California Prison Health Care Receivership Corporation

(CPR, Inc.)

Prison Medical Care System Reform

Plan of Action

November 2007

Revision 11/15/07

Introduction

INRODUCTION TO THE RECEIVER'S NOVEMBER 15, 2007 PLAN OF ACTION

A. Overview of the November 15, 2007 Iteration of the Receiver's Plan of Action

The Receiver's November 15, 2007 Plan of Action (POA) submission is comprised of six components: (1) Introduction; (2) Executive Summary of the Receiver's Initiatives for November 15, 2007 through November 15, 2010; (3) two charts setting forth Initiative objectives that are expected to be piloted or achieved within 6 months, 12 months, 24 months and 36 months; (4) the modified POA; (5) narratives concerning each of the Receiver's 22 Initiatives, including text indicating those objectives that are expected to be piloted or achieved within 6 months, 12 months, 24 months and 36 months; and (6) an Appendix of documents relevant to the Initiatives.

In May 2007, the Receiver submitted his first POA, an initial roadmap for the change necessary to bring the delivery of medical care in California's prisons up to Constitutional levels. That initial POA, drawing upon established conceptual frameworks articulated by the Institute of Medicine and the Malcolm Baldrige National Quality Program, identified seven primary goals and roughly 200 corresponding objectives, as well as setting forth a number of Receivership priorities for the near future.

The Receiver continued to inform the Court about the status of his priorities in the Quarterly Reports. As promised by the Receiver, this second iteration of the POA provides far more specific information about implementation of the POA, focusing attention upon his key priorities, which are presented to the Court in the form of 22 Initiatives. For each such Initiative, background information is provided (including, in many cases, reference to the Court's Findings of Fact and Conclusion of Law re Appointment of Receiver filed October 3, 2005), the current status of the Initiative is explained, an explanation is provided concerning Initiative objectives for 6 months, 12 months, 24 months and 36 months intervals, and relevant metrics relating to the Initiative are established (if possible). Each narrative concludes with an explanation of the potential barriers to successful implementation.

B. The Receiver's Thirty-Six Month Initiatives

The Initiatives are set forth below. The Receiver, working in conjunction with his staff, with CDCR medical providers, and with the consultants he has retained, selected the Initiatives based on two maxims: "Crawl, walk, run" and "First things first." Each Initiative has broad systemic impact, and many relate to one another as precursors to future systemic change. Each of these Initiatives will require extraordinary efforts to implement in a timely and effective manner.

1. Clinical Initiatives
   a. Medical Staff Professional Development (POA Objective A.7)
   b. Nursing Executive Leadership Initiative (POA Objective A.7)
   c. Healthcare Orientation, Nursing Preceptor Program, and Provider Proctoring Program (POA Objective A.8.1 and A.8.5)
   d. Nursing Medication Delivery Process Redesign (POA Objective B.8)

e. Asthma Initiative (POA Objective B.3.1)
f. Emergency Response Initiative (POA Objective B.1.1)

2. Clinical Operations Initiatives
   a. Clinical Quality Measurement and Evaluation Initiative (POA Objective C.2, C.6 and C.8)
   b. Clinical Support Services Initiative (POA Objective B.12)

3. Construction Initiatives
   a. San Quentin Construction Initiative (POA Objective F.2)
   b. 5,000 Prison Medical Bed Construction Initiative (POA Objective F.3)
   c. Facility Improvement Construction Initiative (POA Objective F.1)

4. Custody Access Initiative (POA Goal E)

5. Administrative Initiatives
   a. Out-of-State, Community Correctional Facilities, and Re-entry Oversight Initiative
   b. Contract and Invoice Processing Initiative (POA Objective A.4 and A.6)
   c. Fiscal Services Initiative (POA Objective A.2.4 and A.2.5)
   d. Personnel Services Initiative (POA Objectives A.7, A.8, and A.8.5.3)
   e. Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative (POA Objective C.3)

6. Information Technology Initiative (POA Goal D)

7. Maxor Pharmacy Services Initiative (POA Goal B.8)

8. Pilot Project Initiatives
   a. San Quentin Project Initiative (POA Objective B.2)
   b. Specialty Services Pilot at California State Prison – Los Angeles County and California Correctional Institution (POA B.2 and B.3)

9. Class Action Coordination Initiative

As stated above, the Receiver has continued to inform the Court of his priorities in his Quarterly Reports. Note the following: in the list of 36-month priorities outlined in the Sixth Quarterly Report (*see* Sixth Quarterly Report at 6:9 – 9:27), the following initiatives were organized under other initiatives:

1. Restructuring of the credentialing process is included in the Clinical Quality Measurement and Evaluation Initiative (*see* page 8 of the Sixth Quarterly Report; previously listed as item 9).

2. The pilot project for joint clinical/internal affairs investigations is included in the Clinical Quality Measurement and Evaluation Initiative (*see* page 8 of the Sixth Quarterly Report; previously listed as item 10).

3. Implementation of a clinical peer review-based program to evaluate clinical competency is encompassed in the Clinical Quality Measurement and Evaluation Initiative (*see* page 8 of the Receiver's Sixth Quarterly Report; previously listed as item 12).

4. Establishment of an Office of Evaluation, Measurement and Compliance is encompassed in the Clinical Quality Measurement and Evaluation Initiative (*see* page 9 of the Sixth Quarterly Report; previously listed as item 16).

One new Initiative was not included in the Sixth Quarterly Report but has been added: Creation of a Clinical Support Services Unit within the Plata Support Division to manage statewide radiology services, clinical laboratory services, telemedicine service, and a health information management system. *See* Clinical Operations Initiative.

C. Conceptual Basis for the Receiver's November 15, 2007 Iteration of his Plan of Action

The conceptual basis for this iteration of the POA remains the same as that set forth in May 2007. The overall goals of a constitutionally-adequate prison medical care system are to reduce unnecessary morbidity and mortality, improve inmates' health status and functioning, coordinate care with mental health and dental, and protect public health. The Receiver must create a sustainable, evidence-based, cost-effective system of care that is continually monitored and revised to meet those overall goals.

Two sources of guidance have been particularly useful in framing this plan, the Institute of Medicine and the Malcolm Baldrige National Quality Program, both of which support healthcare's increasing emphasis on safety and high reliability.

Institute of Medicine

The conceptual basis for the Receiver's Plan of Action draws heavily from the experience of free-world, mainstream initiatives launched to move American health care from fragmentation and error to safety and reliability. The Institute of Medicine (IOM), a component of the National Academy of Sciences created in 1970 to provide unbiased evaluations of American health care, has documented many of these advances. In response to the quality crisis within mainstream American health care, the IOM has promulgated a widely-accepted conceptual framework[1] that applies within corrections as well. According to the IOM, personal health care in any setting should be safe, effective, patient-centered, timely, efficient, and equitable. To achieve these goals, the IOM recommends six essential organizational supports for change:

1. Redesign of care processes based on best practices.
2. Information technologies for clinical information and decision support.
3. Knowledge and skills management.
4. Development of effective teams.

[1] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press; 2001.

5. Coordination of care across patient conditions, services and settings over time.
6. Incorporation of performance and outcome measurements for improvement and accountability.

The IOM has demonstrated that these strategies will transform medical care delivery systems. In the 1990s, for example, the Veterans Health Administration used integrated, system-level strategies to move from a culture of low expectations to performance far exceeding the national average. Isolated interventions, such as educating or even replacing groups of physicians or nurses, would not have yielded the same progress.

The IOM's formulation of goals and strategies is reflected in the Plan of Action. The opening sentence of the 2001 IOM report resonates with California's prison medical care crisis: "The American health care delivery system is in need of fundamental change." It is important to remember, however, that the systems described as "dysfunctional" by the IOM have been vastly superior to California's prison medical care system. It is one thing to lack an electronic health record; it is another to try running a patient scheduling system on hundreds of unconnected, unsupported desktop computers by having staff hand-carry data drives from one computer to another in sequence. It is one thing to bemoan a lack of teamwork among clinicians; it is another to work in a system that has traditionally hired any physician with "a license, a pulse, and a pair of shoes," as described in the Court's February 14, 2006 "Order Appointing Receiver." Even worse, some clinicians of that caliber managed to migrate into positions of local leadership. Because of the abject levels of dysfunction and chaos in hiring, review, promotion, and discipline, for example, the Receiver's team has spent countless hours on personnel issues, working to establish the infrastructure required for the most basic of quality initiatives.

Baldrige Systems Framework

The Malcolm Baldrige National Quality Program was created by Congress in 1987 and is administered by the federal National Institute for Science and Technology. The seven categories of the Baldrige Health Care Criteria for Performance Excellence[2] complement the IOM framework, providing an organizational foundation for the Plan of Action:

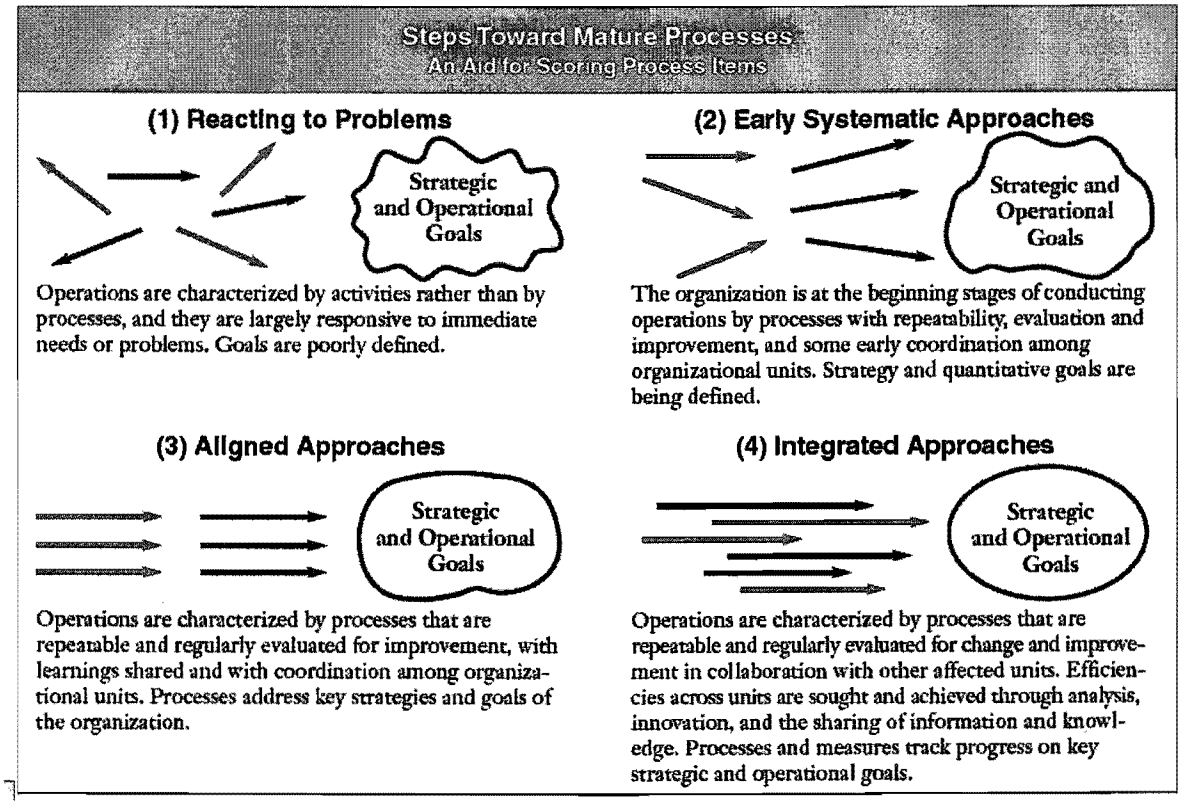
1. Leadership
2. Strategic planning
3. Focus on patients and other customers
4. Measurement, analysis, and knowledge management
5. Workforce focus
6. Process management
7. Results

The Baldrige framework highlights the leadership and personnel dimensions that have captured so much of the Receiver's attention. The November Plan of Action includes multiple initiatives regarding recruitment, hiring, orientation, professional development, and executive leadership. A motion to reform the physician disciplinary process while preserving physicians'

[2] Baldrige National Quality Program. *Health Care Criteria for Performance Excellence*, 2007.

due process rights is pending before the Court. In addition, the Receiver has begun to identify, within existing staff and new recruits, the transformational leaders who can focus the system on new goals and strategies.

The Baldrige framework also highlights the importance of moving from crisis management to alignment and integration of core operations, shown diagrammatically below. Alignment requires "a common understanding of purposes and goals." Plans, processes, information, resource decisions, actions, results, and analyses should all support those goals. "Integration goes beyond alignment and is achieved when the individual components of a performance management system operate as a fully interconnected unit."



Contributing to crisis management in CDCR healthcare are its geographic scatter and quasi-autonomous institutions; its subordination to custody; its silo divisions into medical, mental health, and dental; its vulnerability to political machinations; and its chronically impoverished infrastructure and leadership, all rendering it unable to plan and follow through. The Receiver has begun to address these inherited dysfunctions and to serve a central coordination role among the involved Courts.

