Information Technology Initiative Appendices

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APPENDIX 1

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al., Plaintiffs, v. ARNOLD SCHWARZENNEGER, et al., Defendants	NO. CIV S-90-0520 LKK JFM P (E.D. Cal.)
MARCIANO PLATA, et al., Plaintiffs, v. ARNOLD SCHWARZENEGGER, et al., Defendants.	NO. C01-1351 TEH (N.D. Cal.)
CARLOS PEREZ, et al., Plaintiffs, v. JAMES TILTON, et al., Defendants	NO. C05-05241 JSW (N.D. Cal.) ORDER APPROVING COORDINATION AGREEMENTS ATTACHED TO JOINT MAY 29, 2007 ORDER

The undersigned have carefully considered the six proposed coordination agreements (attached to the May 29, 2007 Order filed jointly in the above-captioned cases), and the responses thereto, filed by Plaintiffs and Defendants on June 15, 2007. We conclude that the six proposed coordination agreements will assist the remedial process in all three cases by avoiding inefficiencies and duplication of effort. The Court does not disagree with the points identified by the parties. Except as expressly ordered herein, however, these are matters that

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the undersigned intend to take into account, and revisit if necessary, as the remedial process moves forward.

The proposed coordination agreements call for the Plata Receiver to assume responsibility for (1) direct oversight of contracting functions for medical, dental, and mental health care; (2) implementation of the long-term information technology program to include the medical, dental, and mental health programs; and (3) oversight of pharmacy operations serving the medical, dental, and mental health programs. The assumption of these responsibilities by the Plata Receiver will be approved subject to the reporting requirements set forth in this order, which follow the order appointing the Receiver filed February 14, 2006 in Plata. See Order filed February 14, 2006, at I (D).

Accordingly, and good cause appearing, IT IS HEREBY ORDERED that:

1. The undersigned HEREBY APPROVE the above-identified six coordination agreements.[1]

2. The Receiver shall henceforth file in Coleman quarterly progress reports which shall address: (a) all tasks and metrics necessary to the contracting functions, implementation of long-term information technology, and pharmacy services for mental health care, with degree of completion and date of anticipated completion for each task and metric; (b) particular problems being faced by the Receiver in connection with the contracting functions, implementation of long-term information technology, and pharmacy services for mental health care; and (c) particular successes achieved by the Receiver in

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[1] Judge Henderson notes that the Union of American Physicians and Dentists ("UAPD"), which represents physicians employed by the California Department of Corrections and Rehabilitation ("CDCR"), has filed an application for leave to file an amicus curiae brief with respect to the credentialing agreement. Judge Henderson grants this request and directs that the Clerk of the Northern District of California permit the filing of the UAPD's "Amicus Curiae Brief on Proposed Agreement to Assign Credentialing to Receiver," which is attached to its request. In its brief, the UAPD states that it supports reassigning credentialing to the Receiver but raises concerns to the extent that some future action by the Receiver in this area might implicate the UAPD collective bargaining agreement with respect to the rights of physicians already employed. The Receiver shall file a response to this concern, in *Plata v. Schwarzenegger* C01-1351, within 7 days from the date of this Order.

connection with the contracting functions, implementation of long-term information technology, and pharmacy services for mental health care. The first report shall be due on October 1, 2007.

3. The Receiver shall henceforth file in Perez quarterly progress reports which shall address: (a) all tasks and metrics necessary to the contracting functions, implementation of long-term information technology, and pharmacy services for dental care, with degree of completion and date of anticipated completion for each task and metric; (b) particular problems being faced by the Receiver in connection with the contracting functions, implementation of long-term information technology, and pharmacy services for dental care; and (c) particular successes achieved by the Receiver in connection with the contracting functions, implementation of long-term information technology, and pharmacy services for dental care. The first report shall be due on October 1, 2007.

IT IS SO ORDERED.

DATED: June 28, 2007

/s/
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

DATED: June 28, 2007

THELTON E. HENDERSON
SENIOR JUDGE
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

DATED: June 28, 2007

/s/
JEFFREY S. WHITE
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

APPENDIX 2

Healthcare IT Executive Committee Charter

1. The system-wide Healthcare IT Executive Committee (HITEC) shall recommend overall strategic direction to Information Technology planning and initiatives.

2. The HITEC duties shall include, but are not be limited to recommendations in the following areas:
   - Prioritization of IT projects and initiatives
   - Determination of appropriate pilot sites for IT projects
   - Coordination of IT project resources for improved efficiency
   - Evaluations of vendors and products
   - Provision of feedback from the user community regarding IT expectations and needs
   - Ensuring stakeholders are kept informed of IT project progress and that the stakeholders participate as required
   - Facilitation of the development and implementation of policies consistent with the needs of the project - privacy, quality, training and control
   - Provision of a forum for the escalation of IT issues and their resolution
   - Advise and support the Chief Information Officer, the Chief Medical Information Officer, and their teams

3. The HITEC will be charged with recommending and helping to create appropriate HIT End-user Group Forums and Committees to ensure all IT projects are designed and implemented with the end-users in mind.

4. The HITEC shall serve in an advisory role regarding the initiation or strategic development of IT projects. Ultimately, all encumbrance of resources or funding for IT projects will require formal approval of the CIO, CMIO, the CPR Chief of Staff, the Receiver, and, when appropriate, the representatives of the Coleman, Armstrong, and Perez Court cases.

5. The HITEC and its subcommittees will be composed of the following membership:

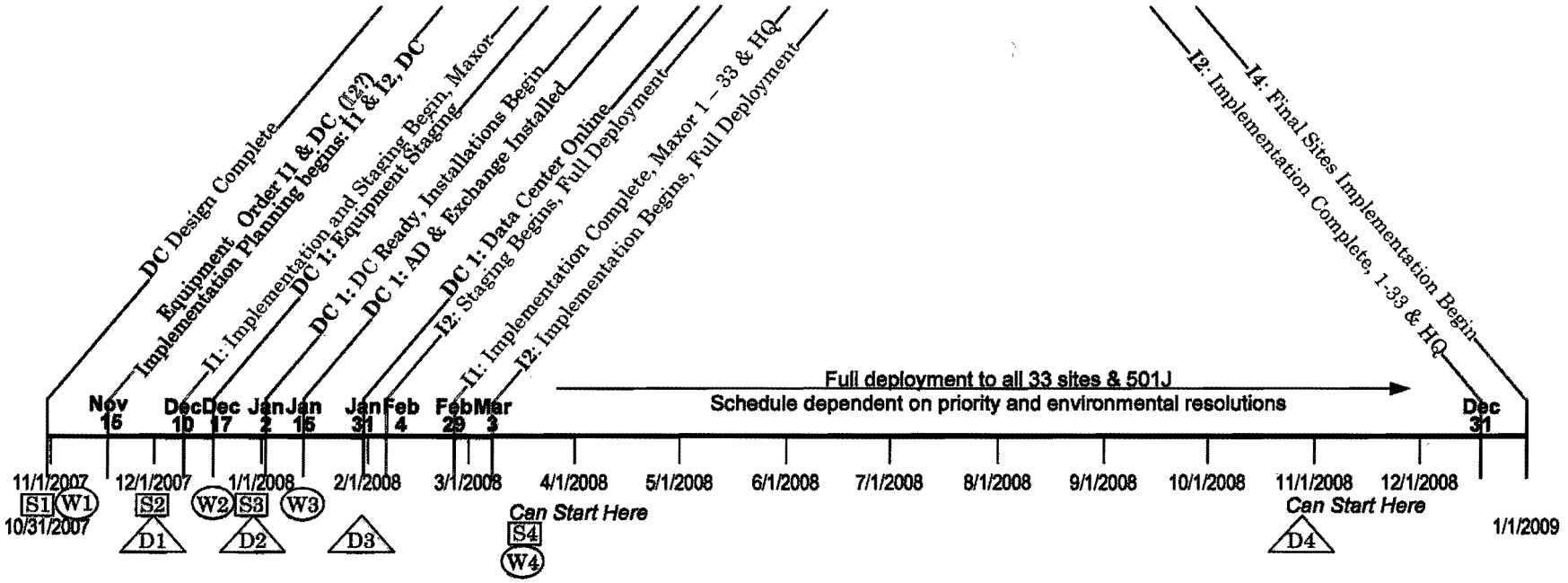
Members
CPR Chief Information Officer
CPR Chief Medical Information Officer
CPR Chief Medical Officer
CPR Chief Nurse Executive
CPR Chief Financial Officer
CDCR Director, Plata Support Division
CPR Chief of Staff
Receiver
Special Master, Coleman or designee (when appropriate)
Court Representatives, Perez or designee (when appropriate)
Court Representative, Armstrong or designee (when appropriate)
Chief Deputy Secretary, Correctional Health Care Services (when appropriate)

Representatives of the Clark Court will be invited as appropriate.

Individual members may send a designee to HITEC meetings when necessary.

