Clinical Initiative Appendices

Clinical Initiative Appendix 1 – Practitioner Performance Evaluation Form

Clinical Initiative Appendix 2 – Nursing Executives Leadership Initiative

Clinical Initiative Appendix 3 – Nursing Executive Classification/Specification

Clinical Initiative Appendix 4 – Pharmacy Operating System Implementation Guide

Clinical Initiative Appendix 5 – October 24, 2007 Asthma Initiative Request For Proposals

APPENDIX 1

PRACTITIONER EVALUATION

Practitioner name: _____ ❑ Self-evaluation

Supervisor: _____ ❑ Supervisor evaluation

Rate each element of performance (1-3 needs improvement; 4-6 meets standards; 7-9 exceeds standards).

1. Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and end of life.

1	2	3	4	5	6	7	8	9
Examples								
Interviews and examines patients poorly; lacks technical proficiency Has poor judgment Disregards patient preference			Satisfactory skills in interviewing, physical exams, procedures Adequate judgment Usually respectful of patient preferences			Performs excellent patient interviews, exams, procedures Uses sound judgment Is highly respectful of patient preference		

Notes, e.g., regarding past performance and future goals:

2. Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

1	2	3	4	5	6	7	8	9
Examples								
Limited knowledge base Minimal interest in learning Poor understanding of complex problems			Solid fund of knowledge Satisfactory learner Adequately understands complex problems			Exceptional knowledge base Committed to continuous learning Comprehensive understanding of complex problems		

Notes, e.g., regarding past performance and future goals:

3. Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

1	2	3	4	5	6	7	8	9
Examples								
Minimizes or ignores self-assessment Avoids new technology Ignores feedback			Intermittently self-assesses Intermittently uses new technology Intermittently seeks feedback			Regularly self-assesses Uses new technology consistently Eagerly accepts feedback		

Notes, e.g., regarding past performance and future goals:

4. Communication and Interpersonal Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare and custody teams.

1	2	3	4	5	6	7	8	9
Examples								
Has poor relationships with patients and colleagues Avoids educating or counseling patients			Maintains satisfactory relationships Intermittently educates, counsels patients			Establishes excellent relationships with patients and colleagues Educates and counsels patients		

Notes, e.g., regarding past performance and future goals:

The six physician competencies were codified by the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS) in 1999 and endorsed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 2006.

5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

1	2	3	4	5	6	7	8	9

Examples

Not respectful	Usually respectful	Consistently respectful
Not compassionate	Usually compassionate	Very compassionate
Dishonest	Endeavors to be honest	Is honest
Avoids responsibility for errors	Recognizes errors	Accepts responsibility for errors
Not considerate of others	Tries to be considerate of others	Considers needs of others (patients, colleagues)

Notes, e.g., regarding past performance and future goals:

6. Systems-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

1	2	3	4	5	6	7	8	9

Examples

Poor utilization of resources	Adequate resource utilization	Effectively uses resources
Makes no attempt to reduce errors	Tries to reduce errors	Reduces errors
Resists improvement to systems of care	Tries to improve systems of care	Improves systems of care

Notes, e.g., regarding past performance and future goals:

7. Work Habits and Productivity: Practitioners are expected to be dependable and accessible, manage multiple priorities, and successfully completed assigned workloads.

1	2	3	4	5	6	7	8	9

Notes, e.g., regarding past performance and future goals:

8. Cooperation and Flexibility: Practitioners are expected to respond to the needs of the overall healthcare mission, facilitate problem-solving, make concessions when appropriate, and adhere to policies and procedures.

1	2	3	4	5	6	7	8	9

Notes, e.g., regarding past performance and future goals:

9. Initiative and Innovation: Practitioners are expected to suggest new ideas and enhancements, collaborate in making improvements, and assist colleagues in working through change.

1	2	3	4	5	6	7	8	9

Notes, e.g., regarding past performance and future goals:

Practitioner signature: _____ Date: _____

Supervisor signature: _____ Date: _____

APPENDIX 2

NURSING EXECUTIVES LEADERSHIP INITIATIVE

BACKGROUND

The Nursing Executive Leadership Initiative will fulfill the Receiver's Career Executive Assignment (RCEA) requirements as defined in the Plan of Action. After further dialogue with the State Personnel Board (SPB), a new Nursing Executive civil services classification has been developed. The Nursing Executive classification which was adopted by the SPB on October 22, 2007, will define a set of minimum qualifications and requirements for all levels of Nursing Executives from the local institution to the headquarters. Appointees will start as two-year limited term civil service employees and be converted into permanent employees subjected to a one year probation period. This Executive classification will first be piloted at the three regional levels, and three institutions before extending to other institutions.

