goals and objectives.

Quality improvement (QI) activities, including corrective action plans: The Plan's provisions regarding QI are limited to peer review (Objective 3.3) and the discipline process to be used for employees found to have committed misconduct (Objective 3.4). Although these are necessary elements of an adequate QI process, they have limited impact. Peer review activities address individual clinical performance, not processes, systems or day-to-day obstacles, and even the best employee discipline system will involve only a small percentage of staff determined to have committed misconduct. The Plan's QI goal and objectives must include efforts, undertaken at the local prison as well as central office level, to improve processes and systems, and to identify and implement solutions when problems are identified. Current policy requires corrective action plans after self-audits, death reviews, and/or other activities identify problems with or opportunities for improving care or policy compliance. See, e.g., Medical Policies,

Volume 3, Chapter 3 (requirement for quality improvement teams to recommend changes, Volume 1, Chapter 7 (requirement of corrective action plans, when necessary, following death reviews). The Receiver's Plan regarding QI must include corrective action plan requirements, including after local prison or other (e.g., Inspector General) audit activities and death reviews.

Preventive Services, and Public Health Initiatives, as part of the essential elements of inmate medical services: Goal 2 of the Plan calls for establishing a prison medical program that addresses the "full continuum of health care services." Plan at 9. The Plan lists four "basic elements" of a prison medical program. *Id*. (listing chronic care, medication distribution, specialty care, and inpatient care). There are, however, other basic elements in the continuum of prison medical services. In fact, the Plan in other sections addresses some of these other basic elements. See, e.g., Goal 1 at pages 5-6 (medical screening, sick call, and emergency response) and Goal 4 at pages 20-21 (radiology and laboratory services). But the Plan does not address two key prison medical service elements: preventive care, and public health, including infectious disease control. Both of these matters are extensively addressed by current policy. See Medical Policies, Vol. 4, chapter 7 (preventive care requirements) and Vol. 10 (public health). The Plan's goals and objectives must be modified to include these matters.

2. The Plan's Goals, Objectives, and Actions are not tied to compliance with the Medical Policies.

The written policies and procedures are a major part of the minimally adequate medical system required here in *Plata*. See Stipulation for Injunctive Relief at ¶ 4, Order September 6, 2007 at 7-8 (stating that the Receiver has authority to change medical policies but rejecting a request to eliminate the ¶ 4 requirement that written policies be followed). The medical policies adopted in *Plata* themselves require that the policies be disseminated, implemented and kept updated, including through the adoption of local operating procedures consistent with the policies. Medical Policies, Vol. 1, Chapter 8. Written policies similarly form the foundation of the remedy for medical care at Pelican Bay (the *Madrid* case), statewide mental health care (the *Coleman* case), and the statewide dental care (the *Perez* case). As such, the Receiver's Goals and Objectives must be tied to compliance with policy requirements.

For example, Objective 2.3 (at page 13) states, "Improve the Provision of Specialty Care . . . to Reduce Unnecessary Morbidity and Mortality." Although that objective is appropriate, it should also reflect the necessity of complying with medical policy requirements regarding specialty care. This can be done by adding a clause to the objective, so that it reads, "Improve the Provision of Specialty Care . . . to Reduce

Unnecessary Morbidity and Mortality and substantially comply with the requirements of the medical policies, including the time-frames for specialty appointments."

Similarly, the "actions" listed by the Plan under the specialty care objective are too limited. The actions listed concern establishing management processes and statewide contracts, and ensuring timely payments to providers. Plan at pages 13-14. Other specialty care related objectives and actions are set forth elsewhere in the Plan. See Plan at Objective 1.4 (staffing for access to care) and Objective 4.1 (use of telemedicine). Although these are all important actions and objectives, an equally if not more fundamental action would to ensure that inmate-patients are provided specialty services in accord with policy requirements. All goals, objectives, and actions in the Plan should be where appropriate revised to incorporate substantial compliance with policy requirements.

Further, where the Plan indicates that changes will be made to the medical policies (see for example Objective 1.2 at page 5, asserting that the "sick call" process may be re-designed), it must reference at least in general the policy provisions that will be modified, rather than simply stating, as it now does, that any changes will be "disseminate[d] via a quality improvement initiative." The "sick call" process is addressed in Vol. 4, chapter 4 of the medical policies, and any changes made to it through the Plan should be made via those written policies.

3. The Action under the Objective relating to chronic care is in part too vague; there needs to be more specificity regarding how chronic care will be improved.