APPENDIX 3

CPR Network Design and Implementation Timeline



I1: Implementation Phase 1: Maxor implementation to all sites. 1 router, 1 core switch, 1 IDF switch to pharmacy. 33 Prisons, 501J
I2: Implementation Phase 2: Full deployment to all sites. 33 Prison Health Care Networks, 501J
I3: n/a
I4: Implementation Phase 4: RAOs, Depot, Mental, Dental and CPR in San Jose. Any additional offices

Data Survey	Wireless Survey	Design	Sites in the Phase
S1	W1	D1	FOL, MCSP, PBSP, CMC, LAC, CCI, SQ, CIW (8) + 501J
S2	W2	D2	SAC, SOL, VSPW, CCC, SVSP, CTF, NKSP, WSP, COR, SATF, RJD, CVSP, ISP (13)
S3	W3	D3	CIM, DVI, CMF, CRC, SCC, ASP, NCWF, CCWF, CAL, CEN, PVSP, HDSP (12)
S4	W4	D4	RAOs: Sacramento, Corcoran, Bakersfield, Stockton, El Centro, Rancho Cordova, Rancho Cucamonga, Paso Robles, (8) CPR San Jose, Depot, Mental Health, Dental Facilities, 'others'

RH 10/25/07

APPENDIX 4

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSAL

CLINICAL DATA REPOSITORY AND PORTAL SOLUTION
FOR THE
CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

SEPTEMBER 26TH, 2007

CONTACT: GLEN MOY
DIRECTOR, HEALTH INFORMATION INTEGRATION
1731 TECHNOLOGY DRIVE, SUITE 700
SAN JOSE, CA 95110
glen.moy@cprinc.org

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REQUEST

The Receiver of the California Department of Corrections and Rehabilitation (CDCR) prison health care system is requesting proposals for the design, development, and implementation of a clinical data repository (CDR) and portal solution to provide CDCR clinical staff with access to patient health information at the point-of-care. The awarded contract will be an agreement with the Receiver through the California Prison Health Care Receivership Corporation (CPR).

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 lawsuit 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 .

The CDCR mental health and dental systems are also under court supervision as a result of two additional inmate class actions: *Coleman v. Schwarzenegger* and *Perez v. Tilton*. To avoid duplication of effort, certain health care initiatives that support the entire health care system are being coordinated by the *Plata*, *Coleman* and *Perez* courts. To facilitate such coordination, the courts have agreed that the Receiver will be responsible, in addition to his management of the medical system, for the oversight and implementation of certain mental health and dental support functions, including health information management and information technology.

SCOPE OF WORK AND DISCUSSION

Background

The CDCR currently delivers healthcare services to over 175,000 inmate-patients in thirty-three institutions throughout the state. The scope of the department's healthcare mission includes primary care, acute and urgent care, chronic care management, long-term care, hemodialysis, physical therapy and rehabilitation, and infirmary-level care. The department also provides extensive mental health services, dentistry, and care of inmates who are incapacitated or developmentally disabled. Cases requiring specialty consultation or complex management are seen remotely by telemedicine or are referred to community medical offices or hospitals.

In addition, the CDCR provides a variety of ancillary services. All thirty-three institutions operate a pharmacy and provide radiology and imaging services, e.g., plain film radiology, CT, MRI, ultrasound, nuclear medicine, etc. Currently the CDCR performs approximately 175,000 imaging and radiology procedures annually, the majority of which (92%) are done in-house. The department also operates eleven in-house clinical laboratories, which collectively perform over 300,000 tests annually, and sends out an additional 1 million plus tests annually to national and regional clinical reference laboratories.

Currently, CDCR clinical staff typically have access to incomplete, inaccurate, and/or untimely patient health information at the point-of-care, if they even have access to patients' paper-based medical charts at all. In addition to the typical issues associated with paper-based charts, a further challenge is the highly mobile nature of the patient population in question. Besides referrals out to community hospitals or medical offices, inmates can transferred to multiple institutions over a period of time due to the prison system's overcrowding situation. Unfortunately, inmates' medical charts and associated information are not nearly as mobile as the inmates themselves.

The current lack of availability of patient health information obstructs medical decision making and the efficient delivery of clinical care not only at the individual patient level, but at the institutional and organizational levels as well.

Current Technology and Information Environment

For an organization that is responsible for over 175,000 lives, the CDCR has very little in the way of enterprise-level systems and technology.

- The CDCR currently employs a wide area network (WAN) that is based on a hub-and-spoke model, utilizes fractional T1 lines, and is at 95% capacity. Within each institution, the majority of desktops are neither networked nor do they have Internet access. The Receivership is currently in the process of establishing a medical grade network infrastructure that will include an MPLS-based network, wireless LAN within each of the institutions, a level 4 hosted

data center, and 24 hour staffed network operations center. This effort is expected to be complete by early 2008.

- CDCR primarily uses two systems developed at different times over the past twenty-two years, called Distributed Data Processing System (DDPS) and Offender Based Information System (OBIS), to identify inmates, track their movement, and maintain demographic and administrative information:
    - DDPS is a UNIX-based, distributed system, with thirty four instances existing across the state that are synchronized via a nightly batch process. The data available from DDPS suffers from issues related to accuracy, completeness, and availability. For example, inmates can have multiple aliases and have been know to provide inaccurate demographic information. In addition, while inmates are assigned a unique CDCR identification number during their incarceration, this number is not a unique lifetime number should an inmate be reincarcerated after completing parole. Finally, daily batch files from individual institutions can potentially be delayed for up to seven days before being received centrally at CDCR headquarters.
    - OBIS is a separate mainframe system that is used to maintain inmate information throughout their time in the correctional system from commitment to final discharge, including sentencing information and institutional movement history.

- Besides DDPS, the department does not employ any other type of enterprise-level system or application. It utilizes approximately 1000 Microsoft Access-based applications for everything from claims/invoice processing to scheduling to utilization management. Many of these databases are "synchronized" manually by untrained staff using CD-ROMs or thumb drives to merge databases. Much of the information in these applications is not considered reliable and will not be migrated over.

- Maxor National Pharmacy Services Corp. of Amarillo, TX is currently implementing a pharmacy information management system across all thirty-three in-house pharmacies. Rollout of the Guardian pharmacy management system is scheduled to be completed in the next twelve months. Once the rollout is complete, Guardian will provide reliable, system-wide inmate medication profiles.

- As described above, the department sends out over 1 million lab tests annually to clinical reference laboratories, such as Quest Diagnostics. The results are currently received via paper; however, the CPR is working with some of these laboratories to receive the results electronically when the CDCR's technical infrastructure is in place. It is anticipated that at least 70% of all laboratory results are readily available in electronic form. The eleven

CDCR in-house laboratories also employ their own separate laboratory information systems (LIS) of uncertain provenance and quality

- As part of its Discharged Offender Record Management System (DORMS) project, the department recently scanned over 8 million pages worth of medical charts for discharged inmates, i.e., inmates who have been released and on parole for more than three years.

- The Receivership may obtain access to a number of other trustworthy data sources useful for patient care. These may include a centralized repository of dictation/transcription; Medi-Cal claims from inmates prior to incarceration; data feeds from community providers where inmates are sent for care; and some legacy CDCR Access databases with unusually high quality data.

- In terms of staffing, it is estimated that the vacancy rate for IT positions within the department is approximately 15 – 25% (if not higher); unfortunately there is no accurate information available regarding budgeted positions, approved positions, etc. There is also a severe shortage of staff knowledgeable about and experienced with healthcare informatics and clinical systems, which significantly impacts any future health IT-related initiatives.

Goals and Objectives

In the Receiver's May 2007 Plan of Action, one of his stated goals was to "compile medical data across all compliant data sources into a unified [system] that can be used to generate information valuable for patient care and health care management." Specifically, the CPR is looking to achieve the following objectives:

- Begin establishing a platform upon which to create a longitudinal electronic health record (EHR) for every CDCR inmate
- Better enable clinical decision making and enhance patient safety through reliable and timely access to patient information at the point-of-care
- Collect reliable data electronically to enhance the overall management and delivery of health care services system-wide
- Begin establishing the foundational components necessary for an enterprise-level, integrated health information system

Solution Requirements

The Receiver is seeking a vendor or group of vendors to design and implement a clinical data repository and portal solution comprised of the following components:

I. *Master Patient Index*
   a) Employs a single, unique identifier for each member of the CDCR's patient population across the enterprise;

b) Maintains demographic and other key patient information, including but not limited to DOB, sex, race, SSN, medical record numbers, etc.;
c) Maintains patient aliases;
d) Supports the management of patients' demographic information and health records, e.g., aggregation, merging, deletion, etc.;
e) Supports a variety of patient matching algorithms, e.g., probabilistic, Soundex, etc., that can utilize modifiable aggregate weights and penalties to groups of data elements;
f) Employs a record locator service (RLS) that stores the location of and provides links to patient health information maintained in disparate clinical systems;
g) Maintains a master provider index and associated information, e.g., national provider ID (NPI), medical license number, DEA number, etc.
h) Maintains indexes or registries for other key information, such as service delivery locations, etc.;
i) Maintains a duplicate checking log and provides web-based tool for record management;
j) Maintains an audit trail of all master patient index (MPI) transactions;
k) Supports integration with other clinical information systems by either employing a service oriented architecture (SOA) or providing an application programming interface (API);

***Note:** The Receivership is currently conducting a needs assessment to determine whether an MPI is required and, if so, the type needed, the timing of its deployment in relation to the clinical data repository, etc. Therefore, the Receivership may or may not initially deploy an MPI as part of its CDR project. Responders to this RFP should include an MPI solution in their proposals; however, responders should structure their proposals such that the MPI is an optional component that can be included/excluded at the discretion of the Receivership.

