CALIFORNIA
PRISON HEALTH CARE
RECEIVERSHIP CORP.

J. Clark Kelso
Receiver

VIA ELECTRONIC MAIL

April 28, 2008

Re: Prison Law Office, Steve Fama

Dear Mr. Fama:

Thank you for your letter in response to the draft strategic plan "Achieving a Constitutional Level of Medical Care in California's Prisons." Your insight and comments are valuable, and we are grateful for your commitment to support the California Prison Health Care Receivership while developing our strategic plan. Below is a response to items addressed in your letter.

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

Adequate death reviews, as part of quality evaluation

Local prison self-audit activities, as part of quality evaluation

Quality improvement (QI) activities, including corrective action plans

Preventive Services, and Public Health Initiatives, as part of the essential elements of inmate medical services

We agree on the importance of these various domains. Some of these programs and processes are reasonably mature, however, and therefore did not warrant mention in the strategic plan. The death review process, for example, is already quite sophisticated. Another example is the new Public Health Unit, which is functioning very well. We have recruited a senior physician executive from the California Department of Public Health (CDPH), and already in 2008 we have worked with the CDPH Division of Communicable Disease Control, Office of AIDS, and State Laboratory Director, as well as local health officers, on outbreak management of influenza, methicillin-resistant staphylococcus aureus (MRSA), norovirus, varicella, and syphilis. In 2007 we developed "Guidelines for Communication and Response to a Communicable Disease Outbreak" through collaborative discussions with the California Conference of Local Health Officers (CCLHO) and CDPH Division of Communicable Disease Control.

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Please note that the strategic plan does not attempt a comprehensive or detailed description of a prison health care system. Several elements highlighted in the May and November 2007 Plans of Action did not rise to strategic importance, e.g., pain management, patient education, peer education, prenatal care and post-delivery services, palliative care, geriatrics, physical rehabilitation, traumatic brain injury, pandemic preparedness, and specialized nutrition programs. Similarly, the November 2007 Plan of Action described local prison audits, which will continue. Local prisons will continue to produce corrective action plans in response to findings of the Office of Inspector General when appropriate. This does not mean these issues are not important, they are, they just do not rise to a "strategic" level.

Quality measurement, evaluation, and patient safety programs are referenced in Goal 4, and the Access-to-Care Initiative plan offers more detail regarding quality improvement initiatives.

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

We agree that policies and procedures are essential to any health care organization. Furthermore, as described in the Access-to-Care Initiative, we are discomfited by the lack of a CDCR Policy Unit, which we will indeed resurrect. Finally, we recognize the enormous effort that went into creating the original *Plata* Policies and Procedures, which continue to be in place.

Having said that, it is obvious from recent CDCR experience that policies and procedures do not drive system change. The high-level strategic plans of health care systems do not generally include a major focus on compliance with internal policies and procedures. Patient-centered goals rather than compliance-centered goals help motivate and organize the change processes necessary for improvements in outcomes.

The Access-to-Care Initiative (attached) will commence a multi-faceted program for compliance with Plata policy and procedures. The program's success will be measured by the Office of Inspector General prison inspection process. The initiative will also provide a focus on policy and procedure and forms revision necessary to bring primary and specialty care up-to-date in preparation for implementation of health information technology and the new health care facilities. In some cases, practice improvements have already preceded policy revision. The provisions of the CDCR Preventive Services policy, for example, are incomplete or out-of-date. The new Public Health Unit, however, has already made significant progress, however, in implementing an acceptable influenza vaccination program.

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

Please see the Access-to-Care Initiative.

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

Please see the Access-to-Care Initiative. We will also be discussing "metrics" on May 3, 2008.

Your comments proved to be very helpful and supportive. We look forward to working collaboratively with you in the future.

Sincerely,

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