Objective 2.1 (at pages 9-10) is to "improve chronic care beginning with asthma." That objective, however, specifically addresses only asthma. The Plan states that "[l]essons learned" regarding asthma "will be incorporated into subsequent programs to improve chronic disease management." Plan at 10. However, the time-frame for improvements for other chronic disease programs (there are approximately a half-dozen besides asthma) is not stated. Will all be done immediately upon completion of the one-year asthma initiated that began in February is completed? Additional "Actions" should address these matters.

4. The Objective regarding medical staffing should include more specific actions relating to the problem of hiring primary care providers (PCPs) and licensed vocational nurses (LVNs) at certain prisons.

Plan Objective 3.1 – to recruit physicians and nurses to fill ninety percent of established positions (Plan at 15-16) – should more fully address the ongoing substantial problem of hiring physicians and nurses in certain geographical areas.[1]

With regard to physicians, the Plan states that, in addition to the increased compensation now offered, a substantial recruiting effort to attract physicians to CDCR is being undertaken. Plan at 16. However, the Plan acknowledges that in certain parts of the state hiring physicians is especially "challenging." *Id*. Plaintiffs agree. For example, according to the most recent information provided by CDCR Health Care Services, the Substance Abuse Training Facility at Corcoran, which houses more than 7,000 inmates, has a greater than 90% vacancy rate among PCP positions (12 of 13 positions vacant).

The Plan states that the Objective regarding tele-medicine, when met, will "partially compensate" for these particular physician hiring challenges. Plan at 16. However, given that the Plan concedes that tele-medicine will only partially resolve the problem, other actions should also be taken or considered. For example, prison-specific compensation bonuses or incentives have been used in the past to increase the number of full-time clinical employees at particular locations.

With regard to nurses, there is a continuing challenge with regard to hiring licensed vocational nurses (LVNs) at certain prisons. According to the CDCR's February 2008 report, eight prisons have LVN vacancy rates of 50% or higher, and two other prisons have a vacancy rate of above 45% for those jobs. The Plan states that a January 2008 agreement permitting LVNs to be paid at varying rates within the established salary range, depending on experience, and that this "should assist" in lowering the vacancy rate. Plan at 15. However, while the ability to adjust LVN salaries within the established range will help recruit and retain those nurses, it is not clear how significant the impact of that action will be, or even whether the inability to do so was a problem hampering recruitment at those prisons that have been persistently unable to hire sufficient numbers of LVNs.

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[1]. The Plan uses the term "physician," which typically means a medical doctor. The medical policies use the term "primary care provider" (PCP), which includes medical doctors, physician assistants, and nurse practitioners, all of which are appropriate care providers. The Plan should thus use the term primary care provider, unless a decision has been made to hire only medical doctors for these positions.

5. The Plan should include more specific implementation milestones, responsibilities, and strategies.

Goals and objectives are a necessary part of any plan, but so too is a plan to attain them. See Order, February 14, 2006 at 2:19-22. Although the Court has stated that it is not necessary to provide an exact step-by-step explication of what will be done when, and by whom, for every goal and objective, an adequate Plan should include some specific milestones or action points, some assignment of responsibility, and some implementation strategy, for all its objectives. Such planning would both increase transparency and accountability and permit the Receiver to determine whether modifications must be made to complete the objectives or attain the goals.

For example, Objective 1.2 (Plan at 5) calls for the redesign and standardization of the sick call program.[2] The "Action" under that objective provides for review of processes, forms and staffing models, redesign as necessary, and then disseminating a new sick process to at least half the prisons, all by January 2009. While an implementation plan need not list each and every form or process to be reviewed, logically there must be a target date well before January 2009 when that task as an entirety must be completed, given the time necessary to complete the subsequent redesign and dissemination tasks. That date, as well as the date when any redesign will be completed, ought to be a part of the Plan. Similarly, while every individual who will review sick call forms and processes need not be included, the Plan ought to name those with the supervisor responsibility for that part of the project. Without at least that level of responsibility, the Plan appears to involve, going forward, a series of ad hoc decisions regarding timing and responsibilities. Next, the Plan should include some strategy regarding implementing any redesigned sick call program. "Disseminating" the new program through a "quality improvement initiative" says very little about how it will actually be done. Presumably, any new program will require the writing not only of new

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[2]. "Sick call" is the shorthand term used to describe the system by which prisoners bring medical concerns to the attention of medical staff, and those concerns are assessed or evaluated to determine when (how quickly) the prisoner needs to see a primary care provider. An adequate sick call process is the bedrock requirement of any prison medical care delivery system. *Madrid v. Gomez*, 559 F.Supp. 1146, 1256 (N.D. Cal. 1995) (the first factor courts consider when determining whether a medical system meets constitutional minima is whether prisoners can make problems known to staff). Given its fundamental importance, and the prison medical expertise available in this state and across the nation regarding how sick call has been and/or could be done, it is to say the least puzzling and unfortunate that the question of whether the CDCR sick call system requires redesign is still to be answered, more than two years after a Receiver was appointed.

statewide policy provisions, but training of local prison staff, the writing of new local operating procedures, perhaps pilot initiatives at local prisons before any prison-wide implementation, and on-site visits and audits by supervisors and regional managers. While a day-by-day schedule is not necessary, a successful plan should set forth significant implementation actions.

