July 9, 2004

Honorable Thelton Henderson
U. S. District Court
450 Golden Gate Ave.
San Francisco, California 94102

Re: Plata v. Schwarzenneger, 2nd report, part 1

Dear Judge Henderson:

Court Experts write to you our second report for Plata v. Schwarzenneger.

1. Compliance with Stipulation Paragraph 6(b)

Plaintiffs asked the Experts to report on CDC adherence to Stipulation Paragraph 6(b), specifically the inter-institutional transfer protocol. This protocol is to ensure that inmates transferred between facilities will have necessary medical information documented on a transfer form (Form 7371) by the transferring institution. That form is to be confidentially transferred to the recipient institution in order that medication will be continued and necessary appointments will be re-scheduled. The recipient facility also documents on the lower half of the form that they verify the information by performing a history questionnaire with the inmate. Plaintiff's concerns were threefold. One, the forms were unavailable to the facilities. Two, the policy had not been implemented at all sites and training of sites had not been done. Three, Plaintiffs do not have the means to adequately verify or monitor compliance at the prisons.

Regarding the issue of the form itself, the policy, procedure and the form have been completed for almost a year. Approval of the form by CDC and getting it to the printer was significantly delayed because of the numerous approvals necessary within the CDC bureaucracy, unnecessary delays because of inattention in passing the form along to the next step, and finally because of the printing process itself. On the latter point, state law requires that all forms printed within the CDC be printed by the Prison Industry Authority (PIA). The number of steps required to get new forms into use is extremely cumbersome. As an example of bureaucratic inefficiency, Experts were told that PIA has a requirement that all requests for printing forms include a copy of the form with the quantity required. In the case of new forms, the sites had no form to send to the PIA because the form was not yet in use and only drafts were available. Thus, without a form to send to the PIA, they were unable to send a legitimate request for printing. There are many similar stories of bureaucratic inefficiency that result in delays. In addition, when the Health Services Division of the CDC rolls out new policy that requires use of a newly

conceived form, each facility is separately required to order the form. This is different from what the Corrections Division of the CDC does. When they set new policy that requires a new form, forms are ordered for all facilities by Central Office and distributed as a first batch with the new policy order so that facilities will not be delayed in getting started. As well, this reduces the number of requests for new forms to PIA. Having a single agency make the initial request to PIA also eliminates many bureaucratic hurdles.

Because facilities do not have forms, implementation of the new transfer policy has not begun at all facilities. It was our impression that interpretation of the term "implementation" is understood by facilities as having ordered the form. Based on the latest self-report from facilities, only one facility does not have health transfer policy in place. Only three facilities have written that they are not yet using the new form and process and two facilities have not responded at all regarding whether they are using the new form and process. Experts did not go to every facility to verify use of the transfer form. Yet on the three tours we made, SAC was the only facility that had the form (and they had just obtained it the day of our visit), and no facility we visited was seeing the form used for inmates being transferred into their facility by other facilities. Our expectation is that this will improve as more facilities get the form from the printing office. Thus printing forms is now the rate-limiting step. Experts did visit the print shop, which is located in the Folsom Prison. On the day of our visit they had few orders for the 7371 in the queue. Experts strongly recommend that for new forms CDC Central Office should provide the initial batch of forms so that facilities can start the process. As well, Central Office should review the process of developing and printing forms. If this process existed on a flow diagram it would be easier to understand and improve barriers in the bureaucratic process of approval.

Experts recommend that the QMAT audit process be used as the means of verification of implementation of use of these forms for the transfer process. The audit process does not include a question as to whether the appropriate form is used, but Defendants could add this question for internal control and as a means to verify use of the form for Plaintiffs. Regarding performance of transferring clinical information regardless of which form is used, the audit process from 3 completed audits (SAC, CCWF, and HDSP) demonstrated scores of 60%, 76%, and 80% respectively. A combined score was 66%. While this score reflects a relatively good start, chart selection is important. For persons transferring without any medical conditions (most individuals) the system is not challenged and the form merely states that an individual is transferring. Experts believe it is more important to audit persons who have medical information to transfer as this judges the ability of the system to evaluate medical response to a serious medical need.