One of the major system failures of the California Department of Corrections and Rehabilitation (CDCR) medical system has been the severe void in qualified health care executive level managers within CDCR prior to the Receivership. Given that the state system did not have an appropriate job classification for the Director of Nursing at the local facility, Supervising Registered Nurses (SRN) II and III, with or without management experience, were given the job designation. The Nursing Executive Leadership Initiative is designed to establish a patient-focused nursing infrastructure with job descriptions that have set of minimum qualifications to attract the most qualified Nursing Executive candidates from the health care industry. This initiative supports the Receiver's Plan of Action Objective A.7. Nursing leadership is a critical prerequisite to the success of other initiatives aimed to improve the delivery of patient-centered care throughout the prison system.

PROGRESS TO DATE

Considering that leadership infrastructure for the CDCR medical services is still under design and construction, the intent of this initiative is to focus on one discipline by testing the new Nurse Executive positions at the state level, regional level, and in three prisons. The pilot will be designed to test three key components:

1. The recruitment and retention of qualified Nurse Executives based on the new minimum job requirements;
2. The roles, responsibilities, and functions defined by the new Nursing Executive job descriptions; and
3. The most effective reporting mechanism [i.e., matrix reporting (dotted line) and direct reporting (solid line)] to ensure the optimal organization structural alignment in order to support the appropriate chains of command at the local facility while maintaining clinical accountabilities at all levels.

The pilot will also test a weighted scoring test system and pay plan designed to determine the most appropriate salary range for various levels of Nursing Executives taking into consideration diverse attributes such as nursing education, credentials, and management experience.

THE WAY FORWARD

Organizational change management literature frequently points out the importance of the leadership role. The Nurse Executive leaders play a pivotal role in the Receiver's prison health care transformation efforts. The Nurse Executive initiative aims to inoculate the current system with qualified nursing leaders by placing these leaders at all levels of the organization with potential capacity to function as change agents. The qualified Nurse Executives will provide mentorship to local nursing teams and develop new, emerging nurse leaders. The pilot sites will serve as future sites to mentor and train new Nurse Executives in a supportive culture. During the pilot, these new positions will be posted internally and externally for qualified applicants. The incumbents will be eligible to apply for these new positions in a competitive process.

The Nurse Executive Classification and salary range for each level of the Nursing Executives will be determined pending approval the Department of Personnel Administration (DPA). The newly established Receiver's Nurse Executive (Safety) classification was adopted by the State Personnel Board (SPB) on October 22, 2007. Upon approval, a new test will be developed by November 2007. Please refer to the Plan of Action 36 Month Priorities for detailed schedule.

Metrics

Considering the new Nursing Executive classification is a cross-breed between civil services and private sector, there is no industry benchmark for quantitative metrics. Therefore, qualitative metrics must be explored and considered. For example, once the positions are filled for the pilot sites, the local and regional experience under the new leadership structure can be captured through regularly structured interviews. An employee survey tool can be adopted or developed for field testing.

The proposed list of metrics will be further evaluated by an external evaluation entity to ensure objective review and feedback.

1. Pilot facilities nursing management retention rate compared with non-pilot sites.
2. Pilot facilities nursing staff retention rate compared with non-pilot sites.
3. Document process of hiring and incorporating Nurse Executives as change agents into the prison health care and custody culture using structured interviews with open-ended questions directed to the Nurse Executive as well as the Nursing and Custody Support Services management and staff. Develop a prototype from the analysis of this information to implement the Nurse Executive program system-wide.
4. Employee survey of the pilot facilities (i.e., employee satisfaction survey instrument).

Exhibits

Exhibit : Nursing Executives Classification / Specification

PLAN OF ACTION 18-24 MONTH PRIORITIES

NURSING EXECUTIVES LEADERSHIP INITIATIVE

	PROJECTED COMPLETION DATE	METRICS	ASSOCIATED COST*
Goal: Establish programs for appropriate and timely recruitment and hiring programs to increase the number and quality of prison clinician personnel (see POA Objective A.8). Establish a program for the recruitment and hiring of 250 Receiver's Career Executive Assignment Staff (see POA Objective A.7)	1/2008	Timely completion of deliverables	
Objective A.7. Create a pool of (limited term) positions in order to populate local, regional, and statewide leadership positions with qualified, responsive leaders.	12/2008	Timely completion of deliverables	
A.7.1. Develop a Nursing Executive classification based on health care industry standard qualifications such as management experience and education requirements by September 1, 2007.	9/1/2007 (Completed)	Timely completion of deliverables	
A.7.1.1. Obtain State Personnel Board approval	10/22/2007 (Completed)	Timely completion of deliverables	
A.7.1.2. Finalize qualification grid, set salary, and test.	11/2007	Timely completion of deliverables	
A.7.1.3. Finalize recruitment plan	11/2007	Timely completion of deliverables	
A.7.1.4. Develop and finalize selection instruction (test)	12/2007	Timely completion of deliverables	
A.7.1.5. Start hiring Nurse Executives	2/15/2008	Timely completion of deliverables	