6. The Plan does not include any interim or stop-gap measures.

Certain plan goals or objectives will take years to achieve, including for example the building of necessary additional medical clinic space at the prisons. The Plan indicates that this will be done in phases, and that "assessments and preliminary planning" for this task will be done for the final 13 prisons by January 2010. See Plan at 24-25. After this preliminary planning, plans will next be completed and then construction will be authorized by the Receiver. Id. at 26. Once each prison upgrade project is approved, it will take 18 to 24 months to complete construction. *Id*. at 26. The Plan thus provides a December 2011 target date for completing clinic and other building upgrades at the final 13 prisons. *Id*.

Given the importance of adequate clinic space, the Plan should provide for interim measures, particularly at those prisons at which the upgrades will not be completed for more than three years. Recent action at Avenal State Prison regarding space deficiencies provides a model for interim measures. At Avenal, the Receiver working with local prison staff and a retained private construction company, established and is now implementing a clinic space initiative that involves emergency, interim, and permanent projects. Emergency and interim measures provide for the immediate or short term use of "5th Wheel Trailer Clinics" and modular space, and the conversion of certain existing space.

Similarly, the Objectives related to specialty care services provide for completion dates in January or July 2009 (see Plan at pages 13-14), with related Objectives slated for completion two years after that (see, e.g, Objective 1.4 at page 7 (full implementation of health care access units at all prisons by July 2011). Given that these time-frames are measured in years, interim measures to improve the provision of specialty care should be taken, at least at those prisons where access to such care is a particularly acute problem. Almost two years ago the Receiver showed that focused efforts regarding specialty care at a specific prison, including reviewing and triaging pending requests, securing additional providers, and emergency measures to increase transportation resources, can greatly reduce the risk of harm to patients with very complicated medical conditions. See Second Report at 30-37 (reporting on activities regarding specialty care at San Quentin during the summer of 2006 that greatly reduced the risk to patients).

7. The Plan does not include adequate time lines or metrics.

Although completion dates for various tasks are provided, the Plan itself states that other time lines are necessary and would be provided. Specifically, the March 11, 2008 cover sheet for the Plan states that an appendix would be provided showing time lines for each action. This has not been provided as of yet.

The Court's directives regarding the Plan call for metrics. See Order, September 6, 2007 at 4-5. The Plan states that over the next three years "balanced scorecards" will be developed to provide information regarding certain medical matters at each prison, and that the OIG is establishing an "audit" process that will measure medical policy compliance at the prisons. See Plan at 22. Further, the March 11, 2008 cover letter that accompanied the Plan states that a "Progress Report" will be established on the Receiver's website, and updated monthly, showing how far along the Receiver is with each goal and objective.

In terms of transparency and accountability with regard to the Plan, the updated-monthly "Progress Report" is most important. It is a great development, and should start immediately. But to be meaningful, the "Progress Report" should be based on milestones for objectives and actions that are set forth in the Plan, and specified methods by which progress will be measured.

In this regard, the Plan to the Receiver's credit does establish date-based milestones for many objectives and actions. See, e.g., Action 3.1.2 at pages 15-16 (90% of physician positions to be filled by January 2009). However, some milestones or targets are not specified. See, e.g., Action 1.3.2 at page 6 (all medical staff to be certified in CPR, but no date established for completing that action). Further, as explained above (see discussion of sick call redesign project under #5), additional milestone or target dates should be established for certain key matters.

Similarly, the method of measuring whether a particular objective has been attained is sometimes self-evident. For example, staffing reports currently provided will show whether the objective of filling 90% of physician positions has been met. However, the Plan does not indicate how progress will be measured regarding certain other objectives and actions. For example, how will it be determined whether all medical staff have been CPR certified (Action 1.3.2, at page 6) or whether preliminary assessments regarding health care access teams have been completed by January, 2009 (Action 1.4.1 at page 7)? Each action and objective should have an identified metric and a means to measure it.