2. Automation of the QMAT audit process

Experts asked for software allowing the entry of QMAT indicator audit data into laptop computers. This also permits easy manipulation of data. We feel stronger about this after performing the practice audits with paper and pen and then tabulating results for different items by hand. Defendants requested the opportunity to develop this system and

provided us a program for use in mid June. We have not had an opportunity to test this software yet, but will up date the Court after using the software.

3. Policy and Procedure

Experts reviewed several policies and procedures and identified lack of policy in relation to tours of the facilities or in relation to performing audit indicator questionnaires.

Equipment and Space

During our tours Experts were disturbed by the conditions of the physical environment in which primary medical examinations were conducted. There is no policy delineating how a patient is to be examined, probably because reasonable medical practice is that examination of any patient would include interview and examination in a private environment with appropriate equipment. However, because of existing practices, Experts recommend development of policy on this issue. At the Salinas Valley facility all administrative segregation sick call is conducted requiring that inmates stand upright in a cage that is approximately 3 foot wide by 3 foot deep by 6 plus a couple of inches high. The physician or nurse examiner is expected to place their hands into the food port in order to contact the inmate. The food port is an approximately 4 inch by 12 inch rectangular opening in the front of the cage. CDC correctional officers we talked to believe that this arrangement permits the officer to leave the inmate alone with the physician and ensures privacy. A correctional official asked Experts whether we had any authority to review this issue because, in his opinion, it was not part of Plata. Regardless of that comment, Experts strongly disagree with this practice and believe that this practice obstructs the ability to examine inmates. We were told that physicians could have patients brought to the clinic for examination at any time. However, no physician we interviewed agreed that this was possible.

At Salinas Valley and at SAC, inmates in multiple clinic areas are examined without benefit of an examination table. At the SAC main health care clinic in the health care unit there is no examination table. In these situations, inmates are examined in a chair, which makes a thorough examination impossible. At SAC, the table was ordered removed by a staff physician who apparently moved the table because of space issues. The willingness of staff at SAC to condone that practice is an additional problem. In administrative segregation units at SAC, inmates are evaluated in chairs either in counselor's offices or at sick call stations. These are unacceptable practices that should be corrected by policy. At CCWF, a large auditorium was converted into clinic space and two separate examination areas are separated only by a collection of used desks, tables and other stored items. Sound privacy was not possible. Experts could hear both discussions between inmate and physician for two separate patient encounters.

At CCWF, there are no available microscopes to examine discharge specimens. This type of equipment should be standard in a woman's facility.

Access to Care Policy

Inmates at both SAC and Salinas Valley are locked down a significant portion of time. In these situations, current policy recommends that access be conducted by the inmate health request process. In this case officers provide inmates with a form that is delivered to the locked box, which is picked up by staff. This relies upon correctional officers to deliver the health request forms and reduces or eliminates exposure of inmates to health care staff. Given that lockdown occur a significant portion of time, inmates have significantly reduced exposure to health care staff and are subject to dependence on officers for access. Experts do not agree with this policy and recommend daily nursing rounds or checks on inmates in segregation or on locked down status. Policy and procedure should be added for these areas so that it is subject to review. As well as lockdowns, minor emergencies (lacerations, fights, etc.) frequently occur at SAC. When these occur sick call is shut down because the only examination room must be used to address the emergency. There are four examination rooms in this area, but three are dedicated to mental health. An additional examination room should be shared with the medical provider so that access to sick call is continuous.