II. *Clinical/Provider Portal*

a) Utilizes a web-based front end interface that employs a SOA;
b) Aggregates a variety of complex patient health information, including but not limited to:
    - Patient demographic information (including inmate location)
    - Problems
    - Medications (including administration)
    - Allergies
    - Lab results
    - Encounter history (including pending/future appointments)
    - Notes, e.g., discharge summaries, progress notes, etc.
    - Images, including radiology, digital photographs, EKGs, scanned documents, etc.
c) Presents a consistent, longitudinal, patient-centric view of health information;
d) Supports clinical portal user functionality requirements specified in Appendix A;

e) Does not persist any clinical data locally; users can access the same patient information regardless of which workstation they are logged on;
f) Provides a customizable user "inbox" for management of incoming results, messages, clinical notifications, etc.;
g) Supports the creation or registration of new patients in the system;
h) Provides authorized users secure access to clinical information either at the point-of-care or remotely via secure socket layer (SSL)/transport layer security (TLS) or equivalent encryption;
i) Supports user and role-based security profiles to prevent unauthorized access to patient health information (See 'Section V: Security' for additional details);
j) Detects security-relevant events that it mediates and generates audit records for them; at a minimum the events shall include: user login/logout, session timeout, account lockout, patient record viewed, patient data created/updated/deleted, and patient health information exported (e.g., printed);
k) Supports user single sign-on and the Clinical Context Object Workgroup (CCOW) standard;
l) Supports linking to external or third-party web-based content;

III. *Clinical Data Repository*

a) Employs a flexible data model that can model complex health care processes and patient information, including but not limited to:
    - General medical care
    - Dental
    - Mental health
    - Encounter history
    - Case management
b) Compliant with or mappable to the HL7 Reference Information Model (RIM);
c) Maintains and organizes data within the repository in a patient-centric manner;
d) Supports the discrete storage of structured patient health information associated with but not limited to:
    - Problems
    - Allergies
    - Medications (including administration)
    - Lab results
    - Encounter history (including pending/future appointments)
    - Notes, e.g., discharge summaries, progress notes, etc.
e) Supports the storage of both structured and unstructured clinical documents (such as discharge summaries, progress notes, etc)., either directly within the repository or via linking to a separate document repository;
f) Supports the storage of radiology-related data and images;
g) Supports organization-definable, custom data fields;

h) Support the storage of information in a variety of formats, such as discrete data types, free text, scanned images, digital multimedia, XML, etc.;
i) Supports the storage of patient health information both in a central database and thru the linking of patients' records to external sources of associated health data, such as hospitals, physician practices, regional health information organizations (RHIOs), etc.;
j) Supports reporting and data analysis via third-party reporting tools;
k) Maintains a corresponding meta-data dictionary or repository;
l) Employs an enterprise-level relational database management system that provides high-availability options, such as clustering, fail-over, etc.;
m) Ability to support potentially 1500+ concurrent users and store several terabytes worth of data;

IV. *Interoperability*

a) Employs a set of services or components that support data aggregation and normalization, including:
   - Terminology maintenance
   - Data mapping
   - Data translation
b) Supports data exchange and messaging standards specified by standards and health information exchange bodies such as CalRHIO, Health Information Technology Standards Panel (HITSP), etc. (See Appendix B for complete list):
   - HL7 v2.x/3.0
   - DICOM
   - ASC X12
   - NCPDP
   - ELINCS v1.0
c) Supports clinical document standards specified by standards and health information exchange bodies such as CalRHIO, Health Information Technology Standards Panel (HITSP), etc. (See Appendix B for complete list):
   - Continuity of Care Document (CCD)
d) Supports terminology standards specified by standards and health information exchange bodies such as CalRHIO, Health Information Technology Standards Panel (HITSP), etc. (See Appendix B for complete list):
   - ICD-9/ ICD-10
   - LOINC 2.15
   - CPT-4
   - SNOMED
   - SNODENT
e) Supports integration with various clinical information systems, such as laboratory information system (LIS), picture archiving and communication system (PACS), claims processing, electronic medical record system

(EMR), etc., and non-clinical systems, such as credentialing, financial, etc.;

f) Capable of health information exchange with legacy point-to-point interface engines/systems;
g) Supports data/message exchange via an integration engine or enterprise service bus that is based on a service oriented architecture and utilizes web services;
h) Employs a set of services which ensure the secure and reliable management of messages, e.g., routing, delivery, queuing, orchestration, encryption, identity management, exception/error handling, etc.

V. *Security*

a) Authenticates the user before any access to protected resources, e.g., patient health information, is allowed;
b) Associates permissions with a user using one or more of the following access controls:
    - user-based (access rights assigned to each user);
    - role-based (users are grouped and access rights assigned to these groups);
    - context-based (role-based with additional access rights assigned or restricted based on the context of the transaction such as time-of-day, workstation location, emergency mode, etc.)
c) Enforces the most restrictive set of rights/privileges needed by users or groups for the performance of specified tasks;
d) Supports the ability to control access to sensitive patient health information:
    - Ability to "blind" sensitive patient health information, thereby prohibiting access to unauthorized users;
    - Provide access to blinded information to a clinician, when the information is necessary for managing an emergency condition; this feature is commonly known as a "break glass" function;
    - "Break glass" function must require the clinician requesting access to document and record the reason(s) for requesting access;
e) Enforces a limit of (configurable) consecutive invalid access attempts by a user. The system shall protect against further, possibly malicious, user authentication attempts using an appropriate mechanism (e.g. locks the account/node until released by an administrator, locks the account/node for a configurable time period, or delays the next login prompt according to a configurable delay algorithm);
f) Upon detection of inactivity of an interactive session shall prevent further viewing and access to the system by that session by terminating the session, or by initiating a session lock that remains in effect until the user reestablishes access using appropriate identification and authentication procedures; the inactivity timeout shall be configurable;
g) Detects security-relevant events that it mediates and generates audit records for them; at a minimum the events shall include: user login/logout,

session timeout, account lockout, patient record viewed, patient data created/updated/deleted, and patient health information exported (e.g., printed);

h) Supports user single sign-on and the CCOW standard;
i) Supports enforcement of enterprise security policies;
j) Provides transport-level security via secure socket layer (SSL)/transport layer security (TLS) or equivalent encryption;
k) Implements web services-related security according to the Web Services Security Framework and corresponding specifications:
    - Content Security: XML Encryption, XML Signature
    - Message Level Security: WS-Security
    - Secure Message Delivery: WS-Addressing, WS-ReliableMessaging, WS-ReliableMessaging Policy Assertion
    - Metadata: WS-Policy, WS-SecurityPolicy
    - Trust Management: SAML, WS-Trust, WS-SecureConversation

Given the current conditions within the system and the overall lack of technology, staff, infrastructure, etc., the Receiver is seeking not only the technical components described above, but also the development, implementation, project management, and training resources critical to ensuring the successful implementation of any proposed solution.

Qualifications

The successful vendor(s) will meet the following qualifications:

- Extensive experience as a health information technology (HIT) vendor developing and/or implementing clinical data repositories, electronic medical records systems, clinical/physician portals, or clinical workflow solutions for large healthcare organizations, such as hospitals, large physician organizations, and regional health information organizations, with the ability to demonstrate multiple "live" clients with 3 or more years of active, continous use and storage of data; experience with correctional healthcare preferred;
- Extensive health information exchange experience, including:
    - Demonstrated knowledge of and experience with health messaging standards, such as HL7, ELINCS, ASC X12, etc.;
    - Development and deployment of either point-to-point interfaces and/or SOA-based clinical messaging/interoperability solutions;
    - Implementation of clinical standard code sets, such as CPT, ICD, LOINC, SNOMED, etc.;
    - Aggregation and normalization of clinical data from disparate health information systems;
    - Knowledge of or experience with national and/or regional clinical interoperability efforts, e.g., Consolidated Health Informatics Initiative, HITSP, CalRHIO, etc.;

- Extensive knowledge of and experience with HIPAA, including demonstrated ability to develop/implement HIT solutions that secure and protect the privacy of patient health information;
- Extensive knowledge of and experience with the development of health care solutions based on service oriented architecture and web services;
- Demonstrated history of success implementing HIT projects at comparable-sized health care organizations, i.e., manage 200,000+ patient lives, have 300+ providers, multiple delivery locations, etc.;
- Capacity to provide the clinical, technical, operational, training, and project management resources necessary to successfully implement the project, utilizing both internal resources and as needed partnerships with other leading health information technology vendors;