High Reliability

The right people and systems must be in place to ensure that inmates get the right care in the right place at the right time. Change must be both top-down and bottom-up, with a focus on staff engagement and empowerment and a relentless emphasis on training and communication. The infrastructure must support innovation among front-line clinicians, must facilitate innovations from the "outside" world, and must be able to disseminate evidence-based practices. Responses to error and bad outcomes must move from finger-pointing to an honest, comprehensive critique that includes analysis of individual human factors as well as team factors, communication, and organizational effectiveness.

The interdependence of medical care and custody presents opportunities as well as challenges. Reliability—ensuring that the right thing happens every time—is a goal of custody just as it is within medical care. Some organizations in the military, law enforcement, and emergency services have achieved remarkable improvements in reliability by developing a strong safety culture, utilizing personnel and equipment back-up systems, promoting inter- and intra-group communication, cross-training personnel, and focusing attention on errors and near-misses without wrongfully blaming or absolving individuals. The CDCR already partners with one such organization, the California Department of Forestry and Fire Protection, in its successful inmate firefighting program. Achieving reliable prison medical care in California will depend upon new levels of collaboration and respect between medical care and custody. Developing shared language and practices for reliability and safety will hasten this collaboration.

D. The Practicalities of Prison Health Care Remediation

Most of Initiatives can be divided into three general categories of remedial activity: (1) establishing the necessary infrastructure for constitutionally adequate prison medical care (*see e.g.*, the Contract and Invoice Processing Initiative, the Personnel Initiative, the Information Technology Initiative, etc.); (2) providing direct improvement to clinicians in the trenches (*see e.g.*, the six Clinical Initiatives and the Maxor Initiative); and (3) running the day-to-day CDCR medical services operations (*see* e.g., the Out-of-State, Community Correctional Facilities, and Re-entry Oversight Initiative and the Class Action Coordination Initiative). A few, however, function to create change in more than one category.

To achieve long-term sustainable reform of the CDCR medical delivery system and thereafter return medical to the State, all three categories of remedial action are necessary. Far too often false visions of the Receivership lead to unreasonable expectations, and demands for remediation which are excessive and hence, unachievable. When evaluating the revised POA and the Receiver's 22 Initiatives, it may be helpful to consider the five common fallacies of prison remediation. And at all times, the final objective of the long-term, sustainable change sought by the Receivership must be kept in mind: return to the State a constitutional prison medical delivery system.

1. "It's simple." No, it's not. For just one example of the complexity of remedial plan development, review carefully the Information Technology Initiative.

2. "We know what's wrong." No, you don't. No one disputes the fact that the end result of the CDCR's medical delivery system is unconstitutional care. However, the underlying cause of this unconstitutional care has proven to be, almost always, far more serious, interconnected, and broken that previously assumed by the CDCR, the Court experts, and counsel. Take, for example, the CDCR's failure to deliver inadequate specialty care. This essential service requires the following: (1) a system that allows prisoner/patients the opportunity to be scheduled for timely sick call regardless of their classification; (2) adequate sick call screening by a competent nurse following appropriate policies and procedures; (3) the appropriate referral to a primary care provider (PCP) (mid-level or physician) through some form of adequate referral system; (4) access, in a timely manner, to a patient's medical record that is organized in a professional manner; (5) an adequate evaluation by a competent primary care provider; (6) an adequate, timely program to review specialty care referrals and to approve valid referrals to the necessary specialist; (7) a system to schedule and track either an in-prison or out-of-prison specialty referral; (8) an adequate contract with a competent specialty provider, regardless of the geographical isolation of the prison; (9) a system to manage specialty provider contracts to ensure adequate statewide specialty coverage, the appropriate compensation to attract specialists, and (10) a system to pay the invoices of specialty providers in a timely manner; (11) a system to escort/transport the patient from his/her cell to either an in-prison specialty care area (space permitting) or to an out-of-prison specialty provider (perhaps 100 miles away); (12) an adequate number of trained correctional officers to effectuate timely medical transportation duties; (13) vehicles for medical transportation services and vehicles to provide the appropriate security escorts for high-security prisoner/patients; (14) a timely system to receive and evaluate the specialist's report; (15) a system to place that report, and thereafter maintain it in a designated section of the patient's medical record; (16) a system to schedule and track the follow-up care and/or tests ordered by the specialist; (17) a system and the competent clinical staffing to review the specialist's recommendation and thereafter effectuate a treatment plan. In some prisons every one of these requirements is inadequate, in other prisons some are adequate and some are not. Concerning certain requirements—for example scheduling and tracking systems, medical records, and correctional officer support staffing—deficiencies exist at every CDCR prison. At present there is not, for example, an adequate medical scheduling and tracking system within the CDCR. Therefore, to fix specialty care, the Receiver must fix a multitude of in-prison clinical problems and, at the same time, establish the necessary information technology, clinical support services, contracts, invoice payment, and transportation infrastructure to effectuate and manage this critical remedial program.

3. "The Receiver can do whatever he wants." No, he can't. The Court created the extraordinary remedy of a Receivership but, at the same time, carefully crafted the Order of February 14, 2006 to ensure compliance with appropriate principles of Federalism. Many of the steps that have proven necessary to bring medical services in California's prisons up to constitutional minima, such as salary increases for clinicians, realistic and effective peer review processes, effective contract procurement, cost effective pharmacy services, and timely, cost effective prison

medical bed construction, have required that the Receiver return to the Court to seek waivers of State law. These processes take time. While the Receiver has extraordinary powers, prison remedial work under the Receiver still requires diligence, cooperation, and sound communication from the State, the CDCR, and counsel.

4. "Change will be much faster under the Receivership" Sometime yes, sometimes no. The Receiver can—and he has—established remedial programs, hired clinical staff, implemented policies, and begun to create the infrastructure necessary for constitutional medical care much faster than the State ever could. Indeed, without the Receiver, many recent and successful programs would neither have been implemented, nor would they be functioning effectively. However, some of the systemic causes of the unconstitutional delivery of medical care, for example, the State's trained incompetence and the CDCR's destructive culture, have proven far less tractable to timely change—no matter how many orders are issued. Changing mindsets and modifying deeply entrenched bureaucratic incompetence and the ingrained CDCR disdain for prisoners will occur more slowly—through the influence caring clinicians, a sound infrastructure, and proven remedial plan success.

And operating day-to-day medical requires far more than simply "brainstorming". It requires directing clinical and support personnel.Straightening out dysfunctional .business and financial systems It also calls for responding to emergencies, a daily occurrence in CDCR. As well it requires responding to new political, administrative and legislative initiatives promulgated by State government.

5. "All the Receiver has to do is to fix things." Not true. Given the absolute disarray of the CDCR, the Receiver and his staff decided, in December 2006, that they also had to manage the day-to-day medical care operation within all of California's prisons, as well as the CDCR medical services central office. And operating day-to-day medical care requires far more than simply providing oversight to clinical personnel. It also requires overhauling dysfunctional business and financial systems. It requires responding to emergencies, a daily occurrence in CDCR. As well, it requires responding to new political, administrative and legislative initiatives promulgated by State government. In many ways, the status of the Receivership is akin to a sailor in a rowboat during a typhoon, steering the rudder with one arm while bailing-out the boat with the other. Responsible for day-to-day medical operations, the Receiver must also carefully coordinate *Plata* remedial Initiatives with *Armstrong*, *Coleman*, and *Perez*, and at the same time deal with custody decisions that have a direct, often negative impact on prisoner medical care, such as out of state transfers, conversion of prison missions, and expansion of community programs, etc. The Receiver is not just fixing the system, he's literally running it while remedies are developed and implemented.

E. A Word on Metrics

As can be seen by the detail provided in the Initiative narratives, the Receiver has taken very seriously the Court's instructions concerning timelines and metrics. The *American*

Heritage Dictionary defines *metric* as "a standard of measurement." *Stedman's Medical Dictionary* defines metrics as "the application of statistics and mathematical analysis to a field of study—biometrics." *Black's Law Dictionary* does not define *metrics*. The Baldrige National Quality Program, on the other hand, defines "measures and indicators" as: "numerical information that quantifies input, output, and performance dimensions of process, programs, projects, services, and the overall organization (outcomes)." There is may be useful to clarify that in the context of the remedial process, the Receiver is measuring his remedial progress by using a number of different, although interrelated, metrics – including the following:

1. Court-Mandated Metrics: The Stipulated Injunctions in this case call for the development and implementation of policies and procedures concerning the delivery of prison medical care. For certain services, standards are required (for example, patients who need to access sick call should do so under time standards which vary according to acuity, and patients with chronic diseases should be seen by a PCP within established time periods, etc.). The Court-mandated metrics, many of which can be characterized as "access-to-care" metrics, will be measured by the Inspector General's prison program that will objectively measure the basics of *Plata* remedial plan compliance at no less than six pilot prisons (as proposed by the Receiver in May 2007).

2. Time-Based Metrics Concerning the Implementation of Receiver Remedial Programs: The Receiver has established time frames for each Initiative in six month, 12 month, 24 month, and 36 month intervals. A chart is attached which illustrate these metrics. Progress will be reported in the Quarterly Reports. Successes and failures to meet these objectives will be public information.

   The Receiver, however, does not believe that it is appropriate to limit his establishment of metrics to those mandated by the Court. In fact, the Receiver has concluded that the limited "access-to-care" metrics of *Plata*, while useful to measure certain end results, were not, in themselves, adequate to determine if an infrastructure existed to support the access-to-care mandates. Therefore, in order to effectuate timely and sustainable change, the Receiver has also begun to implement two additional forms of metrics: administrative performance measures and clinical quality measures.

3. Infrastructure / Administrative Performance Metrics: Now that Receivership has initiated enhancements to the administrative infrastructure, he has also established measurements of the "bottom line" success of the infrastructure. For example, the metric to measure the success of clinical hiring (a process which includes establishing appropriate salaries, recruitment, and hiring itself) is established as a less than 10 percent vacancy rate of full time permanent State employees for physicians, mid-level providers, registered nurses, and licensed vocational nurses by December 2008. As set forth in the Initiatives, certain infrastructure functions are developed to the point where specific performance measures are appropriate now, while others, still developing, will implement performance measures in the future. Without question, however, bottom-line performance measures for infrastructure services will be a Receivership requirement.

4. Clinical Quality Measures: Perhaps the most important set of metrics, however, are those which will evaluate the quality of care delivered to prisoner/patients. This form of metric, not contemplated by the original *Plata* stipulations—but absolutely necessary for remedial plan success—will include information concerning health care outcomes; epidemiological data and population-based health outcomes; practice guidelines; administrative, workforce, cost, and financial performance; benchmark comparisons; patient satisfaction; and compliance with Court orders.

To summarize, the Receivership will, in the 36 months ahead, implement and establish programs to comply with at least four distinct sets of metrics. During this period it is important that all stakeholders in the Plata remedial process understand the importance of *both* Court-mandated metrics and those additional performance and quality-based metrics without which long-term sustainable reform will not be possible.

Executive Summary of November 15, 2007 Initiatives

RECEIVER NOVEMBER 2007 – NOVEMBER 2010 INITIATIVES
EXECUTIVE SUMMARY

INTRODUCTION

The November 2007 iteration of the Receiver's Plan of Action focuses on 22 Initiatives, each of wide-ranging importance and impact. Each Initiative is described by a narrative that includes background information, current status, objectives for the next six months, 12 months, 24 months and 36 months, relevant metrics, and potential barriers. The Initiatives are summarized below:

INITIATIVES

1. Clinical Initiatives
    a. *Medical Staff Professional Development* (POA Objective A.7)

Implement a program to attract and retain excellent physicians, nurse practitioners, and physician assistants through the following strategies: assisting providers in maintaining and improving their clinical acumen with educational programs and support; offering targeted remedial opportunities for providers with remedial deficiencies; developing medical staff and interdisciplinary committees consistent with professional standards; developing a frontline cadre of managerial staff with quality improvement and leadership competencies; and establishing expectations and processes in the prisons in support of professionalism and ethical behavior.

b. *Nursing Executive Leadership Initiative* (POA Objective A.7)

Establish a cadre of nurse executives through the Receiver's Career Executive Assignment program. Implement a three-prong support program: (1) effective recruitment and the establishment of relevant minimum job requirements; (2) defining roles and responsibilities and providing necessary assistance to meet those objectives; and (3) developing effective reporting mechanisms.

c. *Healthcare Orientation, Nursing Preceptor Program, and Provider Proctoring Program* (POA Objective A.8.1 and A.8.5)

Implement a clinically-based nurse (licensed vocational nurse and registered nurse); physician, and mid-level provider orientation program at five prison pilot sites consisting of formal orientation programs, nurse preceptor program, and provider proctoring program.

d. *Nursing Medication Delivery Process Redesign* (POA Objective B.8)

Redesign the prison medical delivery process to ensure patient-centered, common formulary, standardized, quality medication delivery in conjunction with the roll-out of the Maxor GuardianRx pharmacy system.

e. *Asthma Initiative* (POA Objective B.3.1)

Institute a pilot program to eliminate this common cause of preventable deaths within the CDCR, engaging six strategies of organizational change : (1) redesign of care practices based on best practices ; (2) use of information technology to support care givers ; (3) increasing clinical skills ; (4) developing team-based medical delivery systems ; (5) coordination of care ; and (6) incorporation of performance and outcome measures for tracking improvement and accountability.

f. *Emergency Response Initiative* (POA Objective B.1.1)

Improve emergency medical care within prisons, improve patient clinical outcome, and thereby decrease unexpected death due to lack of EMS care by establishing pilot projects to implement the Receiver,s approved statewide Emergency Medical Response System policy. This process will include training of staff, developing mechanisms to improve local preparedness, conducting assessments of emergency equipment, space, vehicles, staffing matrixes, developing accurate data concerning emergency responses, and the creation of prison-specific Emergency Response Review Committees.