Correctional Treatment Center (CTC) Policy

Policy for CTCs only addresses those inmates who actually are admitted to a CTC. At SAC and Salinas Valley, mental health concerns dominate clinical space allocation in large part because of ongoing litigation. Therefore, clinic space is effectively allocated to mental health examination rooms and CTC beds are prioritized to mental health. Although beds are ostensibly divided equally between medical and mental health, many beds for medical allocation are utilized for nursing home type patients who have no acute medical conditions. At Salinas Valley and at SAC there are approximately 2 CTC beds for acute medical conditions out of 30 beds. Though 15 beds are ostensibly devoted to medical most medical beds are used for terminal or nursing home type patients. This is important for Plata because one indicator assesses whether inmates placed on CTC units are appropriately housed. What is not assessed is whether there are patients being housed in general population units who should be on CTC units are not actually housed there. Experts identified that this situation existed at both SAC and Salinas Valley. Doctors at both Salinas Valley and SAC agreed with this assessment. Policy for CTC units should include a recommendation that there should be an appropriate number of CTC beds and what to do in the event that a patient needs CTC or OHU housing but none exists. Also, current policy does not include appropriate monitoring for high acuity persons returning from hospitalization. On numerous patient charts, inmates with high acuity medical disorders discharged from an acute care hospital were returned to general population and were lost to follow up. Given the current inefficiencies and systematic failures of follow up, Experts recommend that all persons returning from an acute care hospital be housed in a CTC until an outpatient treatment plan for general population housing can be developed. As well, Experts recommend some form of tracking of physician requests for CTC housing until such time as it is determined that acute care patients are not being housed in general population.

Pain Management

At Salinas Valley Experts noticed that only 28 patients were on narcotic medication. This equates to only 0.6% of the population. Based on experience, this appears to be a very low number and Experts are concerned that pain may be inadequately managed. This problem was additionally verified by chart review at the Corcoran facility. It is Expert's opinion that there should be a policy on pain management.

Utilization Management

In reviewing off-site specialty care, Experts were unable to obtain relevant information from Utilization Management nurses. At the hospital at Corcoran, no one tracks off-site specialty appointments from the hospital unit. At SAC the Utilization nurse and the physicians are engaged in hostile interactions such that they do not work together. Information on health care requests from SAC was difficult to obtain. Each facility appears to have unique systems for approving off site specialty consultations. At SAC the UM nurse appears to have excessive control over utilization decisions. Doctors perceive this as a barrier. With this as a background, it is not possible to understand whether there is over-utilization or under-utilization. QMAT indicators do not cover this matter. QMAT mostly addresses whether an appointment once scheduled is done on time. Appreciating that the physician staff is weak and many physicians may be incapable of knowing when to appropriately order off-site specialty consultation, Experts are worried that there is underutilization in certain areas and over utilization in other areas. In some situations poorly trained or incompetent physicians may be on committees that are deciding whether to approve or deny medical consultation. At the acute care hospital at Corcoran, specialty consultations in the acute care hospital must be evaluated weekly in the routine review committee. This is a potentially dangerous practice. If physicians in a hospital can not be entrusted to make appropriate specialty referral decisions, then the physicians are not capable to perform hospital work. Experts recommend a review and revision of utilization policy to standardize policy, require a higher level (expert physician) review, and review of systematic underutilization and over utilization.

4. Review of Hospitals Regarding Implications for Plata

Experts have initiated review of the hospitals and will continue to review hospitals and report to the court in the following update.

5. QMAT audit process

QMAT teams still lack physician members and there are insufficient physicians to cover all sites. One new QMAT physician recently started. That physician has training in Medicine, which is currently lacking amongst QMAT trainers. It is more difficult to train staff when the trainers do not have experience in the area in which they are attempting to train on. Physician involvement is a deficiency of QMAT.

Based on interviews with QMAT staff and line staff at the facilities, there is a discrepancy between the extent of training that QMAT staff believe they have given and that which the line staff believe they have received. This is most evident in the area of nursing care. Nurse sick call evaluation has not been initiated for 2 of the three sites we visited. At CCWF utilization of nurse protocols has not been started because a pharmacist in the CDC Central Office has determined that use of nurse protocols is not in conformance with State Pharmacy Regulation. Experts agree with CDC Central Office leadership that nurse protocols, which utilize over-the-counter medication is appropriate and legal under pharmacy regulations nation wide. These nursing protocols should be initiated. CDC Central Office is discussing the matter with the pharmacist and will report. In addition, autonomous functioning at facilities, in part, creates a barrier to establishing the new system of policies and procedures. For nursing, the absence of central leadership detracts from the ability of QMAT to enforce policy and procedure. Experts recommend establishment of a Central Office Director of Nurses. This position should have the authority to establish and enforce nursing policy and practice within CDC.