INSTRUCTIONS FOR PROPOSALS

1. Point of Contact

All communications regarding this Request of Proposal (RFP) must be directed to:

Glen Moy
Director, Health Information Integration
California Prison Health Care Receivership Corp.
1731 Technology Drive, Suite 700
San Jose, CA 95110
-or-
glen.moy@cprinc.org

2. RFP Schedule and Activities

The schedule of RFP-related activities is as follows:

Activity	Date(s)
RFP Issued	Sept. 26, 2007
Bidders' Teleconference	Oct.10, 2007
Deadline for questions regarding RFP	Oct. 12, 2007
Answers to RFP questions posted	Oct. 17, 2007
Proposals due	Oct. 26, 2007
Semi-finalists announced	Nov. 12, 2007 (Estimated)
Presentations and solution demonstrations	Nov. 19 – Dec. 7, 2007 (Estimated)
Final evaluations and reference checks	Nov. 19 – Dec. 14, 2007 (Estimated)
Award announced	Dec. 31, 2007 (Estimated)

Please direct any questions regarding the RFP to Glen Moy electronically at glen.moy@cprinc.org by 5pm PST on the specified deadline; questions will

be answered on a rolling basis, and all answers will be compiled in anonymous fashion and shared with any other prospective contractors.

The Receivership will conduct a bidders' teleconference tentatively scheduled for **Wednesday, Oct. 10**; additional details will be forthcoming. The teleconference will provide bidders with an introduction to Receivership management, learn more about its overall mission and goals, develop a clearer understanding of the environment in which the Receivership operates, and better understand its vision, objectives, and requirements for this project.

Proposals must be submitted to the identified point of contact by the specified deadline; please see 'Format of Proposal' below for additional information regarding proposal submission.

Within two weeks of the proposal submission deadline, the Receivership will announce the semi-finalists. Semi-finalists will then be invited to meet with the project selection committee, make a formal presentation of their solution, and conduct product demonstrations. Concurrently the selection committee will conduct due diligence on all semi-finalists, including corporate and/or client site visits, interviews of references, etc. The committee will subsequently make its recommendations to the Receiver, who will then make the final decision. See 'RFP Evaluation and Contract Award' for additional information.

3. Format of Proposal

a. Proposals must be submitted electronically via e-mail, followed by an original proposal signed by the person or persons authorized to bind the applicant; please include "**CPR CDR RFP**" in the subject line of the e-mail. Originals must be postmarked by the deadline for submission.
b. Submit eight copies of the hard-copy proposal.
c. All proposals must include required attachments, exhibits, etc. All attached materials should reference the applicant's name.
d. Oral, telephone or facsimile proposals will not be considered.
e. Proposals should be printed on 8-1/2" x 11" paper.

4. Content of Proposal

Proposals must provide complete responses to all the items in this section.

a. Executive Summary. Provide a summary of the key aspects of your proposal and the principal advantages of contracting with your company or group of partners.
b. Company or Partners Profile. Provide a brief profile of the company or each of the partners, including:
    - Corporate history

- Profile of executive team (background, years with company)
- Breakdown of employees by functional area (management, research & development, implementation, training, support)
- Current customer base (total number of systems installed, total number of users, geographical distribution, etc.).
- Total annual sales and revenue for past three years
- Number of systems sold and implemented for past three years
- List and description of all relevant third-party relationships
- Company's long term goals for itself and its product(s)

c. Description of company's qualifications and ability to execute this proposal.

d. Description of company's prior relevant experience.

e. List of customer references whom CPR can contact, along with corresponding contact information.

f. Solution Description. Provide a detailed description of the proposed solution that includes:
   - Technical architecture;
   - Solution components and underlying technologies;
   - Features and functions;
   - System requirements;

g. Services Description. Provide a description of the services the company provides to assist customers with:
   - Development, implementation, and project management;
   - Training;
   - On-going support services and resources;
   - Help desk support, including hours of operation, time zone, availability of after-hours support, response levels and times, etc.;

h. Project Plan. Provide a draft project plan that includes:
   - Description of methodology;
   - Proposed schedule with key dates and milestones;
   - Work breakdown structure;
   - Project staffing, including description of the organization of the project team, identification of roles and responsibilities, and estimated work hours or level of effort for each team member;

i. The names and resumes of key personnel to be assigned to this project.

j. Contact person and corresponding information for the purpose of this proposal.

k. Cost. Provide a cost proposal for performing the project, including a methodology for payment based on the successful completion of contract deliverables. Cost proposals must include the anticipated costs to the applicant in providing the proposed services, including

the compensation for each member of the applicant's team providing services under the proposal.

5. **Modification or Withdrawal of Proposal**
Prior to the proposal due date, applicants 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.

6. **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.

7. **General Rules**
   a. Only one proposal will be accepted from any one person, partnership, corporation, vendor or other entity.
   b. Sub-contractors or sub-prime vendors can be associated with two or more separate proposals.
   c. Proposals received after the deadline will not be considered.
   d. 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 applicant.
   e. CPR's failure to address errors or omissions in the proposals shall not constitute a waiver of any requirement of this RFP.

8. **Reservation of Rights**
CPR reserves the right to do the following at any time, at CPR's discretion:

   a. Reject any and all proposals, or cancel this RFP.
   b. Waive or correct any minor or inadvertent defect, irregularity or technical error in any proposal.
   c. Request that certain or all candidates supplement or modify all or certain aspects of their respective proposals or other materials submitted.
   d. Procure any services specified in this RFP by other means.
   e. Modify the specifications or requirements for services in this RFP, or the contents or format of the proposals prior to the due date.
   f. Extend the deadlines specified in this RFP, including the deadline for accepting proposals.
   g. Negotiate with any or none of the candidates.
   h. Terminate negotiations with an applicant without liability, and negotiate with other applicants.

i. Award a contract to any applicant.

9. RFP Evaluation and Contract Award

Each proposal submitted in response to this RFP will be evaluated by a selection committee, which will make recommendations to the Receiver or his designee regarding the best proposal. The committee will take into consideration the bidder's RFP response, solution demonstration, peer-to-peer reference checks, and client and corporate site visits. Key factors in the selection committee's recommendations will include the following:

- Solution functionality and usability
- Technical architecture
- Solution demonstration
- Cost approach
- Project methodology
- Development, implementation, and enhancement support
- Ongoing system maintenance support
- Reference checks
- Install base
- Capacity to meet requirements (company size, financial condition, business capabilities, etc.)

The Receiver or his designee, in his or her sole discretion, will select the candidate with whom CPR will begin negotiations for a contract. If CPR is unable to negotiate a contract with the selected applicant, the Receiver or his designee may select another applicant with whom CPR will begin contract negotiations, or the Receiver may elect not to award the contract.

The Agreement will include the General Terms and Conditions and Contractor Certification Clauses set forth at: http://www.documents.dgs.ca.gov/ols/GTC-307.doc and http://www.documents.dgs.ca.gov/ols/CCC-307.doc, except that all references to the State of California or the Department of General Services will mean the California Prison Health Care Receivership Corporation.

Unsuccessful applicants will be notified as soon as possible either after the selection of the RFP semifinalists or the award of the contract.

Appendix A: Clinical Portal User Functionality

Item No.	Description
Category: Identify and Maintain a Patient Record	
1.1	The system shall automatically create a single patient record for each patient using a single unique identifier.
1.2	The system shall provide the ability to manually create a patient record for a patient.
1.3	The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.
1.4	The system shall provide the ability to store more than one identifier for each patient record.
1.5	The system shall provide the ability to search for a patient using one or more criteria.
Category: Manage Patient Demographics	
2.1	The system shall capture and maintain demographic information as part of the patient record.
2.2	The system shall provide the ability to maintain and make available historic information for demographic data including prior names, aliases, etc.
2.3	The system shall provide the ability to modify demographic information about the patient.
2.4	The system shall provide the ability to store inmate location information.
2.5	The system shall store demographic information in the patient medical record in separate discrete data fields, such that data extraction tools can retrieve these data.
Category: Manage Problem List	
3.1	The system shall provide the ability to maintain all current problems associated with a patient.
3.2	The system shall provide the ability to maintain a history of all problems associated with a patient.
3.3	The system shall provide the ability to maintain the onset date of the problem.
3.4	The system shall provide the ability to associate orders, medications and clinical documents with one or more problems; association to be structured, codified data.
3.5	The system shall provide the ability to maintain a coded list of problems.
3.6	The system shall provide the ability to display inactive and/or resolved problems.
Category: Manage Medication List	
4.1	The system shall provide the ability to maintain medication lists.
4.2	The system shall provide the ability to maintain records for the prescribing of medications, including the identity of the prescriber.
4.3	The system shall provide the ability to maintain medication ordering dates.