2. Clinical Operations Initiatives

a. *Clinical Quality Measurement and Evaluation Initiative* (POA Objective C.2, C.6 and C.8)

Establish a new administrative unit of CDCR employees (who report to the Receiver) to develop and implement necessary clinical measurement and evaluation standards (clinical metrics). In addition, the unit will manage the Receiver's quality-based programs including CDCR healthcare credentialing and privileging unit, headquarters-based peer review (Professional Practice Executive Committee), death reviews, and the new Medical Oversight Unit (a collaborative pilot project to improve clinical investigations involving the Office of the Receiver, CDCR Internal Affairs, CDCR Legal Affairs, and the Office of the Inspector General).

b. *Clinical Support Services Initiative* (POA Objective B.12)

Establish a new administrative unit of CDCR employees (who report to the Receiver) to manage the Receiver's enhanced programs for radiology, medical records, laboratory services, pharmacy, and telemedicine.

3. Construction Initiatives

a. *San Quentin Construction Initiative* (POA Objective F.2)

Continue a number of essential construction projects currently underway at San Quentin State Prison, including establishing new, improved sick call units in facility rotundas, building a

temporary medical building to provide needed clinical offices and space, constructing a medical supply warehouse, and constructing the San Quentin Central Health Services Facility, a state of the art correctional health care center which serves the needs of four Federal Court class actions: *Armstrong*, *Coleman*, *Plata*, and *Perez*.

b. *5,000 Prison Medical Bed Construction Initiative* (POA Objective F.3)

Coordinate and lead a program to construct up to 5000 medical beds and up to 5000 mental health beds, utilizing carefully prepared patient demographic reports to establish the number and acuity levels of the beds needed. Working with a previously selected construction management firm, implement seven pre-construction strategies over the course of the next six months with the objective of commencing construction between April – June 2008: (1) site assessment and selection; (2) CEQA review and evaluation; (3) infrastructure review and development of remediation plans; (4) facility planning (a process which includes representatives from the other class actions); (5) program delivery; (6) obtaining funding; (7) development of an overall Project Management Plan.

c. *Facility Improvement Construction Initiative* (POA Objective F.1)

Provide desperately needed clinical space and clinical support space in existing California prisons, utilizing a carefully developed, coordinated (with other Federal Court class actions and AB 900 planning) formal space evaluation process. Facility improvement planning has been completed at Avenal State Prison and the Correctional Treatment Facility, and has begun at the California Rehabilitation Center. The evaluation/formal planning process will be completed at 15 prisons within 12 months, with an additional 13 prisons completed by December 2009. Construction will proceed according to an aggressive, formalized schedule subject to availability of funding.

4. Custody Access Initiative (POA Goal E)

Perform carefully designed formal health delivery oriented custody operational reviews at every California prison in order to establish the necessary correctional officer posts to provide adequate, timely prisoner/patient access to health care services. An initial review will be followed-up by a second evaluation relating in part to the Facility Improvement Construction Initiative, and eventually, pursuant to a time-phased schedule, the establishment of formal (and cost effective) health care Custody Access Teams at each prison.

5. Administrative Initiatives

a. Out-of-State, Community Correctional Facilities, and Re-entry Facility Oversight Initiative

Commence operation of a new administrative unit which will: (1) establish clinical standards and health care staffing standards for Out-of-State, Community Correctional Facilities, and Re-entry Facilities, manage necessary Out-of-State, Community Correctional Facilities, and Re-entry Facilities contract modifications to ensure compliance with the remedial orders of the

Federal Court health care class actions, establish and implement an Out-of-State, Community Correctional Facilities, and Re-entry Facilities inspection protocol and schedule; and (2) serve as an interface between the Office of the Receiver and the Inspector Generals' pilot *Plata* compliance prison inspection process, participating in the inspections as necessary.

b. *Contract and Invoice Processing Initiative* (POA Objective A.4 and A.6)

Roll out to 33 prisons the new Health Care Document Management System (HCDMS), providing phase one of an Information Technology solution to CDCR contract unit's chronic problems with timely procurement and invoice processing. Centralize, as part of the roll out process, invoice review and payment functions. Process, under HCDMS, 90% of bid contracts within 60 days. Process, under HCDMS, 98% of contract invoices within 30 days. Working with a retained consultant, enter into timely, cost effective agreements with hospitals who serve prisoner/patients, and provide training for contract personnel concerning hospital negotiations and contract processes. Secure a consultant review concerning the entire CDCR health care contracting process with the objective of developing a plan for a Statewide network of hospitals and specialty providers to serve all CDCR prisoner/patients.

c. *Fiscal Services Initiative* (POA Objective A.2.4 and A.2.5)

Develop and implement a Fiscal Management Section within the Plata Support Division to establish the necessary fiscal support infrastructure for the Receiver's medical care operation, both in the Central Office and in the prisons. Prepare budget related documents for the Department of Finance as necessary. Provide timely and accurate budget information to the Receiver and his staff to effectuate a more efficient and cost effective health care operation at all levels. Monitor and participate in the CDCR's implementation of the Business Information System (BIS).

d. *Personnel Services Initiative* (POA Objectives A.7, A.8, and A.8.5.3)

Create the necessary infrastructure, at Central Office and in the field, recruitment programs and expedited hiring practices to reduce the full-time, permanent, State employed clinical vacancies (Physicians, Mid-Level Provider, Registered Nurse, and Licensed Vocational Nurses) to less than 10% by December 2008. Also establish, within 6 months, the following programs: a program for recruiting and hiring of Receiver Career Executive Assignment personnel for key CDCR clinical leadership positions (and executive health care management positions at three pilot institutions); an appropriate credentialing tracking system; and a functioning employee discipline unit to provide manager education and "hands on" assistance concerning employee discipline matters.

e. *Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative* (POA Objective C.3)

Centralize the controls and management over all CDCR health care prisoner/patient Appeals, Correspondence Control, and Habeas Corpus Petition responses, and include in this process a pilot project to utilize clinical personnel to evaluate/screen certain cases. Implement

timely changes to the existing appeal system as it pertains to the initial receipt of appeals and "third level" appeal responses. Develop and provide recommendations to the Receiver a long term, sustainable and improved system for a new appeal process within 6 months.

6. Information Technology Initiative (POA Goal D)

Establish a wide area network connection at all 33 CDCR prisons within six months. Install a local area wireless network within a selected number of pilot prisons within six months. Establish a data center, and thereafter a data repository, and the necessary clinical portal (a web based browser that will allow access by staff into the repository), all within 12 months. Utilize the recently established Health Care Information Technology Executive Committee (HITECH) to formulate recommendations concerning software and those applications which should assume priority for implementation.

7. Maxor Pharmacy Services Initiative (POA Goal B.8)

Continue the Maxor roadmap for change in the CDCR's pharmacy program, including the time-phased roll-out of the GuardianRx pharmacy system, developing and establishing revised policies, procedures and practices within the prison pharmacies, planning for and establishing a central fill pharmacy building, and continuing the implementation of existing Receivership/Maxor programs to manage CDCR pharmacy purchasing contracts.

8. Pilot Project Initiatives

a. *San Quentin Project Initiative* (POA Objective B.2)

Continue the San Quentin Pilot, including the development of improved nursing and administrative initiatives, the implementation of the enhanced , coordinated Reception Center process, and the construction of new clinical facilities at San Quentin as described above.

b. *Specialty Services Pilot at California State Prison – Los Angeles County and California Correctional Institution* (POA B.2 and B.3)

Continue the development of pilot programs at two prisons to provide enhanced prisoner/patient specialty services, focusing on improved contract procurement with specialty providers, more timely specialty provider invoice processing, improved specialty services scheduling and tracking, establishing additional controls and better responses to patient "refusals," and providing additional clinicians, correctional officers, and transport/escort vehicles to effectuate more timely out-of-prison specialty care delivery.

9. Class Action Coordination Initiative

Continue monthly meetings with the Court representatives (and quarterly meetings with the District Court Judges) overseeing the four Federal Court class action cases currently pending: *Armstrong* (Americans with Disabilities Act); *Coleman* (mental health); *Plata* (medical), and *Perez* (dental) to ensure coordinated and cost effective systemic remedial action, and to establish

various "coordination agreements" whereby the District Court Judges agree that the Receiver in *Plata* will take a leadership role when developing and implementing selected remedial programs which impact on all four class actions.

Chart of Initiatives

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
MEDICAL STAFF PROFESSIONAL DEVELOPMENT				
Develop a continuing medical education (CME) committee	◆			
Place a set of medical textbooks in clinic areas of each prison.	◆			
Make the CDCR Drug Formulary available for download to PDAs in partnership with ePocrates.	◆			
Develop CME programs held at local/regional sites and/or via distance learning		◆		
Develop need-based CME options to address specific provider deficiencies noted on assessments and quality reviews.		◆		
Improve access to health information and educational resources at all points of care delivery.		◆		
Develop medical library resources and staff		◆		
Develop a medical leadership curriculum and multimodal deployment strategies in partnership with University of California.		◆		
Collaborate with UC to establish specialized training programs using CDCR staff as clinical preceptors to residents and students (medical, NP, PA).			◆	
Collaborate with UC to establish academic appointments for CDCR clinicians.			◆	
Win accreditation for CDCR as a CME provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education.				◆
NURSING EXECUTIVE LEADERSHIP				
Obtain approval for new salaries from DPA or obtain waiver from Court.	◆			
Begin hiring Nurse Executives.	◆			
Assign a mentor to each new pilot position.	◆			
Hire external evaluator with organizational development and human resources.	◆			
Repeat SPB and DPA process for Physician Executives and begin hiring.	◆			
Repeat SPB and DPA process for Administrators and begin hiring.	◆			
Complete evaluation.		◆		
Create a pool of limited-term positions in order to populate local, regional, and statewide leadership positions with qualified, responsive leaders.			◆	

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
HEALTHCARE ORIENTATION AND PRECEPTOR / PROCTORING				
Design a training approach and mechanism for communication and tracking that will meet the needs of the Health Care Services Division, Employee, IPO, and IST Manager.	◆			
Begin the pilot Healthcare Orientation and Preceptor / Proctoring Initiative at five prisons.	◆			
Complete the pilot Healthcare Orientation and Preceptor / Proctoring Initiative at five prisons and revise curriculum based on evaluation results.		◆		
Implement statewide Healthcare Orientation and Preceptor / Proctoring.			◆	
Standardize orientation, training, and professional development programs through the prison health care system for employees of all levels.			◆	
Develop a human resources program focused on providing patient-centered health care services based on industry standards.				◆
NURSING MEDICATION DELIVERY PROCESS REDESIGN				
Implement GuardianRx System Go-Live in the pharmacy (not in nursing) at MCSP, CMC, SAC, COR, SATF	◆			
Implement GuardianRx System in all nursing medication delivery areas using the CPR healthcare network at MCSP	◆			
Implement GuardianRx System Go-Live in the pharmacy (not in nursing) at HDSP and CCC		◆		
Extend Medication Delivery Initiative to pharmacy in all 33 prisons.		◆		
Extend Medication Delivery Initiative to nursing medication delivery areas in all 33 prisons.			◆	
ASTHMA				
Engage contractor team.	◆			
Begin Asthma Initiative and finalize initial change package for practice redesign, clinical guidelines, policies, documentation tools, and staff education resources.	◆			
Develop culturally and linguistically appropriate education resources and collaborate with CDCR on appropriate peer education programs for patients with asthma.		◆		
Develop a chronic care team model appropriate for corrections, delineating roles, responsibilities, and measures of team function in the asthma context.		◆		
Pilot an implementation plan for a quality measures, disease registry, care coordination, and case management for patients with asthma.		◆		
Implement lessons learned in all 33 prisons.			◆	
Complete evaluation of the Asthma Initiative			◆	