CDC Central Office, with the QMAT process, is working against the legacy of independence by individual sites. This legacy of independence has produced resistance by some sites to rolling out QMAT. Last year, the previous CMO at SAC "locked out" QMAT staff, which delayed rolling out the process at that facility. Physician resistance at that same facility (SAC) was open and seemed hostile to Experts. One physician at SAC told Experts that the physician's union (UAPD) would support members if physician's resisted Plata. The UAPD has officially responded that that information was inaccurate and that they support Plata in principle and practice. This same physician stated that one of the difficulties in meeting appropriate practice parameters required by Plata is the inmates themselves. He said, "You've got to understand what you're dealing with here; people who are bald faced liars and convicted felons". All parties must appreciate that these types of problems are part of the difficulty in rolling out training, system changes, and improved practice. Experts are unanimous in agreement that Central Office must be supported in applying appropriate discipline when outright defiance of the principles of Plata and appropriate medical care for inmates is defied for personal reasons. Central Office is on target in these matters but has a massive legacy of neglect that they are attempting to change. The difficulty in initiating QMAT training at the 2003 sites has resulted in no training yet at 2004 sites.

One example of resistance is the lack of use of the SATS Lite program. This software developed by Central Office allows facilities to track patient encounters and other data necessary for Plata, but is also useful in managing scheduling and other services at the sites. Sites we visited are not uniformly using this program. As a result, accurate sampling of records is not possible. Dual systems remain in place. Audits can not be reasonably performed if the data used for the audit is flawed because staff are not entering all events.

In some cases, Salinas Valley, in particular, QMAT is challenging to roll out because of the enormous number of vacancies. 77% of MTA positions and an almost equal number

of nursing positions are vacant. Budget freezes, reneging on bonus and salary incentives and inability to recruit have all been factors in regards to staffing shortages. Experts do not envision effective nurse training for a staff that turns over repeatedly or when positions can not be filled.

In the same vein, some institutions lack clinical leadership. CCWF and Salinas Valley have no Chief Physician and Surgeon and the Chief Physician and Surgeon at SAC does not have training in Medicine and lacks the ability to clinically supervise the physicians. Effectively, there is no supervision of physicians at SAC, a facility where there has been and may still be outright defiance to rolling out Plata. It is difficult to provide training and supervise physician practice when the leadership physicians do not have the professional training to do so, which is the case at SAC. At SAC and Salinas Valley Experts believe that patients are being harmed by inappropriate and incompetent care. This is evidenced by numerous chart reviews of patients with serious chronic medical conditions who are being mismanaged and harmed. At Salinas Valley, for example, discharge summaries for all patients leaving the Correctional Treatment Center (CTC) are written by the CMO even though he is not caring for the patients. Experts believe this may be due to the lack of ability of the physician who is covering this unit to write a thorough note. Since our last report, Experts have communicated to Dr. Kanan regarding serious deficiencies in care for several patients at SAC. In follow up, it appears that the physicians managing these patients do not understand how to do so. This matter is serious enough that Experts recommend hiring physician(s) through the Court to manage patients with complicated disease at those facilities until such time as CDC can find appropriate physicians to manage these patients. This Court-hired physician's role shall also include training on chronic disease management. Experts also recommend that CDC take appropriate steps to ensure that assignment of physicians within facilities is based on matching the skills of their physicians with the acuity of patients being managed. We recommend this because at SAC, as an example, the best trained physicians do not manage the patients with the highest acuity of illness. What should occur would be for the best trained physician to manage patients with the highest acuity.

Defendants summarized QMAT audit scores to Experts on June 23rd. Experts have not met together to review these scores, but did have several preliminary comments.

Experts agree with Defendants that there remain problems with the audit system. Experts reviewed a sample of records already reviewed by QMAT staff. Expert's scoring was consistently lower that QMAT staff. The reasons for this are not entirely understood, but Experts offer some possible reasons as well as other comments on scoring in QMAT.