* To be determined in collaboration with Finance

A.7.2. Obtain approval of these positions through the DPA.	1/2008	Timely completion of deliverables	
A.7.3. Hire external evaluator with organization development and human resources expertise to develop pilot metric instruments or adopt available survey tools by January 2008.	1/2008	Timely completion of deliverables	
A.7.3.1. Conduct human resources literature research of existing employee survey tools or leadership evaluation instruments.	1/2008	Timely completion of deliverables	
A.7.3.2. Develop tools based on research and modify for correctional health care organization.	2/2008	Timely completion of deliverables	
A.7.4. Establish a pre-pilot baseline metrics at pilot site and selected control sites by February 2008.	2/2008	Timely completion of deliverables	
A.7.4.1. Develop metrics specifications and survey instrument.	2/2008	Timely completion of deliverables	
A.7.4.2. Develop methodology for data or information collection.	2/2008	Timely completion of deliverables	
A.7.4.3. Collect pre-pilot metrics.	3/2008	Timely completion of deliverables	
A.7.4.4. Assign a mentor to each new pilot position.	3/2008	Timely completion of deliverables	
A.7.5. Pilot the new Nursing Executive job classification at the regional level and three local facilities from March through July 2008 (timeline to be adjusted pending approval of the salary range.)	3/2008 – 7/1/2009	Timely completion of deliverables	

APPENDIX 3

SPECIFICATION

Receiver's Nurse Executive (Safety)

SCOPE

This specification describes nurse executive positions at varying organizational levels with comprehensive management responsibility for delivery of nursing patient care. All positions allocated to this classification are responsible for maintaining the safety of persons and property; to prevent escapes of and injury by inmates committed to adult institutions under the auspices of the California Department of Corrections and Rehabilitation to themselves or others or to property; to maintain security in working areas and work materials; and, to inspect premises and search inmates for contraband, such as weapons or illegal drugs.

DEFINITION OF CLASSIFICATION

Each position allocated to this classification manages professional nursing services within the California Department of Correctional and Rehabilitation, and is responsible for comprehensive nursing care services being delivered 24-hours per day and 7 days per week in California Department of Corrections and Rehabilitation adult institutions. Incumbents are responsible for developing and maintaining an ongoing program to deliver, monitor, evaluate and improve the quality and appropriateness of all nursing care. Incumbents are responsible for continuous quality improvements and sustainable constitutional levels of nursing care. Incumbents ensure nursing services are well-functioning and that the timely delivery of patient care is available to all patients in accordance with appropriate standards of nursing care. Incumbents direct the development, and assist with the development of nursing policies, procedures and protocols. Incumbents direct the development, implementation of nursing services staffing plan policies. Incumbents assess nursing professional training and orientation needs; and, participate in the development of orientation and education programs to promote staff development policies. Incumbents identify problems and implement solutions for operational and organizational issues pertaining to nursing. Incumbents formulate and assist with the formulation of operational and capital budgets, and make decisions or effectively recommend a course of action with regard to management of the nursing budget.

MINIMUM QUALIFICATIONS

Possession of a current and unencumbered license as a registered nurse in California. (Applicants who do not meet this requirement will be admitted to the examination, but they must secure the required license before they will be considered eligible for appointment.)

and

A Bachelors of Science in nursing or health services administration or a related field. (Additional qualifying experience performing a full range of duties as a nursing supervisor in a

health care organization/facility with 20 or more full-time subordinate nurses, may be substituted for the required education on a year-for-year basis.)

and

Five years of clinical nursing experience in a comprehensive medical setting, at least three years of which must have been in an administrative or supervisory capacity in a health care organization/facility with 20 or more full-time subordinate nurses.

ADDITIONAL DESIRABLE QUALIFICATIONS

Clinical nursing experience in a correctional facility; Masters Degree in nursing or other health care related field; Basic Care Life Support certification; Advanced Care Life Support certification; and, experience in health care system and program design and development.

REQUIRED CORE COMPETENCIES

Professional/technical expertise: Possesses and applies job know-how

Customer focus: Strives to meet patient needs

Teamwork: Blends one's capabilities and effort with others' in achieving common goals

Valuing diversity: Appreciates differences among people and blends them productively

Managing performance: Takes responsibility for improving the effectiveness of others

Leadership: Promotes goals and shows the way

Planning and organizing: Organizes people and functions into an effective workforce

Organizational savvy: Grasps workings of the total organization as a formal and informal system

Process improvement: Controls and improves cyclical processes

Developing others: Enabling the competency growth of others

Managing change: Ensures that organizational change is smooth and successful

Strategic view: keeps the big, long range picture in mind

SPECIAL PERSONAL CHARACTERISTICS

Incumbents must possess the willingness to work in a correctional facility; possess a sympathetic and objective understanding regarding the problems of inmate-patients; and, be tactful and patient. Incumbents must possess and maintain sufficient strength, agility and endurance to

perform during physically, mentally, and emotionally stressful and emergency situations encountered on the job without endangering their own health and well-being or that of their fellow employees, forensic clients, patients, inmates or the public.