4.4	The system shall provide the ability to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.
4.5	The system shall provide the ability to display medication history for the patient.
4.6	The system shall provide the ability to maintain common content for prescription details, including strength, sig, quantity, and refills to be selected by the ordering clinician.
4.7	The system shall store medication information in discrete data fields such as dose, route, sig, dispense amount, refills, associated diagnoses, etc.
4.8	The system shall provide the ability to print a current medication list.
4.9	The system shall provide the ability to display current medications only.
4.10	The system shall include standard medication codes associated with each medication in the list.
Category: Manage Allergies	
5.1	The system shall provide the ability to maintain lists of medications and other agents to which the patient has had an allergic or other adverse reaction.
5.2	The system shall provide the ability to specify the type of allergic or adverse reaction.
Category: Summarize Patient Record	
6.1	The system shall provide the ability to create and display a summary list for each patient that includes, at a minimum, the active problem list, current medication list, medication allergies and adverse reactions
Category: Manage Clinical Documents	
7.1	The system shall provide the ability to display clinical documentation and notes.
7.2	The system shall provide the ability to filter, search or order notes by document/note type within a patient record.
7.3	The system shall provide the ability to filter, search or order notes by date within a patient record.
7.4	The system shall provide the ability to associate standard codes with discrete data elements in a note.
7.5	The system shall provide the ability to capture and store external documents, such as scanned documents.
7.6	The system shall provide the ability to receive, store in the patient's record, and display text-based outside reports.
7.7	The system shall provide the ability to index and retrieve scanned documents based on the document type, the date of the original document, and the date of scanning.
7.8	The system shall provide access to clinical images. They must be accessible from within the patient's chart and labeled and date-time stamped or included in a patient encounter document. These images may be stored within the system or be provided through direct linkage to external sources.
7.9	The system shall provide the ability to accept, store in the patient's

	record, and display structured text-based reports received from an external source.
7.10	The system shall provide the ability to accept, store in the patient's record, and display, codified data received from an external source.
Category: Manage Results	
8.1	The system shall provide the ability to indicate normal and abnormal results based on data provided from the original data source.
8.2	The system shall provide the ability to display numerical results in flow sheets and graphical form in order to compare results, and shall provide the ability to display values graphed over time.
8.3	The system shall provide the ability to display non-numeric current and historical test results as textual data.
8.4	The system shall provide the ability to notify the relevant providers (ordering, copy to) that new results have been received.
8.5	The system shall provide the ability to filter or sort results by type of test and test date.
Category: Manage Medication or Immunization Administration	
9.1	The system shall provide the ability to maintain medication administration information.
9.2	The system shall provide the ability to maintain, for any medication, the medication type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.
9.3	The system shall provide the ability to maintain immunization administration information.
9.4	The system shall provide the ability to maintain, for any immunization, the immunization type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.
9.5	The system shall provide the ability to maintain information regarding patient adverse reaction to a specific immunization.

Appendix B: Clinical Interoperability Standards

The list below details the clinical interoperability standards which the Receivership to date has adopted to lay the framework for health information exchange and the clinical interoperability of current and future information systems.

As of August 2007

Clinical Interoperability Standards	
Description	Version
Category: Data Exchange Messaging Standards	
Health Level Seven (HL7)	2.x/3.0
Accredited Standards Committee (ASC) X12	--
Digital Imaging and Communications in Medicine Committee (DICOM)	--
EHR-Laboratory Interoperability and Connectivity Specifications (ELINCS)	2.0
National Council for Prescription Drug Programs (NCPDP)	--
Category: Clinical Document Standards	
HL7 Continuity of Care Document (CCD)	--
Category: Terminology Standards	
Current Procedure Terminology (CPT)	4
International Classification of Diseases (ICD)	9/10
Logical Observation Identifiers Names & Codes (LOINC)	2.15
Systematized Nomenclature of Dentistry (SNODENT)	--
Systematized Nomenclature of Medicine (SNOMED)	--
Unified Medical Language System (UMLS)	--
Category: Conceptual Information Standards	
HL7 Reference Information Model (RIM)	--

APPENDIX 5

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSAL

Enterprise Clinical Laboratory Assessment and Planning For The California Department of Corrections and Rehabilitation

June 20, 2007

Proposals Due:

July 27, 2007

CONTACT: **JUSTIN GRAHAM, MD MS**
CHIEF MEDICAL INFORMATION OFFICER
1731 Technology Drive, Suite 700
San Jose, CA 95110
justin.graham@cprinc.org

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REQUEST

The Receiver of the California Department of Corrections and Rehabilitation (CDCR) prison medical system is requesting proposals for an assessment of CDCR's existing clinical laboratory services and assistance developing a plan for improving laboratory services to its inmate-patients. The awarded contract will be a service agreement with the Receiver through the California Prison Health Care Receivership Corporation (CPR).

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 lawsuit 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.

SCOPE OF WORK AND DISCUSSION

CDCR currently delivers healthcare services to over 170,000 inmate-patients in 33 prison facilities. The scope of the healthcare mission includes primary care, acute and urgent care, chronic care management, long-term care, hemodialysis, physical therapy and rehabilitation, and infirmary-level care. Cases requiring specialty consultation or complex management are seen remotely by telemedicine or are referred to community medical offices or hospitals.

A recent survey indicated that annual laboratory testing volumes at the 33 institutions is over 1.2 million bundled tests for both on-site and off-site testing.

There are three general categories of laboratory services within CDCR:

• Eleven laboratories are licensed and providing on-site testing services. The types of services provided by the eleven institutions include chemistry, coagulation studies, endocrinology, hematology, serology, toxicology, urinalysis and blood banking. These eleven laboratories provide anywhere between 9 - 84% of the total laboratory testing volume at the various institutions. The eleven institutions perform a combined total of 68 different tests, primarily in chemistry and hematology. This data indicates that the eleven institutions provide almost 2.2 million individual (non-bundled) tests annually.

• Five laboratories provide limited testing of simple tests and point of care tests. These five laboratories combined provide an estimated 370 on-site tests per month.

• Seventeen sites provide sample collection stations only. Fourteen of these sites have no equipment to perform testing and three could be providing testing services but the lack of a Clinical Laboratory Scientist or a designated Laboratory Director is preventing service provision.

Until recently, healthcare operations in the 33 prisons were confined to silos with no central planning of services. As a result, each facility has been responsible for developing its own clinical laboratory program. Consequently, there is no standardization in services. Neighboring prisons may have contracts with different reference laboratories at wildly different rates and different levels of service. Some facilities have outdated equipment dating from the 1980's; others have purchased new analytic equipment that they lack the expertise and equipment to install. Because CDCR's healthcare information technology infrastructure has suffered from decades of neglect, the current network is insufficient to support an enterprise laboratory information system (LIS); in many cases lab results are not being routinely made available to providers who ordered them. Additionally, facilities in extremely remote California locations have had great difficulty recruiting and retaining qualified laboratory staff and identifying facility space for lab functions such as phlebotomy and pre-analytical processing.

To reduce inefficiency and improve timeliness of medical care for CDCR's inmate-patients, the Receiver is creating a statewide strategy and implementing centralized operations for enterprise clinical laboratory services. This redesign of lab services will occur in concert with other improvements the healthcare system, including overhauls of information technology and telemedicine; consequently, we expect to have the infrastructure to support an enterprise LIS and a clinical data warehouse in the near future.

The Receiver is seeking a contractor to perform an operations assessment of existing CDCR clinical lab services and make recommendations on how to restructure the program for maximum benefit to the healthcare mission of CDCR Healthcare. Specifically, the contractor will

- Provide an assessment of the current state of clinical laboratory services, including capabilities, staffing, contracts, licensure, organizational structure, and technical infrastructure;
- With specific reference to other institutionalized healthcare, including correctional systems, provide a critique of the above findings in light of currently available technology and industry best practices;
- Compare the cost and impact of on-site versus off-site laboratory services, including the cost and timeliness of routine, stat, and after-hours services.
- Evaluate the feasibility of increased point-of-care testing programs and the continuing use of in-house stat labs.
- Estimate the return on investment for the establishment of centralized or regionalized clinical laboratory operations, including staffing, capital equipment investment, LIS, supplies and shared reference laboratory contracts.
- In conjunction with CPR leadership, create a vision of the future state of California prison clinical laboratory services, including
    - The types of lab services CDCR should offer on-site versus by contract with a reference lab
    - The entire enterprise clinical laboratory staffing model, from a statewide lab director down to facility-based staff
    - The feasibility of rapid point-of-care testing devices in primary care and urgent care areas
    - The standardization of lab ordering, standard panels, reference ranges, test dictionaries, and utilization management
    - Which facilities, if any, can and should be CLIA-licensed
    - The strategy for contracting with external reference lab services, especially in extremely remote locations
    - The tactical steps required to centralize all clinical laboratory operations
- Provide a road map, including estimated cost, resources, and duration of effort, for the Receivership to restructure and modernize the enterprise clinical laboratory program at CDCR to achieve the stated vision.