1. In some cases, QMAT staff are making clinical medical judgments in areas in which they have no formal medical training. Some QMAT physician staff do not have training in a primary care medical field. It should not, therefore, be unexpected that Experts judge differently in these cases. In the same vein, training provided by certain QMAT staff may not be sufficient to promote adequate understanding of chronic care guidelines because they may not have the professional background to provide training in primary care medicine.

2. Experts interpret chronic disease care based on national consensus standards that are not completely in sync with chronic disease guidelines. This may result in different scoring from CDC.
3. Defendants have been concerned about "double jeopardy", which we believe they define as negative scoring on multiple indicator questions for the same mistake. Thus if a physician does a poor history, the physical examination may be scored as non-applicable because the examination does not apply to a situation where the history was wrong. In these cases Experts are as worried about selection bias. This is a bias toward favored scoring of the good physician but limited scoring for the poor physician. As an example, if a physician is clinically competent and performs well, it is more likely that all indicator questions will be scored, because the physician has performed in accordance with QMAT requirements. Thus, good physicians have more questions scored. On the other hand, a physician who takes a poor history will have subsequent question not scored (non-applicable) because CDC believes that a poor history means that certain subsequent questions should be eliminated because the physician's examination can not be scored if it applies to an inappropriate history. This methodology results in a bias toward scoring more questions for the good physician and fewer questions for the poor physician and will result in generally higher scores than should be obtained.
4. Facilities had reasonable scores for notifying inmates of test results within 14 days. Experts had concerns because it was reported to Experts that physicians counsel patients without the benefit of having the test result available for their discussion with the patient. In cases like this, facility staff are just checking boxes for credit.
5. The key indicators regarding specialty services fail to identify if there are barriers to obtaining off-site specialty services resulting in suppressed utilization. This will not show up on the audit because the request for consultation will have been rejected and therefore not evaluated. Physicians at SAC for example, were unanimous in their objection to the barriers in obtaining off site consultation. Apparently, the UR nurse is so opposed by physician staff that routine UR meetings are scheduled when the UR nurse is not available. Physicians complain that the UR nurse inappropriately creates obstacles to obtaining her approval for offsite consultation such as requiring physicians to have photocopied records from offsite consultants with the reasons why the consultant desires offsite consultation. This is an excessive barrier, because it should not be the physician's responsibility to obtain offsite reports. Based on interviews, obtaining a consultation at SAC is not professionally adjudicated. QMAT scoring will not identify this problem because QMAT only addresses specialty services that have occurred or were approved and does not consider those that are denied.
6. A large number of records are found to be non-applicable by QMAT scoring (42%). Experts generally scored more records are non-applicable than QMAT scorers. Thus, the number of non-applicable items was significant. This brings into question the validity of certain questions. There has been no assessment of the spread of non-applicable responses so that there is no way to determine whether non-applicable responses are spread evenly over the instrument or if they are selectively spread.