ASSIGNMENT DESCRIPTIONS WITHIN THE CLASSIFICATION

Institution Chief of Nursing Services

Positions assigned to this level are the highest ranking nurse manager within a Department of Corrections and Rehabilitation adult institution. Incumbents report directly to the institution healthcare Chief Executive Officer (aka Health Care Manager) and receive functional supervision from the Regional Director of Nursing Services insofar as it pertains to nursing standards, procedures, protocols and policies.

Directs all nursing activity within the institution and ensures compassionate, safe, effective, timely, efficient and equitable patient-centered care in conjunction with other health care discipline managers, and in coordination with custody. Develops and maintains a competent nursing team to deliver evidence-based patient-centered care. Develops and implements clear and realistic performance expectations, issue letters of instruction and counseling memoranda, effectively recommends formal disciplinary action to the institution Chief Executive Officer, and upon delegation from the Chief Executive Officer acts as the appointing authority and takes disciplinary action.

Regional Chief of Nursing Services

Under the direct supervision of the Regional Health Care Program Administrator, and the functional supervision of the Statewide Chief of Nursing Services, coordinates all patient care services within a region spanning multiple institutions within the California Department of Corrections and Rehabilitation adult institutions, and ensures that nursing practices comply with appropriate professional standards. Ensures institutions within the region have implemented an effective system that certifies competence to perform nursing duties, including the performance of physical assessments and out patient urgent/emergency protocols. Functionally supervises the Institution Chiefs of Nursing Services within the region insofar as it pertains to nursing standards, procedures, protocols and policies. Participates in the selection of the Institution Chiefs of Nursing Services and effectively recommends the appointment of candidates to institution healthcare Chief Executive Officers. Develops and monitors nursing performance expectations; performs competency assessments; mentors and coaches nursing personnel throughout the region. Assists in evaluating nursing staff and effectively recommends corrective and adverse action to Institution Chiefs of Nursing Services, institution Chief Executive Officers and Regional Healthcare Program Administrators (aka Regional Administrators).

Statewide Chief of Nursing Services

Under the direct supervision of the federal court Receiver (or designee), coordinates all nursing services on a statewide basis within the California Department of Corrections and Rehabilitation adult institutions. Ensures that nursing professional practices comply with appropriate standards

to deliver evidence-based patient-centered care. Ensures institutions statewide have implemented an effective system that certifies competence to perform nursing duties, including the performance of physical assessments and out patient urgent/emergency protocols. Functionally supervises the Regional Chiefs of Nursing Services insofar as it pertains to nursing standards, procedures, protocols and policies. Participates in the selection of the Institution and Regional Chiefs of Nursing Services and effectively recommends the appointment of candidates to institution healthcare Chief Executive Officers and Regional Healthcare Program Administrators. Develops and monitors nursing performance expectations; performs competency assessments; mentors and coaches nursing personnel throughout the state. Assists in evaluating nursing staff and effectively recommends corrective and adverse action to Institution and Regional Chiefs of Nursing Services, Institution Chief Executive Officers and Regional Healthcare Program Administrators.

APPENDIX 5

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSALS

ASTHMA INITIATIVE

FOR CALIFORNIA ADULT PRISON FACILITIES

October 24, 2007

PROPOSALS DUE: 2:00 p.m., December 7, 2007

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TABLE OF CONTENTS

I. REQUEST

The Receiver of the California Department of Corrections and Rehabilitation's ("CDCR") prison medical system is requesting proposals for technical assistance, education and training, and evaluation services. The selected contractor will be engaged to lead an interdisciplinary initiative with CDCR staff aimed at eliminating preventable patient deaths due to undiagnosed or uncontrolled asthma. The contract awarded by the Receiver will be a service agreement with either the California Prison Health Care Receivership Corporation ("CPR") or the CDCR.

II. BACKGROUND OF THE RECEIVERSHIP

As a result of the State of California's ongoing failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California has established a Receivership to assume the executive management of the California prison medical system and raise the level of care up to constitutional standards. On February 14, 2006, the Court appointed Robert Sillen to serve as the Receiver and granted him, among other powers, the authority to exercise all powers vested by law in the Secretary of the CDCR as they relate to the administration, control, management, operation, and financing of the California prison medical health care system.

The Court's actions stem from the case of *Plata v. Schwarzenegger* -- a class action law suit brought on behalf of the CDCR's adult inmates. Applicants should refer to the Court's October 3, 2005 "Findings of Fact and Conclusions of Law Re Appointment of Receiver" and the Court's February 14, 2006 "Order Appointing Receiver" for further information regarding the conditions underlying the Receivership and the powers and responsibilities of the Receiver. These and other relevant documents can be found on CPR's website at: http://www.cprinc.org/materials.htm.

III. ANTICIPATED SCOPE OF SERVICES

A. Clinical Background

In 2003 as part of the Plata remedial program, the CDCR introduced a nominal chronic care program to address the deficiencies of the sick call model of primary care. Inmates with one of nine conditions were to be enrolled as chronic care patients and seen at regular intervals by qualified providers. A one-page guideline for "pulmonary disease" included mention of peak flow measurement, theophylline levels, vaccinations, and smoking cessation.