In pursuit of these objectives, the contractor will be expected to

- Visit CDCR's headquarters in downtown Sacramento and a sample set of approximately 8 prisons, including
    - At least two prisons that have significant space constraints limiting availability of on-site capital equipment and full service labs;
    - At least three prisons that currently have extensive laboratory services available onsite;
- At these facilities, assess clinical lab workflow including process for ordering tests, collecting specimens, and reporting results; condition and placement of lab suites and equipment; facility layout constraints,

transport requirements for off-site reference labs; and timeliness and reliability of reference lab results reporting.
- Interview relevant CDCR personnel, including leadership and front-line clinical and technical staff.

The successful contractor will meet the following qualifications:

- Extensive experience with clinical laboratory services in a variety of clinical settings. Experience in correctional healthcare preferred.
- Demonstrated history of success in prior enterprise clinical laboratory projects.
- Knowledge of and experience with both federal and state regulatory environments, e.g. CLIA
- Familiarity with the state of laboratory medicine in California

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 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

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 clinical laboratory 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.

INSTRUCTIONS FOR PROPOSALS

1. Point of Contact

All communications regarding this Request of Proposal (RFP) must be directed to:

Justin Graham, MD MS, Chief Medical Information Officer
California Prison Health Care Receivership Corp.
1731 Technology Drive, Suite 700
San Jose, CA 95110
-or-

justin.graham@cprinc.org

2. Questions and Addenda

Questions in writing are welcome.

Any questions regarding the RFP should be submitted to CPR in writing. CPR will, at its discretion, respond to questions. Questions will be answered on a rolling basis, and answers will be shared with any other prospective contractors, all in anonymous fashion. In addition, any necessary information not included in this RFP that CPR deems necessary and relevant to responding to the RFP will be issued in an addendum. CPR makes no guarantee that all questions submitted will be answered.

Addenda and questions and answers 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 questions and answers or addenda.

3. RFP Schedule

Event	Date
RFP Issued	June 20, 2007
Deadline for questions regarding RFP	July 18, 2007
Proposals due	July 27, 2007
Interviews (estimated)	Week of August 13, 2007
Award announced (estimated)	August 20, 2007

4. Format of Proposal

a. Proposals must be submitted electronically via e-mail, followed by an original proposal signed by the person or persons authorized to bind the applicant. Originals must be postmarked by the deadline for submission.
b. Submit five copies of the hard-copy proposal.
c. All proposals must include required attachments, exhibits, etc. All attached materials should reference the applicant's name.
d. Oral, telephone or facsimile proposals will not be considered.
e. Proposals should be printed on 8-1/2" x 11" paper.

5. Content of Proposal

Proposals must provide complete responses to all the items in this section.

a. 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. Please also indicate the contact person(s) for the selection process along with contact information.

b. Executive Summary. Provide a summary of the key aspects of your proposal and the principal advantages of contracting with your organization.

c. The names and resumes of key personnel for this project.

d. A description of the organization of the project team, identifying which members of the team will be responsible for accomplishing the specific objectives of the project.

e. A description of your company's qualifications and ability to execute this proposal, including:

    1) A brief description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.
    2) A description of your company's prior experience related to correctional and healthcare facilities.
    3) A description of your company's prior experience in California.
    4) A description of your company's specific areas of technical expertise as they relate to this RFP.

f. Strategies for data collection and analysis that will yield credible findings and recommendations, with brief discussion of the strengths and weaknesses of these strategies.

g. A proposed timeline for the performance of the services.

h. 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.

i. 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:

    1) A debtor in bankruptcy;

2) 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;
3) A respondent in an administrative action for deficient performance on a project or in violation of a statute related to professional standards or performance;
4) A defendant in any criminal action;
5) A principal of a performance or payment bond for which the surety has provided performance or compensation to an obligee of the bond; or
6) A defendant or respondent in a governmental inquiry or action regarding accuracy of preparation of financial statements or disclosure documents.

j. Default Termination: Disclose 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.

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

l. Cost. Provide a cost proposal for performing the project, including a methodology for payment based on the successful completion of contract deliverables. Cost proposals must include the anticipated costs to the applicant in providing the proposed services, including the compensation for each member of the applicant's team providing services under the proposal.

6. Modification or Withdrawal of Proposal

Prior to the proposal due date, applicants 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.

7. 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.

8. General Rules

a. Only one proposal will be accepted from any one person, partnership, corporation or other entity.
b. Proposals received after the deadline will not be considered.
c. 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 applicant.
d. CPR's failure to address errors or omissions in the proposals shall not constitute a waiver of any requirement of this RFP.

9. Reservation of Rights

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

a. Reject any and all proposals, or cancel this RFP.
b. Waive or correct any minor or inadvertent defect, irregularity or technical error in any proposal.
c. Request that certain or all candidates supplement or modify all or certain aspects of their respective proposals or other materials submitted.
d. Procure any services specified in this RFP by other means.
e. Modify the specifications or requirements for services in this RFP, or the contents or format of the proposals prior to the due date.
f. Extend the deadlines specified in this RFP, including the deadline for accepting proposals.
g. Negotiate with any or none of the candidates.
h. Terminate negotiations with an applicant without liability, and negotiate with other applicants.
i. Award a contract to any applicant.

APPENDIX 6

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSALS
FOR

Enterprise Imaging and Radiology Assessment and Planning
For The
California Department of Corrections and Rehabilitation
Under Direction of the California Prison Health Care Receivership

FOR CALIFORNIA ADULT PRISON FACILITIES

September 11, 2007

PROPOSALS DUE: 2:00 p.m. October 11, 2007

CONTACT: JUSTIN GRAHAM, MD MS
CHIEF MEDICAL INFORMATION OFFICER
1731 Technology Drive, Suite 700
San Jose, CA 95110
justin.graham@cprinc.org

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SECTION

I. REQUEST

The Receiver of the California Department of Corrections and Rehabilitation (CDCR) prison health care system is requesting proposals for an assessment of CDCR's existing enterprise imaging and radiology services and assistance with the development a plan for the future provisioning of imaging and radiology services to its inmate -patient population. The awarded contract will be a service agreement with the Receiver through the California Prison Health Care Receivership Corporation (CPR).

II. BACKGROUND

As a result of the State of California's ongoing failure to provide medical care to pr ison 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 ca re 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 Rec eivership 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.

The CDCR mental health and dental systems are also under court supervision as a result of two additional inmate class actions: *Coleman v. Schwarzenegger* and *Perez v. Tilton*. To avoid duplication of effort, certain health care initiatives that support the entire health care system are being coordinated by the *Plata*, *Coleman* and *Perez* courts. To facilitate such coordination, the courts have agreed that the Receiver will be responsible, in addition to his management of the medical system, for the oversight and implementation of certain mental health and dental support functions, including radiology.

While the problems identified by the courts and the Receiver reach into almost every element of the health care system, it is without question that the existing radiology services are inadequate to meet the needs of the confined adult populatio n. The selected contractor will be expected to provide a plan for centralization and management of enterprise imaging services in the most expeditious and cost -effective manner.

CDCR currently delivers healthcare services to over 175,000 inmate -patients in thirty-three institutions throughout the state. The scope of the healthcare mission includes dental care, primary care, acute and urgent care, chronic care management, long -term care, hemodialysis, physical therapy and rehabilitation, and infirmary -level care. Cases requiring specialty consultation or complex management are seen remotely by telemedicine or are referred to neighboring medical/dental offices or hospitals. The scope of imaging services required by the patient population includes plai n film radiology, CT, MRI, ultrasound, nuclear medicine, dental radiology (digital and plain film), and angiography, as well as emerging imaging modalities, such at PET and SPECT scans. Currently the CDCR performs approximately 175,000 imaging and radiology procedures annually, the majority of which (92%) are done in -house. General film radiology is the most common medical imaging procedure performed (150,100 exams/yr), followed by MRI (7123), ultrasound (7098), CT (4753), and mammography (4142). Also, approximately 3 million dental radiographs are taken each year.

Until recently, healthcare operations in the thirty -three institutions were confined to silos, with no central planning, management, or oversight of services. Consequently, each institution has been responsible for managing its own radiology program, resulting in widely varying methods of service delivery and operation. For example, several institutions maintain their own CT scanners, while others contract out for these services. Neighboring institutions may have contracts with different radiology medical groups at wildly different rates and levels of service. Some institutions have outdated equipment dating from the 1980's; others meanwhile have purchased new imaging devices, although they lack the expertise and equipment necessary to install them. Several prisons have purchased and installed new computed radiography imaging systems that may be mutually incompatible with one another.

The effects of the lack of central management and plann ing are not limited solely to the institutions themselves. Because the CDCR's healthcare information technology infrastructure has suffered from a decade of neglect, the current network is insufficient to support a PACS, and all digital images must be prin ted and stored as hard copies. Additionally, facilities in extremely remote California locations have had great difficulty recruiting and retaining radiology staff and identifying neighboring radiology groups that can provide timely reads of films.