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
EMERGENCY RESPONSE				
Identify equipment, supplies, security, location, transport methods by facility.	◆			
Create standardized orientation for clinical providers and RN staff about EMRS policy and staff response.	◆			
Evaluate existing equipment/supplies for TTA/ERs and emergency response bags.	◆			
Standardize EMR equipment, supplies for TTA/ERs in all facilities.	◆			
Create standardize EMR response bags for all facilities.	◆			
Evaluate local facility transport vehicles for moving patients to TTA.	◆			
Designate all clinical staff to have CPR certification within 10 days of hire.	◆			
Establish / reestablish Emergency Response Review Committee (ERRC) at each facility to review all emergency response events.	◆			
Coordinate custody officer emergency response functions with healthcare staff via meetings, education and drills.		◆		
Create sally port log for community Emergency Medical Services (EMS) vehicles.		◆		
Develop tracking system for ACLS annual certification for clinical providers and nursing staff.		◆		
Coordinate with custody officer tracking of BLS annual certification.		◆		
Establish method to obtain community EMS pre-hospital care field reports (PFRs) on ambulance transports of inmates to community facilities to track patient care.		◆		
Designate TTA and R&R provider and nursing staff to have ACLS within 6 months of hire.			◆	
Create EMR criteria for TTA, R&R nursing and medical providers			◆	
Develop and implement emergency response training program for clinical and custody staff.			◆	
Provide inmates and staff within the California prison system with the same level and quality of emergency medical care that the community receives.				◆

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
OTHER QUALITY IMPROVEMENT ACTIVITIES				
Fill CEA position to head the Quality Measurement and Evaluation Unit.	◆			
Begin contract with external consultants to develop meaningful and valid access-to-care measures.	◆			
Coordinate with the Office of the Inspector General on a pilot program for inspecting medical care at California prisons	◆			
Develop dedicated project management infrastructure to support major quality initiatives.	◆			
Begin Asthma Initiative	◆			
Provide support staff and technical assistance to facilitate data collection efforts		◆		
Pilot use of patient satisfaction surveys.		◆		
Implement electronic tool for reporting incidents and near-misses.		◆		
Implement process improvement methodologies within the CDCR			◆	
Complete the Asthma Initiative, encompassing chronic care model, practice redesign, clinical guidelines, policies, documentation tools, and staff education resources.			◆	
Develop culturally and linguistically appropriate patient education resources and peer education programs for patients with asthma.			◆	
Design and pilot an implementation plan for a disease registry, care coordination, and case management for patients with asthma.			◆	
Complete three other chronic care quality initiatives.			◆	
Develop balanced scorecards showing each institution's disease burden, utilization, staffing, access-to-care measures, clinical quality indicators, and financial performance.				◆
CREDENTIALING AND PRIVILEGING				
Impliment credentialing software program	◆			
Incorporate evidenced-based validation of a provider's knowledge, skills, ability, and behavior into provider re-credentialing.			◆	
PEER REVIEW				
Modify the PPEC disciplinary process after the Court ruling	◆			
Implement the modified PPEC disciplinary process	◆			

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
DEATH REVIEW				
Standardize the Death Review Committee criteria for preventability of deaths.	◆			
Implement policies and practices to ensure coordination between the Death Review Committee and the Medical Oversight Unit.	◆			
Standardize the list of the lapses and system vulnerabilities that contribute to preventable deaths		◆		
Produce another death review analysis with improved methodology for determining preventability and with expanded lessons learned.		◆		
MEDICAL OVERSIGHT				
Hire initial Medical Oversight Unit clinical and non-clinical staff and begin pilot.	◆			
Modify the CDCR Employee Disciplinary Matrix to be clinically relevant	◆			
Train clinicians assigned to Medical Oversight Unit	◆			
Develop a train-the-trainer program		◆		
Submit a formal evaluation of the Medical Oversight Unit pilot to the Receiver		◆		
PROFESSIONAL EVALUATION AND STANDARDS				
Require CPR and ACLS certification for all providers.	◆			
Implement software to track license and certificate renewals and continuing education.	◆			
Expand proctoring to all new mid-level and physician hires.	◆			
Continue QICM evaluations for a limited number of new hires, e.g., new graduates without board certification and providers whose practice raises concern.	◆			
Revamp the 10- and 60-day Clinical Evaluation Program.		◆		
Implement universal use of annual practitioner performance evaluation form.		◆		
Incorporate evidenced-based validation of a provider's knowledge, skills, ability, and behavior into provider re-credentialing.			◆	

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
QUALITY INFRASTRUCTURE AND ORGANIZATIONAL CHANGE				
Maintain Professional Practice Executive Committee (PPEC) commitment to ensuring patient safety, investigating incidents of potential clinical misconduct and conducting pattern-of-practice reviews when appropriate.	◆			
Establish an Ethics Committee and develop ethics resources		◆		
Develop on-site and telemedicine pain management programs in collaboration with UC San Francisco.		◆		
Encourage and clarify expectations for death reviews and other quality reviews at the local level.		◆		
Institute sentinel event reviews and root cause analysis at the local level with assistance from CSU.		◆		
Develop team training resources including use of SBAR communication, consistent with state-of-the-art crew resource management (CRM).		◆		
Collect medical staff satisfaction data including targeted feedback from key groups, e.g., recently-hired staff.		◆		
Establish a Well-Being Committee to address the needs of impaired clinicians.			◆	
Implement process improvement methodologies within the CDCR including use of quality measures, rapid-cycle quality improvement, high-reliability practices, sentinel event review, and root cause analysis.			◆	
Develop full spectrum of medical staff and interdisciplinary committees that are consistent with professional standards and that identify and address clinical system dysfunctions.				◆
CLINICAL SUPPORT SERVICES				
Laboratory consulting engagement with Navigant Consulting, followed by Receiver's strategic plan for lab services	◆			
Telemedicine consulting engagement with UTMB, followed by Receiver's srtategic plan for telemedicine	◆			
Create a pilot program to maximize telemedicine utilization at all prisons for one clinical specialty	◆			
Hire a Director of Telemedicine Services to implement the UTMB recommendations;	◆			
Begin the transition from telephone-based ISDN to Internet-based telemedicine video services	◆			
Pilot usage of telemedicine to provide pre- and post-procedure telemedicine visits for patients requiring off-site hands-on procedures	◆			
Begin to re-evaluate telemedicine contracting methodologies	◆			
Dictation/transcription consulting engagement with Sandra Hirsch, followed by Receiver's srtategic plan for transcription		◆		
Radiology consulting engagement with vendor TBD, followed by Receiver's srtategic plan for radiology		◆		
Health information management (HIM) consulting engagement with vendor TBD, followed by Receiver's srtategic plan for HIM		◆		
Formation of the Clinical Support Division		◆		

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
SAN QUENTIN CONSTRUCTION				
Personnel Offices, West and East block rotunda sick call units, primary care/specialty modular in the upper yard will be under construction.	◆			
Relocation of the exercise yards will be complete.	◆			
Medical Warehouse will have a design-builder on board, with design and some construction started.	◆			
Central Health Services Building construction will have started.	◆			
Personnel offices, West & East block rotunda project & the primary care/ specialty modular projects will be complete.		◆		
Structural steel erection will be well underway for the Central health Services Building.		◆		
Medical warehouse will be nearing completion.		◆		
All projects will be complete with the exception of the Central health Services Building. This project will be nearing completion.			◆	
All projects, including the Central Health Facility, will be complete, occupied and fully functional.				◆
5,000 PRISON MEDICAL BED CONSTRUCTION INITIATIVE				
Site assessment will be completed with final recommendations issued.	◆			
All major CEQA issues will be identified and a remedial plan of action prepared.	◆			
All major infrastructure and site improvement needs will be identified and the initial and most critical phases of facility planning for both medical and mental health services will be completed.	◆			
A project delivery plan will be produced to effectuate facility design as well as construction delivery programming.	◆			
The specifics of funding needs will be established and an overall Program Management Plan approved and implemented.	◆			
FACILITY IMPROVEMENT CONSTRUCTION				
Project planning for MCSP, CIM, CIW, FSP, SAC, CCC, HDSP		◆		
Project planning for DVI, SCC, CCI, LAC, WSP, CMC, SVSP, PVSP		◆		
Project planning for all remaining prisons			◆	

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
CUSTODY ACCESS				
Complete Facility Master Plans and Follow-Up Assessments for staffing at 6 prisons.	◆			
ASP Health Care Access Unit project	◆			
Health Care Access Units Established and Operational at SQ, CMF, ASP	◆			
Complete Facility Master Plans and Follow-Up Assessments for staffing at 7 additional prisons.		◆		
Complete Facility Master Plans and Follow-Up Assessments for staffing at the remaining 17 prisons.			◆	
Healthcare Access Units established at 4 additional institutions.			◆	
Health Care Access Units are scheduled at 6 additional institutions				◆

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
MONITORING OUT-OF-STATE, CCFS, AND RE-ENTRY FACILITIES				
Establish an initial baseline or "core," expectation for field compliance with Plata standards for delivery of medical care.	◆			
Work with the Receiver's legal staff to ensure that COCF, CCF and RTC contracts contain provisions necessary to ensure compliance with Plata mandates.	◆			
Conduct an initial series of inspections and reviews of all COCFs and 50% of CCFs.	◆			
Provide initial assistance as necessary to all COCFs and those CCFs inspected concerning the delivery of adequate medical care as called for by Plata mandates.	◆			
Receive and manage the medical records of prisoner/patients housed in COCF facilities. Develop policies and procedures to appropriately manage the medical records of prisoner/patients housed in CCFs and RTCs.	◆			
Establish an audit tool to accurately reflect compliance with medical standards. Implement a program to document deficiencies and require timely corrective action or contract cancellation.	◆			
Hire initial Unit personnel	◆			
Establish agreements with the Court representatives in Armstrong, Coleman, and Perez, and the CDCR officials responsible for A.D.A., mental health, and dental services delivery to conduct inspections and review.	◆			
Establish liaison with the pilot OIG prison monitoring program and participate in data collection and inspections as necessary.	◆			
Hire secondary staff		◆		
Audit the remaining 50% of CCFs.		◆		
Conduct a second, follow-up audit of all COCF facilities.		◆		
Continue remediation action as necessary.		◆		
Commence inspection program of RTC facilities as necessary.		◆		
Physically audit all COCFs, CCFs, and RTCs annually, and on an unannounced basis as deemed appropriate.			◆	
CONTRACTS & INVOICE PROCESSING				
Phase 1: Complete and stabilize implementation of HCDMS at the four initial pilot institutions:	◆			
Phase 2: Roll out HCDMS to six additional institutions:	◆			
Phase 3: Roll out HCDMS to eleven additional institutions:		◆		
Phase 4: Roll out HCDMS to the final 12 institutions		◆		
Establish an administrative support unit		◆		
Establish an internal post review unit		◆		

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
FISCAL SERVICES				
Define CDCR's current accounting structure and processes	◆			
Engage an independent consulting firm to review CDCRs current recording and reporting of financial information	◆			
Evaluate existing reporting capabilities of CALSTARS and MIRS	◆			
Create a database to maintain the data elements in useable and "report friendly" formats and develop of a limited number of critical reports	◆			
Assist with developing support for the 2008-09 CDCR Division of Health Care Services (DCHCS) budget, with an emphasis on staff hours development and support	◆			
Prepare critical, high level financial and management reports that are timely, accurate and compliant with Generally Accepted Accounting Principles (GAAP) on a regular and periodic basis.	◆			
Develop a Fiscal Management Section to establish a financial infrastructure for headquarters and institutions statewide.	◆			
Define headquarters Fiscal Management Section organizational structure and hire staffing	◆			
Establish all field medical budget analyst positions and hire staff	◆			
Define and implement a structure for required budgeting processes for CDCR	◆			
Identify funding issues related to the Fiscal Year 2007/08 budget developed by CDCR Budget Management Branch (BMB)	◆			
Identify position reconciliation issues related to FY 07/08 budget developed by CDCR BMB	◆			
Develop a budget timetable for the Plata Support Division	◆			
Establish Position Roster Report for the Receiver and executive staff	◆			
Develop a process for requesting additional positions and funding for the field and headquarters	◆			
Define internal budget processes that BMB will transfer responsibility to the FMS		◆		
Develop process for reviewing Monthly Budget Plans and conducting Fiscal Reviews.		◆		
Develop training program for all headquarters' FMS staff and for institution's Medical Budget Analysts statewide.		◆		
Define and implement accounting structure and processes for CDCR		◆		
Develop process for ensuring allotments are accurate and within budget authority		◆		
Develop process for reconciling institution medical position authority on quarterly basis		◆		
Reconcile budgeted Post Assignment Schedules (PAS) for all posted positions		◆		

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
FISCAL SERVICES (continued)				
Define and implement accounting structure and processes for CDCR			◆	
The BIS financial applications replace reports provided by the Interim Financial Reporting and Decision Tool entirely.			◆	
Define and implement a structure for required budgeting processes for CDCR.			◆	
Assume responsibility for completing all required budget processes			◆	
PERSONNEL SERVICES				
Implement a system to track credentialing and continuing education requirements for all clinicians	◆			
Implement an Executive Medical Management team at pilot institutions	◆			
Establish a fully functional disciplinary unit	◆			
Reduce the vacancy rate for primary care providers to no more than 10%.			◆	
Reduce the number of vacancies in all nursing classifications to no more than 10%			◆	
Establish a new Executive Heath Care Manager classification			◆	
Separate out the administrative functions of the business services operation of the medical department at several pilot institutions			◆	
Conduct job analysis and salary surveys for all clinical classifications				◆
HEALTH CARE APPEALS, CORRESPONDENCE CONTROL, AND HABEAS CORPUS PETITIONS				
Consolidate all inmate health care inquiries functions into a single unit	◆			
Conduct a system-wide analysis of the current statewide appeals process & develop a framework for a new streamlined prisoner/patient health care inquiry system	◆			
All prisoner medical appeals will be provided directly to medical appeal personnel & all third level appeals will be answered by the medical staff who report to the Receiver,	◆			
Make the habeas corpus pilot program permanent	◆			