The Plata remedial program was a failure on many fronts for many reasons, including inadequate medical records, almost non-existent information technology, and a shortage of qualified clinicians and managers. Sobering evidence of that failure can be found in the six asthma deaths that occurred in California prisons in 2006. While not all of the deaths may have been preventable, it was clear from quality reviews that system factors and provider practice contributed to at least several of the deaths.

CPR is rapidly deploying healthcare information technology and a sophisticated pharmacy management system, and CDCR is hiring increasing numbers of qualified clinicians and managers. The Pharmacy and Therapeutics Committee has adopted medication guidelines for acute and chronic asthma based on the National Asthma Education and Prevention Program Expert Panel Report (Update 2002).[1] But the CDCR still lacks a quality improvement infrastructure, clinicians are unfamiliar with process redesign, and episodic care rather than planned care is still the norm. There is still no care coordination or case management program, no decision support, and precious little patient education.

B. The Way Forward

The Receiver's Plan of Action[2] draws heavily from the past decade of work by the Institute of Medicine (IOM) in response to the quality crisis within mainstream American health care. According to the IOM, health care should be safe, effective, patient-centered, timely, efficient, and equitable. The IOM has endorsed adoption of chronic care programs.

The Chronic Care Model[3] provides a proven framework for implementation of the asthma guidelines. It includes six fundamental areas, illustrated below, comprising a system that encourages high-quality chronic disease management.

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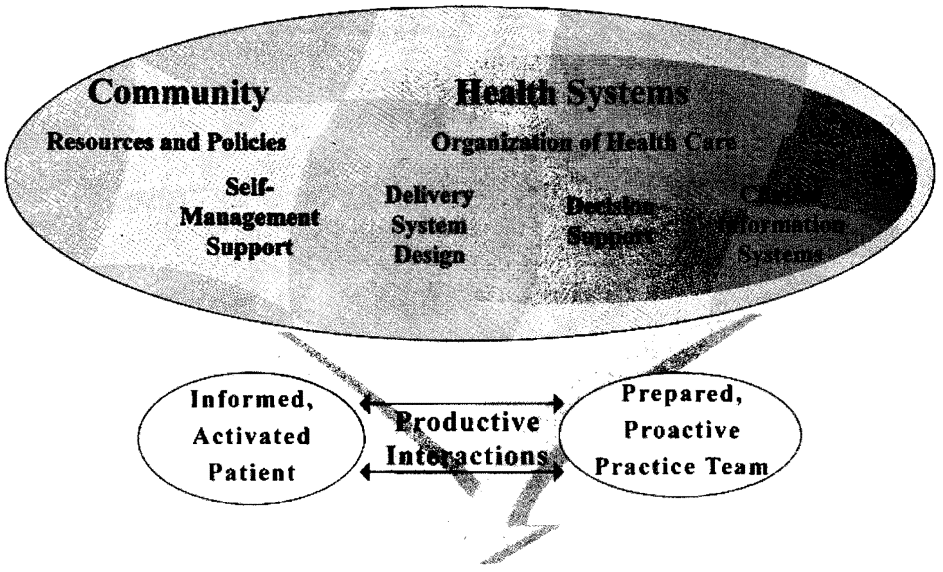
[1] NIH National Asthma Education and Prevention Program. Expert panel report: guidelines for the diagnosis and management of asthma: update on selected topics 2002. Available at http://www.nhlbi.nih.gov/guidelines/archives/epr-2_upd/index.htm.

[2] California Prison Health Care Receivership Corporation. Prison Medical Care System Reform: Plan of Action. May 2007. See www.cprinc.org/materials.htm.

[3] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1):2-4.

The Chronic Care Model



The Chronic Care Model has been successfully implemented in settings serving uninsured patients, the homeless, migrants, and minority populations, often using the Model for Improvement promulgated by the Institute for Healthcare Improvement.[4] Asthma disproportionately affects African-American, Latino, and low-income communities, so the prison population is adversely at risk. Even so, it is a chronic condition that can be proactively managed using evidence-based clinical guidelines within a chronic care framework.

The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. More than that, however, it will provide a testing ground for implementation of interdisciplinary quality improvement (QI) projects. It will engage all six of the organizational change strategies that the Institute of Medicine considers necessary to improve health care: (a) redesign of care processes based on best practices; (b) use of information technology for clinical information and support for caregivers; (c) increasing and deepening clinical knowledge and skills (d) development of a team-based, rather than a physician-centric, delivery system; (e) coordination of care; and (f) incorporation of performance and outcome measurements for improvement and accountability. The Asthma Initiative will demonstrate how to use data to inform the clinical care process while orienting our providers and management staff to patient safety issues. The end result of this specific disease management initiative will be a heightened awareness of chronic disease management leading to the improved care of other conditions and the beginning of a safety culture.