To improve the quality, efficiency, and timeliness of radiology services delivered to the CDCR's patient population, the Receiver is seeking to create a statewide strategy for centralizing the oversight, management, and delivery of imaging and radiology service s. This redesign of imaging and radiology services will occur in concert with other improvements taking place throughout the prison healthcare system, including overhauls of information technology and telemedicine; consequently, we expect to have the infrastructure to support PACS and teleradiology in 2008.

III. ANTICIPATED SCOPE OF SERVICES

The Receiver is seeking a contractor to perform an operational assessment of existing CDCR imaging and radiology services and subsequently make recommendations on how to restructure the program for maximum benefit to the CDCR's healthcare mission and its patients. Specifically, the contractor will

- Provide an assessment of the current state of imaging and radiology services, including capabilities, staffing, organizational/management structure, and technical infrastructure;
- With specific reference to other institutionalized healthcare settings, including correctional systems, provide a critique of the above findings in light of currently available technology and industry best practices;
- Estimate the return on investment which can be realized from the establishment of centralized radiology operations, including staffing, capital equipment investment, implementation of information systems, purchasing of supplies, and the reading of images in-house by centralized, internal staff (as compared to outsourcing this function).
- In conjunction with CPR leadership and the *Perez* and *Coleman* court representatives, create a vision of the future state of California prison enterprise imaging and radiology services, including
    - The types of imaging services CDCR should perform in-house versus outsourcing
    - A comprehensive, enterprise-wide staffing model, from senior management on down to individual institutions
    - The feasibility of mobile CT scanners and other capital equipment
    - An approach to integrating radiology services between dental and medical
    - A strategy for implementing teleradiology, including contracting with remote providers
    - The tactical steps required to centralize all enterprise imaging and radiology operations and to transition from multiple analog film systems to a single, centralized PACS system with both a clinical archive and a separate off-site back-up archive for disaster recovery.
- Provide a road map, including estimated costs, resources required, and duration of effort, for the Receivership to restructure and modernize the CDCR's enterprise imaging and radiology program to achieve the stated vision.

In pursuit of these objectives, the contractor will be expected to

- Lead a kick-off meeting for the project in Sacramento, CA.
- Visit CDCR's headquarters in downtown Sacramento and a sample set of approximately 8 prisons, including
    - At least two prisons that have significant space constraints limiting availability of on-site capital equipment;
    - At least two prisons that currently use advanced imaging modalities on-site, such as CT scanning or ultrasound;

    - At least two prisons that have installed digital imaging equipment.
- At these facilities, assess imaging and radiology clinical workflow ; the condition and placement of imaging suites; dental radiology equipment; facility layout constraints; transport requirements for off-site imaging; timeliness , quality (as related to meeting the ACR standards for radiology reporting) and reliability of contracted radiologist evaluations; and perceived need for imaging services.
- Interview relevant CDCR personnel, including leadership and front-line clinical (medical and dental) and technical staff.
- Participate in a teleconference open to all CDCR radiology staff at all prisons intended to gather suggestions and feedback from front-line personnel and inform them of this project.
- Present interim findings and analysis no later than the fourth month of the engagement in Sacramento, CA.
- Present the final report and recommendations at a meeting in Sacramento, CA.

The successful contractor will meet the following qualifications:

- Extensive experience with imaging and radiology services in a variety of clinical settings. Experience in correctional healthcare preferred.
- Demonstrated history of success in prior enterprise-scale imaging assessment and strategic planning projects.
- Familiarity with the state of teleradiology in California, including California's regulatory environment as it affects the provision of distance medical services both within the state and beyond the state's borders.
- Familiarity with dental radiology and the need for storage and accessibility statewide.
- Familiarity with color digital dental intraoral imaging.

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 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 General Terms and Conditions and Contractor Certification Clauses set forth at: http://www.documents.dgs.ca.gov/ols/GTC-307.doc and http://www.documents.dgs.ca.gov/ols/CCC-307.doc, except that all references to the State of California or the Department of General Services will mean the California Prison Health Care Receivership Corporation.

The Agreement is anticipated to be for a period of not more than 6 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 imaging consulting 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	September 11, 2007
Deadline for questions regarding RFP	September 24, 2007
Responses to questions	September 28, 2007
Statements of Qualifications due	October 11, 2007
Notification for interviews	October 16, 2007 (estimated)
Interviews	October 24 - 26, 2007 (estimated)
Selection announced	November 19, 2007 (estimated)
Estimated project start date	December 6, 2007 (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 September 25, 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 graph ic 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 offi cer 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 cl ear 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 o ri 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 sta tute 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 o r 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 relat ionships with other vendors 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:

JUSTIN GRAHAM, MD MS
CHIEF MEDICAL INFORMATION OFFICER
1731 Technology Drive, Suite 700
San Jose, CA 95110
justin.graham@cprinc.org

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APPENDIX 7

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSALS
FOR CORRECTIONAL HEALTH RECORDS BEST PRACTICE
PROFESSIONAL SERVICES
FOR CALIFORNIA ADULT PRISON FACILITIES

September 24, 2007

PROPOSALS DUE: 2:00 p.m. October 24, 2007

CONTACT: JUSTIN GRAHAM, MD MS
CHIEF MEDICAL INFORMATION OFFICER
1731 Technology Drive, Suite 700
San Jose, CA 95110
justin.graham@cprinc.org

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SECTION

I. REQUEST

The Receiver of the California Department of Corrections and Rehabilitation's ("CDCR") prison medical system is requesting proposals for consulting services to assist the Department of Correctional Healthcare Services (DCHCS) in addressing staffing and organizational issues relating to the effective processing and management of inmate health records prior to our transition to electronic medical records . 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

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 Sill en 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" ("FFCL") 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.

The CDCR mental health and dental systems are also under court supervision as a result of two additional inmate class actions: *Coleman v. Schwarzenegger* and *Perez v. Tilton*. To avoid duplication of effort, certain health care initiatives that support the entire health care system are being coordinated by the *Plata*, *Coleman* and *Perez* courts. To facilitate such coordination, the courts have agreed that the Receiver will be responsible, in addition to his management of the medical system, for the oversight and implementation of certain mental health and dental support functions, including health information management.

While the problems identified by the courts and the Receiver reach into almost every element of the medical care system, it is without question that the health information management (HIM) system is inadequate to meet the needs of the confined adult population. The *Plata* Court has found that "[t]he medical records in most CDCR prisons are either in shambles or non-existent." FFCL, at p. 20. As stated by the Court:

> The amount of unfiled disorganized and literally unusable medical records paperwork at some prisons is staggering. At California Institution for Men (CIM), the records were kept in a 30 foot long trailer with no light except for a small hole cut into the roof and were arranged into piles without any apparent order. Conditions are similar at other prisons as well. At some prisons medical records are completely lost or are unavailable in emergency situations.
>
> At CIM, the use of temporary medical records creates a confusing and dangerous situation for practicing physicians who often have access only to little or none of a patient's history. The Court observed first-hand at CIM that doctors were forced to continually open new files on patients simply because the doctors could not get access to the permanent files. As a result, the risk of misdiagnosis, mistreatment, and at a minimum, wasted time, increase unnecessarily.

Id., at p. 21 (internal citations omitted). Simply put, "the CDCR medical records system is 'broken' and results in dangerous mistakes, delay in patient care, and severe harm." *Id.*

The court monitors in *Plata v. Schwarzenegger, Coleman v. Schwarzenegger, and Perez v. Tilton* voiced some of the following additional concerns:

- CDCR lacks a uniform and standardized health information system.
- The health records departments need better trained and more appropriate staffing.
- A uniform priority system for filing does not exist in all institutions.
- At several institutions each yard has a separate health records unit.
- Duplicative forms are filed in the health record in multiple sections.
- Loose filing is not being completed, resulting in incorrectly packaged health records and delays in treatment. In some facilities the amount of loose filing exceeds 8 feet.

CDCR appears to have no functional centralized oversight or management of health care recordkeeping in any of its 33 prisons. Medical recordkeeping, although quite variable from prison to prison, appears, in the Receiver's experience, to be problematic, with frequent anecdotes about:

- lost or missing charts;
- misfiled documentation;
- stacks of unfiled paper documents dating back months to years;
- hundreds of conflicting and redundant documentation forms that are poorly understood by clinicians

The above problems have been compounded by an increase in new forms without uniformity among the 33 prisons. For example, in response to several lawsuits filed since 1993 relating to medical, mental and dental programs, the CDCR has created or

is developing more than 30 new forms to document compliance. These new forms increase the workload of health records staff, who must ensure the documents are properly incorporated in the Unit Health Record (UHR). Additionally, there has been a dramatic increase in the pulling and filing of health records for visits and court monitor reviews. The result is a backlog in the updating of the UHRs, and a proliferation of loose documents.

Additionally, efforts to protect inmate privacy and compliance with privacy laws present additional challenges. The probability of unauthorized release of confidential inmate health information is increased by the lack of an effective system of maintenance for health records, posing a serious risk of a breach in privacy. Moreover, the above factors have concurrently affected the transfer and receipt of documents by Parole and Community Services Division and Archives. The consequences of error can be significant, with public safety impacted and the ability of CDCR to comply with federal mandates compromised.