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
INFORMATION TECHNOLOGY				
Establish a wide area network (WAN) interconnecting all prisons and health care operations centers	◆			
Install wireless local area networks (LANs) for health care areas at pilot sites	◆			
Establish a data center that can host all clinical IT services and guarantee 99.9% availability for clinical care	◆			
Provide the following IT support services on an as-needed basis: help desk, desktop support, server maintenance, connectivity troubleshooting, security etc.	◆			
Engage consultants to help determine how we will handle inmate-patient identity and location management.	◆			
Purchase subscriptions to high quality online clinical reference tools	◆			
Create a plan for the remediation of telemedicine services.	◆			
Install wireless local area networks (WLANs) for healthcare areas at all remaining sites		◆		
Utilize Microsoft enterprise license to roll out Microsoft Outlook and associated communication tools to all healthcare personnel		◆		
Implement the Clinical Data Repository and Clinical Portal		◆		
Present a project plan for online, shared clinical "groupware" workspaces		◆		
Create a CDCR private web site for clinical providers		◆		
Implement an information system to track credentialing and education requirements		◆		
Implement contract management software		◆		
Complete roll out of the CDR and Clinical Portal to all 33 institutions			◆	
Implement telephone, teleconference, and video conferencing systems			◆	
Kick off a clinical data warehouse (CDW) project			◆	
Create and implement a process and methodology for redesigning all clinical forms, flow sheets, and order sheets			◆	
Implement a statewide scheduling and tracking information system			◆	
Initiate a laboratory information system project, considering the forthcoming recommendation of our clinical laboratory consultants.			◆	
Initiate a radiology information system and picture archiving and communications system (PACS) project, considering the forthcoming recommendation of our enterprise imaging consultants			◆	

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
INFORMATION TECHNOLOGY (continued)				
Complete Maxor's deployment of their automated pharmacy delivery and information system ("Guardian") at all 33 institutions				◆
Improve patient safety by implementing a pharmacy bar code system in conjunction with Maxor Pharmacy.				◆
Improve patient safety by implementing an electronic medication administration record (eMAR) in conjunction with Maxor Pharmacy.				◆
Initiate projects for electronic health records functions such as online clinical note documentation and computerized provider order entry.				◆

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
MAXOR				
Develop and implement effective and enforceable Disease medication Management Guidelines.	◆			
Update and maintain system-wide pharmacy policies and procedures.		◆		
Establish key performance metrics used to evaluate the performance of the pharmacy services program.			◆	
Establish standardized monitoring reports and processes designed to continually assess program performance.			◆	
Design, construct and operate a centralized pharmacy facility.			◆	
Identify and solve connectivity issues throughout all pharmacies to ensure that web-based software, reporting, and data can be easily accessed at each facility.			◆	
Consolidate and standardize pharmacy purchasing through development of a centralized supply procurement system.			◆	
Transition each institution to a uniform interim pharmacy information management system (Guardian Rx).			◆	
Develop and implement reporting tools to facilitate clinical, operational, and fiscal management of the CDCR pharmacy operation.			◆	
Establish methodologies and schedules for tracking and monitoring formulary compliance and prescribing behavior.				◆
Develop process to monitor inventory shrinkage.				◆
Implement process to ensure that the best value contracted item is used.				◆
Hire and train new employees as needed to replace registry personnel.				◆
Complete skill set inventory of State and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing employees.				◆
Evaluate feasibility of achieving 340 B preferential pricing on all drug purchases.				◆
Reevaluate previous staffing patterns at each institution in light of the adoption of new technologies to improve efficiency and transition of volume to the centralized pharmacy.				◆
Integrate pharmacy information management system with auxiliary technologies such as central supply management, physician order entry, electronic MAR, and barcode checking.				◆
Establish CDCR commitment to pursue accreditation and determine the accrediting organization standard to be followed				◆
Develop a readiness grid identifying the standards and assigning assessment responsibilities to members of the team.				◆
Complete mock audit using credentialed audit for target credentialing body.				◆
Prior to centralization, implement standardized operations in all existing institution level operations to correct problems identified in audits.				◆
Apply for accreditation audit at one or more institutions. Expand audits to all institutions on a defined schedule.				◆

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
SAN QUENTIN PILOT				
Refine the primary care intake processes	◆			
Reduce unnecessary and avoidable TTA or Community Hospital transfers due to chronic care conditions within the first 30 days of inmate-patient admission to San Quentin.	◆			
Hire a Nurse Instructor to provide required RN training to all newly hired RC RNs and monitor ongoing competency of existing RNs.	◆			
Continue networking efforts with local county jails for intake and release related activities.	◆			
Recruit and hire permanent Health Care Manager, Chief Medical Officer, and Chief Physician.	◆			
Provide in-depth regular training to RN Care Managers to identify early signs of decompensation.	◆			
Pilot collaborative patient care teams including care managers/coordinators, case managers, and support staff.	◆			
Formalize the primary care management model		◆		
Refine and replicate Diabetes Group in H Unit and measure outcomes.		◆		
Train staff to give accurate and consistent educational messages during reception processing and at key patient encounters.		◆		
Implement a collaborative primary care management model			◆	
Design and fully implement strategic orientation program to emphasize collaborative teams, integrative care, and clinical operations within a correctional environment.			◆	
Include inmate-patients as peer educators.			◆	
Transfer the clinical expert role to State employed providers				◆
Design and institute professional development programs				◆

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
SPECIALTY SERVICES PILOT				
Evaluate progress made in reducing cancellations	◆			
Complete hiring and training of essential staff	◆			
Coordinate the scheduling/tracking project under development with the Receiver's IT team	◆			
Identify barriers that are not related to IT or space issues for providing on-site specialty services and develop plans for reducing them.	◆			
Determine which specialty services are best provided off-site and on-site.		◆		
Evaluate staff satisfaction with new processes		◆		
Evaluate timeliness of referral reports		◆		
Identify criteria for selecting other institutions to establish similar Specialty Services Coordination efforts		◆		
Develop a regular report to introduce the project to other institutions		◆		
Evaluate current charting systems and medical record processes in relation to changes being made in information technology.		◆		
Develop orientation for new specialty consultants		◆		
Evaluate the quality of potential on-site specialists, the contracting process, and the payment process to ensure best business practices are in place		◆		
Plan the transition from a "pilot" program to a routine referral services for off-site specialty care beyond the LAC and CCI programs.			◆	
Develop criteria to select "early adopter" institutions to begin to implement findings from this pilot in these institutions.			◆	
Establish a Specialty Services Project Team at the selected new institutions and implement new programs through technology transfer of best practices			◆	
Implement the new on-site specialty services component of the Pilot			◆	
Orient on-site specialists to providing health care within the prison setting			◆	
Evaluate the methodology for the Specialty Services Coordination Pilot metrics and adjust			◆	
Plan dissemination of redesigned on-site specialty services for other institutions			◆	
Continue to disseminate Off-site specialty referral services through Care Coordination teams in all CDCR institutions.				◆
Finalize and submit the evaluation of the Specialty Care Coordination Pilot.				◆
Implement dissemination of Pilot findings to other institutions including the hiring and orientation of Specialty Services Coordinators for each institution.				◆
Finalize evaluation report from Pilot project				◆

Receiver's Timeline for Accomplishing Plan of Action Objectives

Description	6 months	12 months	24 months	36 months
CLASS ACTION COORDINATION				
Obtain approval from the Courts on the proposed one-page agreement on construction.	◆			
Finalize a one-page agreement on Emergency Response and obtain approval from the Courts.	◆			
Finalize a one-page agreement on oversight of out of state, community care facilities and return to custody facilities, and obtain approval from Courts.	◆			
Develop a governance model on health care management and obtain approval from the Court for a pilot program at four Institutions.		◆		
Through a work group, coordinate medical management policies and align that effort with Maxor and the Pharmacy and Therapeutic committee.		◆		
Develop a one page agreement on Nurse Supervision of Psychiatric Technicians and obtain approval from the courts.		◆		

November 15, 2007
Plan of Action

PLAN OF ACTION GOALS AND OBJECTIVES

The Plan of Action is organized into seven domains. Goals A and B emphasize building critical administrative and clinical capacities required as the foundation to support timely, effective, and efficient patient-centered care; Goal C outlines activities required to build a quality and patient safety infrastructure; Goal D focuses on developing information technology (IT) from the ground up. A scalable IT network with adequate local technical support is the requisite foundation for our future electronic health record.

Goal E addresses the interdependency of custody and clinical functions required to transform the health care system and provide effective care. For example, one of the objectives under Goal E is to implement a Health Care Access Team to provide dedicated custody escort support to the health care team, thus ensuring inmate-patient access to health care services in a timely and safe manner.

Goal F focuses on create new clinical and administrative space to provide a safe, efficient clinical environment for staff and patients. Lastly, Goal G speaks to the need to envision the end from the beginning, pointing beyond development of a successful system to its transition from the Receiver back to the State.

Key Plan of Action Goals

Goal A: Establish meaningful and effective financial and administrative infrastructure and processes that are precursors to clinical transformation.

Goal B: Redesign, pilot, and implement an effective prison health care continuum of services utilizing evidence-based, standardized processes and including screening, medical management, care coordination, case management, patient movement, parole, discharge planning, ancillary services, and other clinical support.

Goal C: Design, pilot, and implement a CDCR quality and patient safety infrastructure including measurement and evaluation components to guide system improvement, accountability, and effectiveness.

Goal D: Design, pilot, and implement an integrated health information system(s) including network infrastructure, electronic health records, patient scheduling and tracking, disease registry, medical management including utilization management, decision support, performance measurement, and reporting to support safe, effective, timely, and cost-efficient, patient-centered care based on a thorough understanding of redesigned work and pilot results.

Goal E: Develop, pilot, and implement institution-specific, on-site custody capacity to ensure safe and timely patient access to health care services.

Goal F: Create new clinical and administrative space to provide a safe environment for staff and patients based on the new clinical process redesign and on projections of future bed capacity needs.

Goal G: Develop a transition plan including timelines, knowledge management, and oversight monitoring to ensure successful transition of the new prison health care system from the Receiver back to the State, with continuing mandates which guarantee that medical services meet constitutional standards for access and quality.

Plan of Action Goals and Objectives

Goal A: Establish meaningful and effective financial and administrative infrastructure and processes that are precursors to clinical transformation.

Objective A.1. Develop manageable state, regional, and local structures including clearly delineated leadership roles, responsibilities, and accountabilities among headquarters, regions, and local prisons.

A.1.1. Define regional Chief Executive Officer, Chief Medical Officer, Director of Nursing, and Health Care Administrator roles, responsibilities, and accountabilities.

A.1.2. Define local institutional Chief Executive Officer, Chief Medical Officer, Director of Nursing, and Health Care Administrator roles, responsibilities, and accountabilities.

A.1.3. Define headquarters, regional administrative, and support functions.

A.1.4. Develop and implement a performance management system to align individual and team performance results with organizational mission, vision, goals, and objectives.

Objective A.2: Implement structure, business processes, and metrics for finance, accounting, budgeting, and reporting functions for CPR and CDCR to ensure accountability and transparency

A.2.1. Define and implement financial structure and processes for CPR.

A.2.1.1. Establish protocols for the ongoing funding of Receivership initiatives; a protocol for identifying funding provided to the Receivership by the Executive and Legislative branches; and a process for the Receivership's access to and control of identified funds.

A.2.2. Define and implement accounting structure and processes for CPR.

A.2.2.1. Develop and document a system of internal control that meets the Court's requirements for transparency of CPR operations and that is acceptable to other governmental and non-governmental stakeholders.

A.2.3. Define and implement accounting structure and budgeting

processes for CDCR medical care system.

A.2.3.1. Engage an independent consulting firm with recognized public sector financial expertise to review CDCR's current recording and reporting of financial information and to produce necessary interim information prior to CDCR's implementation of the Business Information System (BIS, an automated system designed to improve the forecasting, tracking, and reporting of its financial/budget, human resources, and procurement/contract activities on a statewide basis).

A.2.3.2. Work in partnership with CDCR and IBM to ensure that the budgeting functions of BIS meet the needs of the medical care system.

A.2.4. Define and implement budgeting structure and processes for CPR.

A.2.5. Establish a Fiscal Management Section (FMS) to implement a financial infrastructure for headquarters and institutions statewide.

A.2.5.1. Develop a shadow budget with CDCR for FY 08/09 budget processes.

A.2.5.2. Accept full fiscal responsibility for all medical budget processes for FY 2009/10.

Objective A.3. Establish mechanisms to ensure CPR financial and operating transparency.

A.3.1. Identify a nationally recognized standard of financial operating transparency and model CPR's operating and reporting systems as appropriate. For example, consider voluntary certification as Sarbanes- Oxley compliant.