[4] See: How to Improve at www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprov.

C. Asthma Initiative Design

The new National Asthma Education and Prevention Program Expert Panel Report (Update 2007)[5] calls for interventions and measures within four broad components of care: (1) assessment and monitoring, both initial and periodic, including classification by severity; (2) education for a partnership in asthma care, including use of individual patient action plans; (3) control of factors contributing to asthma severity, and (4) pharmacotherapy.

Developing a medication guideline through the Pharmacy and Therapeutics Committee was a relatively easy first step. Educating the CDCR clinicians on the guideline will be more of a challenge, given the current lack of an effective education infrastructure. Education alone, however, is not likely to produce significant improvements in clinical outcomes.

The focus of the Asthma Initiative will be full-fledged, real-world practice redesign. The initiative leaders and ground-level clinicians must work together to address a multitude of issues to redesign the processes of care. For example, there is no mystery with regard to the need to assess the breathing capacity of asthma patients at each visit, but in the CDCR there is no agreement as to how to do so. Who will do the assessments, and how? Who will do the documentation, and how should verbal communication occur between patient and nurse, nurse and physician, physician and patient? What is the role of a respiratory therapist? How can we assure that information flows from on-site urgent care, off-site emergency department, or off-site consultant back to the yard clinic at the next appointment? More specifically, how should we address these questions now—in a system with chaotic medical records, pharmacies and laboratories, in which nurses and physicians have rarely worked together in teams, and in which custody and healthcare staff have often worked at cross purposes?

In order to achieve significant practice change and clinical improvement, the Asthma Initiative will involve headquarters, regional, and institutional staff, pharmacy/Maxor staff, and the external clinical and organizational change consultants. The local interdisciplinary teams will include provider, nursing, pharmacy, health records, and clerical staff. Each local interdisciplinary team will be led by a clinical champion well-respected by his/her peers. The external clinical change experts will provide a change package, project management, and QI technical support. The project will follow established clinical guidelines. The pharmacy information system will identify patients using asthma medications. Data on medication usage will help stratify patients by severity.

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[5] NIH National Asthma Education and Prevention Program. Expert panel report 3: guidelines for the diagnosis and management of asthma. 2007. Available at http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.

The contractor team may want to propose using an adaptation of the original Breakthrough Series Learning Collaboratives.[6] Adaptations of the collaborative model have proven to be effective and efficient.[7]

The contractor team should consider engaging a small number of facilities initially, but staff from all 33 prisons should have the opportunity to participate in the initiative within a year. Under this scenario, the initial Asthma Initiative sites would be selected based on local leadership capacity, organizational resource availability, pharmacy stability, and prior implementation of a pharmacy information system, all factors that will also contribute to success in the Asthma Initiative. The pilot sites chosen will have been exposed to QI tools and process redesign; therefore, these sites are most likely to embrace a QI collaborative pilot and the chronic care model.

Although the CDCR's 33 prisons often differ in their patient populations, organizational cultures, and clinical effectiveness, they share a core set of policies and procedures. Their limited heterogeneity and autonomy should allow faster dissemination of practice improvement than could be achieved among separate organizations.

D. Aim, Goals, and Measures

The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. The initiative will improve asthma care by engaging physicians, nurses, pharmacists, and patients in implementation of the chronic care model using proven methods of organizational change.

At a minimum, the contractor team is to address the following outcomes and outputs with work plans including strategies, time lines, and accountabilities (responsible parties):

1. Design and direct a quality initiative to achieve evidence-based asthma care in the CDCR, encompassing practice redesign, clinical guidelines, policies, documentation tools, and staff education resources.
2. Develop culturally and linguistically appropriate education resources and collaborate with CDCR on appropriate peer education programs for patients with asthma.
3. Develop and lead implementation of a chronic care team model appropriate for corrections, delineating roles, responsibilities, and measures of team function in the asthma context.
4. Design and pilot an implementation plan for a disease registry, care coordination, and case management for patients with asthma.
5. Develop process improvement methodologies within the CDCR including use of quality measures, rapid-cycle quality improvement, and high-reliability practices in the asthma context.

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[6] The Breakthrough Series: IHI's Collaborative model for achieving breakthrough improvement. (2003) Boston, Massachusetts: Institute for Healthcare Improvement.

[7] Gould DA, et al. New York City Palliative Care Quality Improvement Collaborative. *Joint Commission Journal on Quality and Safety*. 2007: 33;307.

E. Work Plan

Applicants should submit a work plan consistent with the above aim, goals, and strategies. The work plan should include the proposed clinical measures and details as to how the contractor will use and/or adapt the Breakthrough Series model, as well as the proposed schedule, metrics, evaluation, key staff, budget, and contractor qualifications.

F. Organization and Direction

The contractor will work at the direction of the Receiver or the Receiver's designee. All work of contractor's staff will be at the day-to-day direction of a Project Executive or Project Director designated by the contractor.