The processing of a UHR involves many individual yet interconnected activities including record retrieval, concurrent record maintenance, transcription and filing of loose documents, and follow-up. The staff required for coding, analysis, release of information, retrieval, indexing and confidentiality must be specially trained and knowledgeable in all aspects of an efficient and standardized health records management system.

The current system of health records management, however, is not efficient and standardized according to best practice and industry standards, and the current allocation of health records staff is insufficient to meet these responsibilities and challenges. The existing health records management staff in the institutions are overwhelmed. While changes in the provision of health care have resulted in increased clinical staff, there has been no concurrent augmentation of qualified and registered health records staff.

Furthermore, CDCR is in the initial planning stages for a system -wide electronic health record (EHR) system for all inmates. If the EHR is to be implemented in a timely and efficient fashion, paper-based health records processes and clinical documentation at all CDCR facilities will first need to be standardized and streamlined.

III. ANTICIPATED SCOPE OF SERVICES

A. General Scope of Services

CDCR seeks to commission a health records management study based on best practices and standards in the industry applicable to our environment, and on-site assessments of several health records departments. The contractor will identify and propose an effective, uniform and standardized statewide paper-based health records management system, and identify staffing requirements to maintain such a system.

The contractor will identify industry standards and best practices in health records management; identify and analyze gaps between best practice and industry standards; and recommend strategies and specific actions that can be taken to fill those gaps.

The contractor will work with CDCR to develop appropriate HIM remediation plans in preparation for an eventual transition to electronic medical records. The contractor will provide a road map for the system-wide adoption of procedural and technological approaches that will streamline documentation availability and efficiency.

Because CDCR's healthcare records are multi-disciplinary, the contractor should pay particular attention to any unique healthcare records requirements of mental health, dentistry, and services for the disabled, in addition to overall medical care. The contractor should consult with CDCR's medical, dental and mental health staff as well as the *Plata*, *Coleman*, and *Perez*, and *Armstrong* court representatives.

B. Detailed Scope of Services

The contractor shall organize its analysis of HIM Services into the following dimensions:

1. Medical Record Continuity: The use of a single master medical record across the prison system, across multiple illness episodes, across various domains of care (i.e., medical, mental health, and dental) and across multiple incarcerations. (Patient indexing and medical record numbers can be a part of this analysis; however, development of an enterprise master patient index (MPI) will be the subject of a separate Receivership initiative.)

2. Filing Systems: The design of the paper chart filing systems across prison system, including the file rooms and fire and safety, warehoused and basement record system, digit filing, the use of multiple volumes, receipt and filing of orders, the results of

diagnostic testing, loose sheet filing, chart thinning, and receipt of records following an illness episode.

3. Chart Structure and Forms: The chart order, how volumes are created and numbered, forms design, and forms control with an eye for how forms can be designed to facilitate transition to an EHR.

4. Chart Retrieval and Movement: The retrieval of the charts when needed by a health care provider (including multiple volumes), the movement of charts between institutions and to parole, and the retrieval of an old medical record if an inmate has returned to the system after parole and release.

5. Chart Analysis / Chart Deficiency: The effectiveness of chart deficiency systems to insure that records are appropriately completed after an episode of care.

6. Release of Records: The types of records released, to whom, and the quality of the service.

7. Metrics: The use of metrics within the medical record areas to monitor, evaluate, and analyze department and individual performance.

8. HIM Organization and Staffing: The structure of the HIM organization at the local and head quarters levels, the number of staff, job roles and job descriptions, recruitment, training, retention, compensation, and staff productivity.

9. Information technology and HIM software: The quality and nature of information technology specific to HIM areas and processes, such as bar-coded forms, document scanning, chart locator systems, and standardized identification labels.

10. Policies and Procedures: The quality and use of policies and procedures, the extent to which policy is actually set (established), and policy issues that should be addressed and have not been.

11. HIM Leadership and Governance: The quality and nature of the HIM leadership at the local and headquarters levels, the designation of, use and effectiveness of HIM Governance Committees such as a Medical Record Committee, a Forms Committee, and a Privacy and Security Committee.

12. Administrative Climate: The relationship of the HIM Department to healthcare leadership, physicians, nursing, dentistry, mental health, and custodial staff.

13. Integrative Services: The extent to which any of the dimensions of HIM management are integrated across and among institutions and those areas that would best lend themselves to integration.

The contractor may also discuss the coding of records using ICD-9/ICD-10 and/or CPT-4 codes; however, keep in mind that very few encounters are actually subject to coding because no prison healthcare requires billing of outside providers (CDCR is the sole payer for all inmates).

Dictation and transcription is the subject of a separate CDCR consulting engagement and need not be addressed in detail by the contractor.

The contractor shall provide the following deliverables to the Receiver:

Deliverable One: Assessment of CDCR's health information management systems

The contractor shall make onsite assessments medical records processes in the following locations:

- 8 state prisons, at least two of which have Reception Centers, one of which has a licensed hospital and one of which has a Correctional Treatment Center
- The discharged offender document warehouse near Folsom, CA;
- Telemedicine headquarters in Sacramento, CA;
- One Community Correctional Facility where CDCR's health records are in active use;
- One Fire Camp where CDCR's health records are in active use ;
- One Parole Field Office where CDCR's health records are in active use;
- Any additional locations deemed necessary by CDCR to complete the assessment.

CDCR staff will work with the contractor to choose the 8 appropriate prisons and other site visit locations.

Within 2 months, a written report shall be prepared documenting the site visits, addressing the dimensions listed above. The report should give an overview of findings, patterns, and trends, and provide an unvarnished assessment of the existing system.

Deliverable Two: Regulatory Analysis and Best Practices.

By the end of the third month, the contractor shall provide identify and provide a regulatory and best practices review on each of the dimensions listed above.

The regulatory analysis, at a minimum, shall address federal regulations such as HIPAA, California healthcare regulations such as Title 22 as well as those relevant from the following California state agencies: Department of Health Services; Department of Managed Care; Department of Mental Health, and Department of Corrections and Rehabilitation. In addition, the regulatory analysis should address relevant standards (as they pertain to health records) established by accrediting agencies such as the JCAHO , the National Commission on Correctional Healthcare, and the American Correctional Association. Reference should be made to other correctional systems and the Federal Bureau of Prisons.

Best practices standards should be focused on paper-based systems and standards presented should be grounded with the type of institution from which it is derived (e.g.; other correctional system, government based public health, academic medical center, or for-profit system).

Deliverable Three: Gap Analysis.

By the end of the fourth month, the contractor shall analyze the HIM services within the California prison system on each of the dimensions listed above.

The written report shall analyze how closely the overall HIM Services conform to established regulatory and best practice standards as well as the effectiveness of each of the specific institutions visited. An executive report shall provide a high level summary of finding, trends, and patterns.

Deliverable Four: Strategies to Close the Gap.

By the end of the fifth month, the contractor shall make recommendations to close the gap between current practice of the HIM services within the California prison system and best practice on each of the dimensions listed above.

The written report shall be organized by each of the HIM Dimensions and list practical recommendations to improve each . Each recommendation , within a dimension, should detail its priority, time required to achieve, and staffing and resource support required. All recommendations should be considered in light of the future transition to a system-wide electronic

health records, and ongoing Receivership healthcare information technology projects, such as a clinical data repository that will be available in 2008.

During the course of this engagement, the contractor will be expected to

- Lead a kick-off meeting for the project in Sacramento, CA.
- Participate in a teleconference open to all CDCR health records staff at all prisons intended to gather suggestions and feedback from front -line personnel and inform them of this project.
- Present interim findings and analysis no later than the fourth month of the engagement in Sacramento, CA.
- Present the final report and recommendations at a meeting in Sacramento, CA.

C. 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 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 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 General Terms and Conditions and Contractor Certification Clauses set forth at:

http://www.documents.dgs.ca.gov/ols/GTC-307.doc and
http://www.documents.dgs.ca.gov/ols/CCC-307.doc,

except that all references to the State of California or the Department of General Services will mean the California Prison Health Care Receivership Corporation.
The Agreement is anticipated to be for a period of not more than five 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 health records management 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	September 24, 2007
Deadline for questions regarding RFP	October 12, 2007
Responses to questions	October 17, 2007
Statements of Qualifications due	October 24, 2007
Notification for interviews	October 31, 2007 (estimated)
Interviews	November 8 - 9, 2007 (estimated)
Selection announced	December 3, 2007 (estimated)
Estimated project start date	December 19, 2007 (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 October 17, 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 t o 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 comm itment 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. Proposed changes to Scope of Services: Respondent should provide any proposed modifications to the objectives, deliverables and timelines identified in this RFP.

7. 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.

8. Default Termination: A disclosure of 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

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

10. 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:

JUSTIN GRAHAM, MD MS
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