A.3.2. Develop an internal control document that details CPR's reporting, recording, and management of the Receivership's assets, liabilities, and contractual commitments including input from State oversight agencies. Ensure this document is focused on operational transparency; facilitates knowledge transfer, particularly when responsibilities are reassigned; and includes input from State oversight agencies such as the OIG.

Objective A.4. Improve provider contracts and contracting processes to ensure accountability and transparency. (Refer to A.6.)

Objective A.4.1. Redesign the CDCR contracting "model" relative to network development, rate setting, contract management, quality and utilization management.

Objective A.5. Develop a Responsibility-Focused Financial Reporting Process and System.

A.5.1. Identify appropriate metrics as a basis for monitoring CDCR DCHCS financial operations.

A.5.2.Create a "Controller" position solely dedicated and responsible to CPR leadership.

A.5.2.1. Identify key staff members to fill top technical/decision making financial positions at CDCR and DCHCS headquarters.

A.5.3. Focus on timely and accurate reporting of financial information useful in decision making to CDCR and DCHCS headquarters and from/to regions, and facilities.

Objective A.6. Redesign, pilot, and implement a sound contract negotiation and management process based on industry standard and ethical business practices. (Refer to A.4.)

A.6.1. Implement contracting redesign of Objective A.4, creating negotiation team and processes, establishing policies, implementing information technology for contract procurement and invoice payment, and establishing a post-review quality control process.

Objective A.7. Create a pool of at-will, civil service, Career Executive Appointment (CEA) positions in order to populate local, regional, and statewide leadership positions with qualified, responsive leaders.

Objective A.8. Develop recruiting, retention, and human resources programs focused on providing patient-centered health care services based on industry standards that effectively manages staffing, compensation, job descriptions, competency, performance evaluation, professional development, and training in collaboration with clinical teams or other subject matter experts.

A.8.1. Restore and standardize competency levels of clinical staff based on health care industry standards.

A.8.2. Redesign, pilot, and implement clinical staffing model for all levels of care within the prison health care system.

A.8.2.1. Define roles, responsibilities, and clinical accountabilities for mid-level practitioners and advanced practice professionals.

A.8.2.2. Develop, pilot, and implement plan for adequate minimum staffing including physicians, nurses, and ancillary services throughout the system with enhanced staffing to match needs at particular prisons.

A.8.3. Recruit adequate numbers of qualified clinical staff within each discipline.

A.8.3.1. Adjust clinical and support salaries as needed based on competitive industry, market, and community rates.

A.8.3.2. Implement a loan forgiveness program as an incentive to recruit and retain qualified physicians and nurses.

A.8.3.3. Design and implement "24-hour" expedited hiring process to address clinical staff vacancies.

A.8.4. Develop appropriate administrative and clerical support after the redesign of work processes.

A.8.5. Standardize orientation, training, and professional development programs through the prison health care system for employees of all levels in collaboration with clinical team and other subject matter experts.

A.8.5.1. Review and revise orientation programs including appropriate prison health care information and specific orientation for providers, nurses, and ancillary clinical staff.

A.8.5.2. Develop a centralized approach to education and training in collaboration with academic institutions.

A.8.5.3. Develop adequate leadership and support for medical staff credentialing, privileging, and peer review, as well as for other essential committees of all other disciplines.

A.8.5.3.1. Implement an information system to track credentialing and education requirements including Continued Medical Education (CME) and Continued Education Units (CEU).

A.8.5.4. Develop ongoing leadership and managerial training

programs to support clinical professionals in leadership positions as well as direct patient care areas.

A.8.5.5. Develop communities of practice within each clinical discipline with designated leadership and appropriate communication tools.

A.8.5.6. Develop interdisciplinary communities of practice within clinical topic areas with designated leadership and appropriate communication tools.

A.8.5.7. Develop systems for routinely reviewing and revising health care policies and procedures and making them readily accessible to staff.

A.8.6. Develop and implement innovative approaches to address professional staffing needs of remote facilities.

Goal B: Redesign, pilot, and implement an effective prison health care continuum of services utilizing evidence-based, standardized processes and including screening, medical management, care coordination, case management, discharge planning, ancillary services, and other clinical support.

Objective B.1. Develop, pilot, and implement emergency response staffing models, protocols, and programs to prevent unnecessary patient or staff injury or death.

B.1.1. Develop and implement emergency response training programs for clinical and custody staff.

B.1.2. Develop an ongoing mechanism to improve interface with local ambulance services.

Objective B.2. Pilot and implement statewide initiatives to redesign and support screening, primary care and chronic care processes and programs. (Refer to Objective D.6.)

B.2.1. Redesign and replicate reception center intake processes and staffing model based on the San Quentin pilot or alternative pilot site.

B.2.2. Redesign and replicate primary care processes and staffing model based on the San Quentin pilot and other pilot sites.

B.2.3. Develop a pain management initiative and implement

statewide, building on CDCR's current collaboration with the University of California.

B.2.4. Expand cultural and linguistically appropriate patient education resources by collaborating with community health education programs.

B.2.5. Develop and pilot appropriate inmate peer education programs, *e.g.*, for diabetes and asthma.

B.2.6. Design and implement structure, process, and staffing to support evidence-based chronic care management including overall vision and leadership.

B.2.6.1. Establish clinical/administrative leadership for chronic care program by condition, e.g., cardiovascular, diabetes, asthma, seizure disorders, HIV/AIDS, hepatitis C.

B.2.6.2. Pilot and implement disease registries for chronic disease management and monitoring.

B.2.6.3. Review and revise Plata chronic care policies and procedures to be consistent with community chronic care standards.

B.2.7. Design and implement structure, process, and staffing to support evidence-based prenatal care and post-delivery services, including appropriate and timely management of high risk pregnancies.

Objective B.3. Design and implement programs and processes to ensure patient-centered continuity of care including care coordination, case management, utilization management, and quality management. (Refer to Goal C)

B.3.1. Design, pilot, and implement care coordination and case management mechanism to ensure continuity of care.

B.3.1.1. Develop position descriptions, recruit, and train care coordinators and case managers.

B.3.1.2. Direct high-risk chronic care patients to qualified providers, teams, prisons (including telemedicine option).

B.3.1.3. Develop a new nursing functional assessment and acuity assessment form based on experience and data from the

medical bed assessment sweep conducted in March 2007.

B.3.1.4. Plan and implement case management software as part of an enterprise-wide electronic health record. (Refer to Goal D)

B.3.1.5. Incorporate social worker expertise into care coordination and case management teams by developing new social worker positions and recruiting qualified professionals.

B.3.1.6. Develop care transitions programs to ensure continuity of care from jail to prison, general population (GP) to medical beds and back, prison to prison, and prison to community.

B.3.1.7. Redesign and pilot community hospital utilization management and optimize the use of utilization review nursing knowledge in case management.

B.3.1.8. Redesign and pilot a standardized specialty utilization management process including indicators to monitor specialty utilization and quality of services.

Objective B.4. Improve coordination of medical, mental, and substance abuse services to promote patient-centered care.

B.4.1. Incorporate behavioral/mental health and substance abuse knowledge competencies into primary care and chronic care programs via interdisciplinary collaboration, staff training, and/or new staff recruitment.

Objective B.5. Optimize placement and care of impaired and/or aging prisoners with chronic conditions by expanding long-term care (LTC) services and bed capacity in the prison health care system.

B.5.1. Increase LTC services and bed capacity to address immediate needs.

B.5.1.1. Develop additional sheltered dorms within CDCR.

B.5.1.3. Support aging inmates and inmates with disabilities in general population housing via environmental modifications, inmate helper programs, care management, staff training, and adult day health programs.

B.5.1.4. Develop inpatient neurobehavioral programs with appropriate levels of care.

B.5.1.5. Develop palliative care program for terminal inmates not requiring hospice placement, and optimize use of hospice beds at California Medical Facility (CMF) and Central California Women's Facility (CCWF).

B.5.1.6. Recruit and optimize use of clinical staff with geriatric and LTC nursing expertise.

B.5.1.7. Recruit and optimize use of clinical staff with physiatry and rehabilitation expertise, including expertise in traumatic brain injury.

B.5.1.7.1. Optimize use of physical, occupational, and speech therapies to keep inmates functional at lowest possible level of care.

B.5.2. Design and implement new clinical assessment forms and processes and placement criteria based on Abt Associates project (medical beds assessment sweep and 5000 beds planning).

B.5.2.1. Incorporate new custody risk assessment distinguishing inmates who could be in dorm setting from those requiring cells.

B.5.2.2. Enhance Health Care Placement Unit (HCPU) capacity with information technology support and clinical leadership including medical and mental health services collaboration.

B.5.2.3. Implement new criteria for placement in medical beds such as Correctional Treatment Center (CTC), Outpatient Housing Unit (OHU), and sheltered dorms.

B.5.2.4. Convert inappropriately used General Acute Care Hospital (GACH) beds to infirmary and long-term care medical beds.

B.5.3. Design new LTC facilities planning (5000 beds project) for physical plants and clinical programming to address future needs.

B.5.3.1. Plan clinical programs for new facilities.

B.5.3.2. Begin working with construction management contractors, CDCR, and other state agencies to oversee facility location, design, and construction.

Objective B.6. Develop a centralized Public Health Unit to be responsible for pandemic preparedness; communicable disease outbreak response; immunization and tuberculosis testing administration; and surveillance, communication, and training to prevent the spread of infectious diseases.

B.6.1. Establish centralized clinical/administrative leadership for public health and infection control.

B.6.2. Develop communication and training infrastructure for regional and local prison health care teams.

B.6.3. Develop outbreak response collaboration and other projects with local public health officers and Department of Health Services (DHS).

Objective B.7. Redesign, pilot, and implement clinical post hours to optimize space and coverage to ensure patient access to care.

B.7.1. Develop, pilot, and implement statewide model hours of operation for yard clinics and central clinics including provider lines, face-to-face RN triage, and specialty clinics.

B.7.2. Develop, pilot, and implement statewide model hours of operation for pharmacies, labs, radiology, and other ancillary and support services.

Objective B.8. Improve CDCR's pharmacy management and operations system by implementing the Maxor's road map to produce sustainable, patient-centered, and outcome-driven processes.

Objective B.8.1. Redesign the nursing medication delivery system in preparation for the Maxor system implementation to ensure timely and accurate delivery of medication to patients.

Objective B.9. Develop nutrition programs for inmate-patients who are pregnant or who have chronic conditions or dysphagia requiring modifications in diet.

B.9.1. Recruit and hire a team of Registered Dietitians with centralized leadership to develop statewide nutrition programs.

Objective B.10. Create ethics resources within health care services to support health care and custody staff, inmates, and families.

B.10.1. Develop expertise, resources, and quality metrics for

advance care planning.

B.10.2. Provide ethics education for health care and custody staff.

B.10.3. Make ethics consultation available to health care and custody staff, inmates, and families.

Objective B.11. Continue to expand CDCR collaborations with University of California campuses, California State University, other universities, and community colleges to enhance clinical service delivery, system improvement, staff education, staff recruitment, and health services research.

Objective B.12. Redesign, pilot, and implement centrally-managed clinical operations to ensure standardization of data, processes, and costs across the system and to take advantage of economies of scale in driving efficiency.

B.12.1. Design, pilot, and implement a statewide, centrally-managed approach to imaging and radiology, including equipment, supplies, staffing, training, certification, external contracts and information systems.

B.12.2. Design, pilot, and implement a statewide, centrally-managed approach to clinical laboratory services, including equipment, supplies, staffing, training, certification, external contracts and information systems.

B.12.3. Design, pilot, and implement a statewide, centrally-managed approach to materials management, including a modern, just-in-time supply chain, equipment, supplies, staffing, external contracts and information systems.

Goal C: Design, pilot, and implement a CDCR quality and patient safety infrastructure including measurement and evaluation components to guide system improvement, accountability, and effectiveness.

Objective C.1. Establish leadership to develop and manage the CDCR quality and patient safety programs.

C.1.1. Develop and lead implementation of quality and patient safety programs that integrate clinical quality measures, complaints and appeals, incident reporting, sentinel event reviews and root cause analysis, and clinical improvement initiatives.

C.1.2. Ensure linkage of interdisciplinary quality improvement and peer review to education and training.

Objective C.2. Design, pilot, and implement clinical quality measures consistent with appropriate free world health care delivery systems.

C. 2.1. Pilot measurement of patient-centered care, *e.g.*, using patient satisfaction surveys.

C. 2.2. Pilot measurement of organizational culture, *e.g.*, using nursing turnover rates.

C.2.3. Collaborate with other correctional systems in efforts to standardize correctional metrics throughout the country.

Objective C.3. Redesign, pilot, and implement a credible complaint and appeal process that is efficient, responsive, and effective in achieving rapid resolutions.

C.3.1. Build on lessons learned from the San Quentin Patient Advocacy model.

C.3.2. Develop adequate staffing and software to track and analyze complaints and appeals.

Objective C.4. Institute reliable patient safety, incident, and near-miss incident reporting and link reports to improvement initiatives and education.

Objective C.5. Develop sentinel event and root cause analysis policies, protocols, and curricula.