IV. DELIVERABLES

The deliverables required will be stipulated in conjunction with the approved goals, measures, work plan, and associated staffing plans and schedules. **ALL DELIVERABLES CREATED BY THE CONTRACTOR UNDER THE AGREEMENT, WHETHER OR NOT IDENTIFIED AS CONTRACTUAL DELIVERABLES, WILL BE THE PROPERTY OF THE RECEIVER.**

V. SELECTION AND CONTRACTING PROCESS

An Evaluation Committee (the "Committee") will review the submitted proposals in accordance with submittal requirements and evaluation criteria set forth below and will recommend to the Receiver a short list of firms for further consideration. Upon acceptance of the short list, the Receiver may invite short-listed firms to make oral presentations to the Committee.

If the Receiver elects to conduct oral interviews, the entire proposed Key Staff of any short-listed teams must be available to participate in these interviews. The Committee will then make a final evaluation and submit its recommendation to the Receiver. The Receiver will make a final determination and authorize negotiations with one or more of the firms that have submitted their qualifications and whose responses are most advantageous to the Receiver.

The Receiver reserves the right to seek clarification of information submitted in response to this RFP and/or request additional information during the evaluation process. The Receiver reserves the right to accept or reject any or all qualifications and selections when it is determined, in the sole discretion of the Receiver, to be in the best interest of the Receiver.

The Receiver intends to negotiate and enter into a services agreement ("the Agreement") with the selected Respondent promptly upon selection. Prior to commencing the Services, the selected contractor must sign the Agreement and provide proof of insurance. The Agreement will include the Standard State Terms And Conditions set forth at:

http://www.cprinc.org/docs/special/STATE_REQUIRED_TERMS_AND_CONDITIONS_FOR_CONTRACTS.pdf

The Agreement is anticipated to be for a period of not more than 18 months.

VI. EVALUATION CRITERIA

The Committee will review Proposals in accordance with the following criteria:

A. Respondent's proven experience, capabilities and resources, at both the corporate and individual levels, in providing consulting and technical assistance services to programs comparable in size, scope of work, and urgency.

B. Qualifications, availability and commitment of key staff. Respondents shall clearly identify the key staff that will perform each of the above-described areas of scope, what role each is anticipated to fulfill in connection with the Project, and what percentage of their time will be devoted exclusively to this Project.

C. Proven systems, management techniques, required expertise and resources designed to facilitate timely and effective decision-making and stakeholder coordination.

D. Cost or relative value of services provided.

E. Completeness and comprehensiveness of response to this RFP and compliance with the submittal requirements.

F. Quality of oral interviews including technical analysis and presentation (if requested by the Receiver).

G. Legal actions that might affect Respondent's ability to perform as contracted.

H. Absence of any relationship that could constitute a conflict of interest or otherwise impede the ability of the Respondent to protect the interests of the Receiver.

VII. SUBMITTAL REQUIREMENTS

A. RFP Schedule

Event	Date
RFP Issued	October 24, 2007
Bidders' teleconference	November 8, 2007
Deadline for questions regarding RFP	November 13, 2007
Responses to questions	November 19, 2007
Proposals due	December 7, 2007
Notification for interviews	December 12, 2007 (estimated)
Interviews	December 17-21, 2007 (estimated)
Selection announced	January 3, 2008 (estimated)
Estimated project start date	January 21, 2008 (estimated)

B. Addenda

Any questions regarding the RFP should be submitted to CPR in writing. CPR will, at its discretion, respond to questions in an addendum. Any necessary information not included in this RFP that CPR deems necessary and relevant to responding to the RFP will also be issued in an addendum. CPR makes no guarantee that all questions submitted will be answered.

Addenda will be sent to all known applicants. If the Respondent did not receive this RFP directly from CPR, notify CPR in writing of a request to receive any addenda by November 19, 2007.

C. Format

Proposals should be clear, concise, complete, well organized and demonstrate both Respondent's qualifications and its ability to follow instructions.

8 (eight) bound copies of the Proposal should be provided, with all materials spiral bound into books of approximately 8-1/2" x 11" format, not to exceed forty (40) single-sided pages total length. At least one (1) copy must contain original signatures and be marked ORIGINAL.

Pages must be numbered. We will not count, in the total, the graphic cover sheet, cover letter, table of contents, blank section dividers (tabs), explanations about legal actions, and a maximum of 12 resumes, which may be included in an appendix. The entire Proposal shall also be submitted in electronic (pdf) format on CD, organized in the same manner as the printed submissions.

The Proposal shall be placed in a sealed envelope with the submitting firm's name on the outside of the envelope.

All respondents are requested to follow the order and format specified below. Please tab each section of the submittal to correspond to the numbers/headers shown below.

Respondents are advised to adhere to submittal requirements. Failure to comply with the instructions of this RFP may be cause for rejection of submittals.

The Receiver reserves the right to waive any informalities in any submittal and/or to reject any or all submittals. The Receiver reserves the right to seek clarification of information submitted in response to this RFP during the evaluation and selection process. The Committee may solicit relevant information concerning the firm's record of past performance from previous clients or consultants who have worked with the Respondent.