7. The actual audits reviewed a large number of charts in certain areas but many fewer charts in other areas. There has been no determination of the number of charts that need to be reviewed to yield a sufficient power to be sufficiently confident that the sample size is adequate to provide a reliable survey. Experts believe this should be determined.
8. Charts for chronic illness are audited against strict interpretive criteria in a check box format that Experts believe is not always consistent with national consensus standards of care. Experts use consensus guidelines for chronic disease management that does not always form the basis for interpretation of indicator questions that QMAT staff use. Thus there is and probably will remain a difference in interpretation of scoring between QMAT and Experts.
9. Nurses at SAC and Salinas Valley are not currently performing any sick call evaluations and are not using nursing protocols. At SAC there were requests for sick call that were in piles in the nursing station that had not been reviewed and if reviewed had not been scheduled dating from months previous. Nurses were changing priority ranking of sick call requests after a nurse had already assigned an acuity ranking because there was such a backlog and urgent was forced into routine. Routine sick call requests for physicians were backlogged over a month in one clinic because nurses did not do sick call and all sick call was referred to the physician. The Salinas Valley audit was not available to Experts. However, the audit from SAC scored sick call at 62% even though all of the existing circumstances were in existence. The instrument is obviously not capturing a valid representation of reality. Charts are randomly chosen only from persons who get to be seen in sick call, but there is no assessment of those who do not even get into sick call. Also, SATS Lite is the software program that contains the data from which charts are selected. Because this software is not universally used, charts were selected only on the basis of what was entered. If staff selectively enter data or if SATS Lite is not uniformly used, a selection bias will occur. Qualitative findings on tours, such as these, will not find their way into scoring. Because the examples cited may be unique and because other similar serious deficiencies are to be expected at other institutions, Experts will make qualitative recommendations regarding practice not picked up by the audit instrument that will have to be accommodated into our overall scoring practice.
10. Currently, facility physicians and staff have indicated their belief that only 4 chronic illnesses are subject to scoring in QMAT (diabetes, hypertension, epilepsy, and asthma). Obviously, there are many more chronic illnesses which must be included in the audits that will be performed. Our understanding of the current CDC practice is that only these diseases will be used for auditing for the initial audit simply as a convenience which allows the CDC to introduce the concept of auditing and the system of providing care for disease with simpler, more common illnesses. We are in agreement with this early stage plan, but staff should understand that the selection process needs to be improved.
11. Experts believe that there may be a selection bias when random selection of patients is performed. Under all circumstances, the audit should uncover the ability of the system to provide care to those with serious illness and complex medical conditions. For common illnesses many and possibly most patients will

have mild disease, the selection on a random basis will have a bias toward mild disease and may miss entirely those with complicated medical conditions. For example it is the belief of CDC that approximately 85% of patients with asthma have mild disease. It is entirely possible in a random selection process to only review those with the mildest form of disease in which it is easier to score well, even if questionable care is provided. If selection is based proportionate to the prevalence of persons with mild, moderate or severe disease, then it is entirely possible to score only persons with mild disease. This type of situation is a bias. At SAC for example, chronic illness scoring was in the 40% range. While this certainly was not passing, Experts found that not a single chart review of complicated medical patients was managed appropriately. Indeed, care was so poor that patients were harmed and Experts believe immediate help is indicated to support chronic care management at that facility. Therefore, it is the Expert's opinion that there should be a selection bias toward sicker patients in order to reflect that the system of care is adequate.

12. Certain questions such as whether the record documents that the patient was educated on his/her chronic illness were overwhelmingly scored as yes and yielded a positive result. Both CDC and Experts have discussed whether this question should be removed because its meaningfulness to the audit was questioned. However, it was apparent to Experts that this scoring did not reflect whether the patient actually received the education (it only scored whether the health care staff checked the education box) and it did not score the type of education provided. The latter point is important because at SAC, for example, some physicians were so poorly trained that they did not understand how to use asthma inhalers and could not therefore have been capable of providing appropriate education to patients even though they check the education box. As well, what is important in education, (asthma in particular), is that the patient understands how to use their inhaler and how to modify their therapy based on their condition. So what is important is what their understanding is. In this regard, patient interview should be used as a means to verify that education was given. What the patient understands is more important than documentation of clinician checking of boxes. Experts therefore recommend that education questions include patient interviews.

Summary of Recommendations

1. Experts continue to review hospital facilities in order to report an opinion regarding whether hospitals should be included in Plata review.
2. Experts will review the automated data entry program of the CDC.
3. Experts recommend hiring physicians to manage serious illness at several facilities and to train on QMAT until CDC can hire appropriate staff.
4. Experts recommend initiation, review or possible revision of certain policies and procedures.
5. Experts will continue to meet with CDC staff to improve the QMAT instrument.
6. Experts recommend establishment of nursing leadership at CDC Central Office.

7. Experts would like to discuss with the Court confidential matters regarding physician staffing and recommendations to improve.

Sincerely for the Experts

Michael Puisis, D.O.

Joe Goldenson, M.D.

Madie LaMarre, CNP