C.5.1. Train clinical, administrative, and custody leadership in sentinel event review and root cause analysis.

Objective C.6. Design and implement organizational structures, staff and technological support, and processes for evaluation, measurement, analysis, and improvement of organizational and clinical performance. (Refer to D.4)

C.6.1. Introduce a culture of ongoing clinical improvement initiatives at all levels of health care delivery.

C.6.2. Develop and implement strategies for utilizing process improvement methodologies in the prison system.

C.6.3. Train clinical and administrative staff in rapid-cycle quality improvement and high-reliability practices.

C.6.4. Develop custody/health care collaborations in high-reliability practices.

Objective C.7. Design, pilot, and implement a combined clinical-administrative crisis management team model to provide timely response to address prison crises with potential for adverse impact to access or quality.

Objective C.8. Enhance system-wide clinical accountability through peer review mechanisms.

C.8.1. Expand the focus of the Professional Practices Executive Committee (PPEC) beyond review of individual performance to focus on process and system vulnerabilities and link findings to educational and quality improvement initiatives.

C.8.2. Develop custody/health care capacity for joint investigations as needed.

Goal D: Design, pilot, and implement integrated health information technology (and supporting infrastructure) that enables secure, ubiquitous statewide access to inmate patient medical data and healthcare operational business data.

Objective D.1. Design, pilot, and implement network and operational infrastructures to support healthcare clinical and business operations.

D.1.1. Implement a highly reliable, ubiquitous, high speed, high bandwidth wide-area network (WAN) statewide useable for all healthcare operations.

D.1.2. Implement highly reliable, ubiquitous, high speed, high bandwidth local-area networks (LANs) intended for desktop connectivity in all areas where healthcare is delivered or where healthcare operations take place.

D.1.3. Implement IT support operations to provide essential IT services, such as help desk, change control process, data center maintenance, testing and quality assurance, and disaster recovery and back-up processes to assure 99.9% availability of all critical systems.

D.1.4. Institute industry-standard project management methodology for all IT projects including project charters, steering committees, budget projections, and post-implementation project reviews.

D.1.5. Institute operations to ensure security, confidentiality, and compliance with all relevant Federal and State laws regarding

protected healthcare information, as well as the security needs of correctional institutions.

D.1.6. Implement communication tools, such as email systems, telephones, video conferencing, and wireless pagers, which are required for healthcare operations.

Objective D.2. Synthesize clinical and business data from all healthcare operations into an enterprise-wide set of databases that meet all industry standards for reliability, security, and interoperability.

D.2.1. Synthesize all relevant clinical data (including, but not limited to, pharmacy, lab, radiology) into a single database, indexed by patient, integrated across the entire statewide enterprise.

D.2.2. Implement computer tools, intended for clinicians, which permit easy access to all synthesized clinical data available for each patient.

D.2.3. Synthesize all relevant healthcare operations data (including, but not limited to, provider claims, utilization, quality metrics, population demographics) into a single, statewide data warehouse.

D.2.4. Implement computer tools, intended for managers and analysts, which permit reporting and analysis of synthesized healthcare operations data and ongoing performance monitoring.

D.2.5. Automate routine and ad hoc reporting of metrics required by the Federal Court in Plata, Coleman, Perez, and Armstrong.

Objective D.3. Create systems for compiling and managing medical knowledge[1] and clinical documentation that will enable healthcare providers to make the appropriate clinical decisions for their patients at the point-of-care.

D.3.1. Create and implement a system for developing, documenting, disseminating, and maintaining clinical protocols, guidelines, and algorithms endorsed by CDCR clinical leaders.

D.3.2. Implement online medical library services to support clinical information, research, and clinical continuing medical education (CME) requirements.

[1] Including, but not limited to, clinical guidelines, care plans, protocols and algorithms, best practices, and medical reference tools.

D.3.3. Implement appropriate clinical decision support tools[2], both electronically and on paper, that provide just-in-time information to clinicians to ensure that patients continually receive the highest quality care.

D.3.4. Redesign, pilot, implement, and maintain clinical information tools that inform and influence patient care, including clinical documentation forms, flow sheets, and order sheets.

D.3.5. Implement information technology tools that allow healthcare providers to record clinical encounters and patient care information in documents[3] that are readable, shareable, analyzable, and always available.

Objective D.4. Improve and streamline healthcare processes to improve efficiency and effectiveness and prepare for automation through computer applications.

D.4.1. Redesign, pilot, and implement laboratory processes and required IT systems to allow for standardized test panels, point-of-care testing, automated assays and accurate and timely results reporting (See also Objective B.12.2)

D.4.2. Develop and implement radiology processes and required IT systems to allow for central image storage, remote image retrieval, and review (See also Objective B.12.1)

D.4.3. Provide IT support to the rollout of pharmacy improvements highlighted in Objective B.8

D.4.4. Develop and implement health records management processes and required IT systems to allow for centralized management of the paper-based Unit Health Record prior to implementation of electronic health records. (See also Objective B.12.3)

D.4.5 Develop and implement processes and IT systems to support

[2] Such as chronic disease care reminders, adverse drug reaction prevention alerts, drug dosing calculators, formulary compliance alerts, etc.

[3] Such as history and physicals, progress notes, problem lists, care plans, etc.

[4] A "closed loop" medication ordering process automates the entire order entry, fulfillment, dispensing, and administration processes, eliminating the potential for dangerous errors from poor handwriting, mistaken transcription, or human error. These systems ensure that the right patient, right medication, right time, right route and right dose are confirmed every time a drug is given.

[5] Upgrade from ISDN-based network to IP-enabled.

patient case management, including managing appointment scheduling, referral tracking, and compliance with court mandates for healthcare access.

D.4.6 Implement information technology tools that facilitate the process by which clinicians create unambiguous, readable medication and treatment orders that are always transmitted reliably to nursing, pharmacy, and ancillary clinical services and allowing tracking of quality metrics.

D.4.7 Create a "closed loop" medication ordering process[4], reducing the possibility for human error and patient harm due to medication mistakes.

D.4.8 Develop and implement processes and IT systems to support healthcare business operations including provider credentialing; continuing education tracking; staff timekeeping; contracting for provider services equipment, and supplies; materials management; and supply chain.

D.4.9 Implement system–wide change management initiatives and training to ensure end-user acceptance and adoption of information technology solutions.

Objective D.5 Improve and enhance the existing telemedicine program and integrate it into continuum of inmate medical care to provide primary, emergency and specialty care to allow for greater access to inmates while reducing cost of care as well as custody inmate transportation to outside clinical care locations.

D.5.1 Expand telemedicine clinical processes from 13 prisons to all correctional facilities as part of core primary and specialty care operations for inmate health care including medical, dental, and mental health.

D.5.2 Upgrade CDCR telemedicine technology from its current state of obsolescence to new technology that allows sufficient bandwidth, high security and flexible location of telemedicine units in correctional facilities[5].

D.5.3 Redesign telemedicine workflows to ensure efficient, effective, and timely care consistent with all other care delivered for a given condition.

Objective D.6 Establish a statewide project governance model for integrated health information system(s) and related applications, with

representation by medical, dental, mental health, and other key stakeholders.

Goal E: Develop, pilot, and implement institution-specific, on-site custody capacity to ensure safe and timely patient access to health care services.

Objective E.1. Design, pilot, and implement necessary institution-specific on-site custody components that ensure appropriate patient security, escorting and transporting for health care services.

E.1.1. Analyze, develop, and implement institution specific on-site health care access teams to ensure patient access to health care services.

E.1.2. Conduct analyses of custody requirements for the day-to-day operations and security for each institution's health care services.

E.1.3. Conduct analyses of custody personnel and equipment/vehicles needs for institution access teams.

E.1.4.Conduct analyses of personnel needs for community hospital custody coverage.

E.1.5. Activate San Quentin pilot custody access team and replicate model statewide.

Objective E.2. Redesign, pilot, and implement transportation support for off-site health care teams to ensure safe and timely transport of patients to services in the community.

E.2.1. Analyze current statewide transportation operations to determine necessary resources for providing adequate/timely medical transportation.

E.2.2. Develop, and implement institution-specific off-site custody transportation unit to ensure patient access to community-based health care services.

Goal F Create new clinical and administrative space to provide a safe environment for staff and patients based on the new clinical process redesign and on projections of future bed capacity needs.

Objective F.1. Plan, design, and build clinical space to provide a safe environment for staff to deliver appropriate patient care at all levels.

F.1.1. Review reception center space needs based on reception center

process redesign and supplement or redesign the space to match the new processes.

F.1.1.1. Review primary care (sick call, chronic care, TTA) and infirmary space needs at all prisons and supplement or redesign the space.

F.1.2. Plan, design, and build work space to provide a safe environment for staff to provide support to the delivery of safe patient care at all levels.

F.1.2.1. Conduct reviews of clinical space around the state to ensure inmate access areas and holding cell areas are adequate.

F.1.2.2. Identify areas, where clinical space is inadequate, to place new space, e.g., modular buildings, within secure areas of the prison.

F.1.2.3. Establish adequate custody work stations within institution clinics and institution medical housing areas.

F.1.2.4. Implement space additions at the prison sites in collaboration with contract construction managers.

Objective F.2. Oversee construction of comprehensive new clinical complex at San Quentin to provide medical, mental health, and dental services.

Objective F.3. Plan, design, and build 5,000 new medical beds and 5,000 new mental health beds (estimates) in various regions to provide additional bed space and appropriate levels of care.

Goal G: Develop a transition plan including timelines, knowledge management, and oversight monitoring to ensure successful transition of the new prison health care system from the Receiver back to the State, with continuing mandates which guarantee that medical services meet constitutional standards for access and quality.

Initiative Narratives

CLINICAL INITIATIVES
(POA OBJECTIVES A.7, A.8.1, A.8.5, B.8, B.3.1 AND B.1.1)

BACKGROUND AND INTRODUCTION

Providing day-to-day medical care in a dysfunctional, overcrowded, and beleaguered system while simultaneously trying to transform all the elements of the system has been likened to changing the tires on a passenger-filled bus while the bus is in motion. Daunting as this task may be, CDCR clinical and administrative staff, under the direction of the Receiver and his staff, are getting increasingly engaged and excited by the change process, with increasing support from custody. Achieving care that is safe, effective, patient-centered, timely, efficient, and equitable will require that yet more staff become actively engaged in the effort.

The Receiver is committed to using evidence-based change strategies to achieve evidence-based care. In diabetes, for example, a meta-analysis of 39 controlled trials of diabetes care showed that the following interventions improve outcomes: provider education, provider reminders, audit with feedback to providers, patient education, case management, and team-based changes. And yet each of these interventions requires infrastructure elements that still do not exist within the CDCR. Cutting-edge interventions or even the most basic educational strategies are futile in the absence of stable staff and functional management.

While addressing other infrastructure needs as well, the Receiver has focused heavily on leadership and human resources. Recruiting has been a top priority, and salary increases have helped those efforts. The shift from using peace officer MTAs to using LVNs has been a time-consuming challenge, yet one that is essential for aligning all clinical staff with the clinical mission. The Receiver has prioritized restoring a statewide nursing structure, empowering nursing leadership, and launching comprehensive nursing workforce initiatives, discussed below. Nurses must function as change agents and drivers of patient-centered care throughout the organization in order to create and implement new clinical models. Contracting pharmacy management to Maxor National Pharmacy Corporation is another illustration of the Receiver's early emphasis on the leadership and human resources infrastructure. The Receiver has also launched a new medical staff professional development initiative, also discussed below.

As the infrastructure elements develop, including leadership, human resources, space, and information technology, the Receiver will be able to implement Institute Of Medicine strategies for process redesign, knowledge management, teamwork, and care coordination, and the pace of change at the patient care level will accelerate. Meanwhile, one should not underestimate the clinical impact, even now as good clinicians assume medical care, and competent local leaders begin to exert managerial direction.

This section includes detailed descriptions of the following initiatives:

1. Medical Staff Professional Development (POA Objective A.7)
2. Nursing Executive Leadership Initiative (POA Objective A.7)

3. Healthcare Orientation, Nursing Preceptor Program, and Provider Proctoring Program (POA Objective A.8.1 and A.8.5)
4. Nursing Medication Delivery Process Redesign (POA Objective B.8)
5. Asthma Initiative (POA Objective B.3.1)
6. Emergency Response Initiative (POA Objective B.1.1)

PROGRESS TO DATE

For two days in August and again in September, the Receiver hosted focus groups with several dozen state and regional nurse and physician leaders and administrators to review and critique the May Plan of Action and discuss its implementation. Consistent with the Baldrige leadership, workforce, and strategic planning imperatives,[1] the groups represented initial efforts to engage, align, and activate leadership in service of the Receiver's transformation efforts. The groups endorsed the need to redesign the medical care delivery system from the ground up, to develop new primary care models, to support the clinicians with adequate medical records and information technology, and to professionalize the working environment. They also endorsed the need for a vigorous care management system, for a staff education infrastructure, and for leadership and managerial training.