D. Contents

The Proposal must include the following items:

1. A cover letter signed by an officer of the firm submitting the Proposal, or signed by another person with authority to act on behalf of and bind the firm. The cover letter must contain a commitment to provide the required Services described with the personnel specified in the submission. The letter should certify that the information contained in the Proposal is true and correct. Please also indicate the contact person(s) for the selection process along with contact information.

2. Executive Summary: The Executive Summary must include a clear description of the primary advantages of contracting with your organization. It should also include a brief explanation of how the Respondent satisfies the evaluation criteria, and a brief statement that demonstrates Respondent's understanding of the desired Services.

3. Demonstration of the Respondent's Qualifications: Please provide the following information:

    a) Your company's name, business address and telephone numbers, including headquarters and local offices.

    b) A brief description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.

    c) A description of your company's prior experience related to correctional and healthcare facilities.

    d) A description of your company's prior experience in California.

e) A description of your company's specific areas of technical expertise as they relate to this RFP.

f) A description of your company's internal training and quality assurance programs.

4. Professional references: Describe previous work on no more than three projects of comparable scope and magnitude for which you provided similar types of services. Provide complete reference information including project name, location, client, total contract amount (and firm's amount if different), principal-in-charge, day-to-day technical project director/manager, key staff, date completed, client reference (name, current position and phone number), and a brief narrative of project description for each project identified and described above. **Experience may not be considered if complete reference data is not provided or if named client contact is unavailable or unwilling to share required information.**

5. Qualifications of Technical Personnel: Submit current resumes for Key Personnel committed to this project and a statement regarding their local availability. Specifically describe previous related experience, its pertinence to this program, and provide references including the name, address and telephone number of a contact person who can verify the information provided. Provide brief description of referenced project(s), as well as any professional certifications, accreditation, special licensing or other qualifications which qualifies the professional to perform in their designated area of responsibility.

6. Legal action: Respondent must provide a listing and a brief description of all material legal actions, together with any fines and penalties, for the past five (5) years in which (i) Respondent or any division, subsidiary or parent company of Respondent, or (ii) any member, partner, etc., of Respondent if Respondent is a business entity other than a corporation, has been:

   a) A debtor in bankruptcy;

   b) A defendant in a legal action alleging deficient performance under a services contract or in violation of any statute related to professional standards or performance;

   c) A respondent in an administrative action for deficient performance on a project or in violation of a statute related to professional standards or performance;

   d) A defendant in any criminal action;

e) A principal of a performance or payment bond for which the surety has provided performance or compensation to an obligee of the bond; or

f) A defendant or respondent in a governmental inquiry or action regarding accuracy of preparation of financial statements or disclosure documents.

7. Default Termination: Disclosure whether your company has defaulted in its performance on a contract in the last five years, which has led to the termination of a contract.

8. Conflict of Interest: Identify any existing financial relationships with other contractors that may be a part of your proposal, and explain why those relationships will not constitute a real or perceived conflict of interest.

9. Cost Proposal: Provide a cost proposal for performing the Services.

E. Modification or Withdrawal of Proposal.

Prior to the Proposal due date, Respondents may modify or withdraw a submitted Proposal. Such modifications or withdrawals must be submitted to CPR in writing. Any modification must be clearly identified as such and must be submitted in the same manner as the original (e.g., appropriate copies, paper size, etc.). No modifications or withdrawals will be allowed after the Proposal due date.

F. Public Opening

There will be no public opening of responses to this RFP. However, after a contract is awarded all Proposals may be available for public review. CPR makes no guarantee that any or all of a Proposal will be kept confidential, even if the Proposal is marked "confidential," "proprietary," etc.

G. General Rules

1. Only one Proposal will be accepted from any one person, partnership, corporation or other entity.

2. Proposals received after the deadline will not be considered.

3. This is an RFP, not a work order. All costs associated with a response to this RFP, or negotiating a contract, shall be borne by the Respondent.

4. CPR's failure to address errors or omissions in the Proposals shall not constitute a waiver of any requirement of this RFP.

H. Reservation of Rights

The Receiver reserves the right to do the following at any time, at the Receiver's discretion:

1. Reject any and all Proposals, or cancel this RFP.

2. Waive or correct any minor or inadvertent defect, irregularity or technical error in any Proposal.

3. Request that certain or all candidates supplement or modify all or certain aspects of their respective Proposals or other materials submitted.

4. Procure any services specified in this RFP by other means.

5. Modify the specifications or requirements for services in this RFP, or the required contents or format of the Proposals prior to the due date.

6. Extend the deadlines specified in this RFP, including the deadline for accepting Proposals.

7. Negotiate with any or none of the Respondents.

8. Terminate negotiations with a Respondent without liability, and negotiate with other Respondents.

9. Award a contract to any Respondent.

Inquiries in regard to this RFP should be addressed to:

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