Following these discussions, the regional and statewide leaders have initiated a formal Clinical Leaders Group under the direction of the Receiver's Chief Medical Officer and Chief Nursing Executive, with administrative support from the Chief, Clinical Operations Branch. The Clinical Leaders Group will provide a collaborative interdisciplinary leadership forum to discuss operational issues, strategies for clinical oversight, and deployment of the Plan of Action. In addition, local facility leaders have gathered regionally for Plan of Action meetings.

These groups represented early steps toward activating a broad clinical leadership cadre who will contribute to and fulfill the Plan of Action. The IOM discussion on evidence-based management[2] stresses the importance of involving workers in the redesign process, creating trust, managing the change process, and supporting transformation with knowledge management and resources. Changes of this magnitude, disruptive of the status quo and people's personal lives, are likely to succeed only when they engage health professionals' deepest aspirations:

> A leadership approach that aims to achieve a collective goal rather than a multitude of individual goals and aims to transform all workers—both managers and staff—in pursuit of the higher collective purpose can be the most efficient and effective means of achieving widespread and fundamental organizational change.... In health care organizations, where many workers have strong professional identifications, trust of leadership by subordinates often reflects the extent to which leadership is committed to the values inherent in the professions of medicine and nursing.

---

[1] Baldrige National Quality Program. *Health Care Criteria for Performance Excellence*, 2007.
[2] Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academy Press; 2004.

While this level of change must ultimately be felt and engaged at the patient level, *i.e.*, in the CDCR yard clinics, new resources and relationships will be necessary to make this engagement possible. The Receiver is depending in particular on the Receiver Career Executive Assignment (CEA) positions at the local, regional, and statewide levels, described below; on the physicians in the new Clinical Support Unit (CSU); and on the Nurse Consultants.

The CSU physician positions and Nurse Consultant Program Review positions originated in the Quality Management Assistance Teams (QMAT) but were overwhelmed, under-resourced, and misdirected in those roles. Some of their current and future activities are described in the Quality Measurement and Evaluation Initiative, as well as below in the Professional Development Initiative. Once fully aligned with the Plan of Action and fully trained in new functions, these physicians and nurses will comprise a cadre of clinical change agents. In addition to education, supervision, performance evaluation, coaching, investigations, sentinel event reviews and quality oversight, their duties will include leading quality initiatives such those on medication management and asthma, described below. They will also form crisis response teams as needed. They helped respond to Avenal's clinical leadership implosion last winter. While there have been no recent crises on quite the same scale, the potential remains ever-present.

Other recent accomplishments not fully discussed elsewhere include the establishment of an interdisciplinary HIV/HCV Advisory Committee and revitalization of the ever-busy Public Health Unit. The Public Health Unit has begun recruiting and hiring for seven new positions, including a new Chief Medical Officer. The California Department of Public Health is providing assistance with expansion of the Public Health Unit in addition to day-to-day assistance regarding threats and outbreaks of tuberculosis, chickenpox, methicillin-resistant Staphylococcus aureus (MRSA), Salmonella, Coccidioidomycosis, norovirus, influenza, and other pathogens.

Challenges for the Receiver, as identified during the Plan of Action focus groups, include supporting the energy and enthusiasm of clinical leaders in the face of apathy and active resistance and in the absence of an effective communication and education structure.

The Receiver's initiatives will require continued focus and dedicated resources in order to sustain momentum and realize completion. Since the publication of the May Plan of Action, the priorities have evolved from conceptual designs to actual pilot programs. Successful implement of initiatives in the next thirty-six months will depend on having a cohesive high-performing leadership team. These senior leaders must be able to set directions and create high expectations with patient-focused, clear, visible values that are in alignment with the Receiver's POA. As the initiatives are being piloted at the selected prisons, the Receiver has to orchestrate the intricate interdependencies of all the initiatives. The quality initiatives in particular will require a drop-in team of external experts to provide project management, technical support, training, measurement and analysis. The Receivership will have to compete with the free-world health care systems to procure these highly trained professionals.

The Receiver's staff has begun to work more closely with Mental Health staff, *e.g.* a joint policy recommendation to address clinical integration of nurse and mental health staffing, on new facility planning, and on information system planning. But here too, the challenges are

significant because the silos are long-standing and deep, reinforced by the very Court cases that have initiated reform. Physicians have not worked in concert with nurses, medical care personnel have not worked with mental health, and healthcare has not worked with custody. And neither medical nor mental health programs have incorporated substance abuse knowledge and practice into their day-to-day work, in spite of the enormous impact of substance abuse on medical and mental health status. There have been no process redesign initiatives involving medical and mental health. Until these divisions are overcome, care will remain provider-centered, and patient-centered care will remain a distant dream.

1. MEDICAL STAFF PROFESSIONAL DEVELOPMENT

BACKGROUND AND INTRODUCTION

Although the CDCR has long been blessed with some excellent clinicians, the CDCR workplace has failed to promote excellence. Rather, clinicians have been working in remarkably dispiriting environments. Professional expectations and support have been lacking. Good physicians have often been isolated among those considerably less competent and/or less dedicated than themselves. Physicians and mid-level providers have been trying to treat patients in miserable physical environments, often lacking even hand-washing facilities. Medical records have been a jumbled mess, or missing results, or missing altogether. Providers have been uncertain when or if their orders for tests or medications would be fulfilled. They have lacked appropriate supervision. They have often lacked any information technology, textbooks, or other clinicians to call upon for assistance in making decisions. With few support and safety mechanisms in place, the possibility of making serious errors has been ever-present.

The Office of the Receiver is rapidly deploying healthcare information technology and a sophisticated pharmacy management system, and CDCR, resultant from Receivership and court intervention, is hiring increasing numbers of highly qualified clinicians and managers as a result of Receivership and Court intervention. Some prisons have new or dramatically improved clinical facilities. The Pharmacy and Therapeutics Committee has begun to develop evidence-based medication guidelines. The Professional Practice Executive Committee (PPEC) has labored diligently to devise reliable and judicious peer review mechanisms. But the CDCR still lacks a quality improvement infrastructure, and clinicians are unfamiliar with process redesign. There is no methodology for identification and dissemination of best practices. The lack of communication channels among staff inhibits collective problem-solving. The lack of a care coordination or case management program means that episodic care rather than planned care is still the norm. There is still no decision support for clinicians and little disease education for patients.

Correctional medicine offers wonderful opportunities for clinicians who enjoy a challenging and diverse practice, can tolerate a gritty environment, and are drawn to serving the underserved. Prisons are a vital part of the healthcare safety net, along with public hospitals and community clinics. For those who insist on achieving high-quality outcomes, however, the CDCR can still be a frustrating setting. It is critically important, therefore, to recruit clinicians who want to act as change agents and equally important to develop change competencies within existing staff. Hence one of the Receiver's priorities is the Professional Development Initiative,

which shifts the focus of professional practice from individual disciplinary activities to system improvements and professional growth. Many of these activities are interdisciplinary from inception, and others will warrant spread to other disciplines.

The Medical Staff Professional Development Initiative aims to:

1. Attract and retain excellent physicians, nurse practitioners, and physician assistants
2. Assist these providers in maintaining and improving their clinical acumen via educational programs and decision support
3. Offer targeted remedial opportunities for providers with remediable deficiencies
4. Develop medical staff and interdisciplinary committees that are consistent with professional standards and that identify and address clinical system dysfunctions
5. Develop a cadre of frontline and managerial staff with quality improvement and leadership competencies
6. Establish expectations and processes at local institutions in support of professionalism, ongoing professional development, and retention of high-quality clinical staff

Genuine change at the point of care must engage frontline clinicians. Indeed, only with the emergence of change agents and champions among the clinical staff will transformation be possible. The Professional Development Initiative, in conjunction with the Receiver's other priorities, will create the preconditions under which this change can take root and grow.

Within the regions, the recently-formed Clinical Support Unit (CSU) will provide the initial cadre of staff to carry out the activities noted below in support of CDCR's primary care providers. Staff members from the now-disbanded Quality Management Assistance Teams (QMAT) form the core of the CSU, which will expand to include a CMO and approximately seven providers in each of the three regions. Each provider will be responsible for knowing the missions, personnel, specific issues and needs of one or two assigned locations. They will be responsible for assisting the local leadership with quality, education, and clinical programs at their institutions.

From headquarters, the newly-created Clinical Operations Branch will provide appropriate structure and administrative support for an expanding spectrum of statewide medical staff and interdisciplinary committees, as described below. CSU staff, Regional CMOs, and the CMOs assigned to headquarters will be the workhorses of these committees and the professional development activities. CSU staff will be trained and cross-trained to carry out educational programs, quality and safety initiatives, performance reviews, quality oversight, sentinel event reviews, investigations, program development, and crisis response, all in addition to supporting particular local institutions. As the Receiver's information technology and teleconferencing capacity expands, there will be increasing opportunities to engage local leaders and frontline clinicians in these transformation efforts and committees.

No healthcare organization would presume to have the internal resources necessary for such a monumental change process, and the CDCR is particularly limited in leadership depth and change competencies. The Receiver and CDCR will continue to partner with the University of

California, other academic partners, healthcare organizations, and consultants in order to move the professional development agenda.

Many of these professional development activities are interdisciplinary in nature. Indeed, they must occur in the context of an ongoing interdisciplinary search for correctional primary care models that are safe, timely, effective, efficient, equitable, and patient-centered. Physicians, nurse practitioners, physician assistants, nurses, pharmacists, and other clinicians must all engage in the hard work of system redesign. Illustrative of one such cross-over effort is PPEC's new Mid-Level Provider Subcommittee, which will address issues of recruitment, privileging, proctoring, supervision, and best practices with regard to nurse practitioners and physician assistants.

Lest all of these aspirations appear pie-in-the-sky, it is worth reviewing recent accomplishments, sorted into three inter-related domains.

PROGRESS TO DATE

Professional Education and Support

- Enrolled regional CMOs, statewide CMO, and two CSU physicians in the Institute for Healthcare Improvement program entitled "Engaging with Physicians in a Shared Quality Agenda".
- Held training for local Chief Medical Officers (CMOs) addressing clinical guidelines developed by the Pharmacy and Therapeutics Committee and addressing new clinical policies.
- Sent several cohorts of CDCR physicians to Regional HIV/AIDS Training for Correctional Health Care Providers sponsored by the UCSF-San Francisco Area AIDS Education and Training Center (SFAETC).
- Enrolled nearly half of CDCR physicians in four-day Ethics and Communication Training developed by UC San Diego, on track to complete for rest in 2008.
- Enrolled providers identified via QICM as needing remediation into Primary Care Update course developed by UC San Diego.
- Revised clinical orientation in conjunction with nursing, including separate track for physicians, nurse practitioners, and physician assistants.
- Designed a tiered privileging and proctoring program for nurse practitioners and physician assistants.
- Completed plans for Emergency Response Training in conjunction with nursing.
- Created security policies, in concert with custody, to allow providers to bring into institutions their own personal digital assistants (PDAs) containing updated medical reference information.
- Negotiated contract for UpToDate, the leading medical online reference resource, to be available to all physicians and nurses practicing in CDCR prisons (as web access becomes increasingly available).
- Distributed disease-specific clinical training modules developed by UC San Diego for CDCR.

Professional Evaluation and Standards

- Established board certification in primary care as a desirable qualification for new physician hires; in practice, began hiring only board-certified physicians.
- Established Credentialing Committee for all disciplines (mental health, dental, and medical).
- Completed competency evaluations via Quality Improvement in Correctional Medicine (QICM) for all mid-level providers and physicians without time-limited board certification, with the exception of two clinicians awaiting development of a specialized gynecology evaluation.
- Developed practitioner performance evaluation form incorporating the six physician competencies as codified by the Accreditation Council for Graduate Medical Education, the American Board of Medical Specialties, and the Joint Commission on Accreditation of Healthcare Organizations: patient care, medical knowledge, practice-based learning and improvement, communication and interpersonal skills, professionalism, and systems-based practice. Refer to Clinical Initiate Appendix 1 – Practitioner Performance Evaluation Form.

Quality Infrastructure and Organizational Change

- Created Clinical Operations Branch to resolve prior dysfunctional support structure for peer review, death review, and credentialing.
- Hired Branch Chief responsible for developing appropriate clinical staff support and full spectrum of medical staff and interdisciplinary committees.
- Established HIV/HCV Advisory Committee, which has addressed formulary issues, housing policy, and coordination issues among prisons and UC San Francisco.
- Established statewide interdisciplinary Pharmacy and Therapeutics Committee with support and leadership from Maxor; adopted initial set of medication guidelines and implemented formulary.
- Improved and standardized Death Review Committee processes.
- Reorganized providers from Quality Management Assistance Teams (QMAT) into Clinical Support Unit (CSU) responsible for realizing professional development goals at the local level.
- Partnered with UCSF to expand HIV care services on-site and via telemedicine.
- Initiated Pain Management Initiative in partnership with University of California.
- Posted RFP for outside assistance with Asthma Initiative designed to eliminate preventable patient deaths, engaging physicians, nurses, pharmacists, and patients in implementation of the chronic care model.
- Initiated quarterly newsletter, *Under the Microscope*, addressing clinical and medical staff issues.

THE WAY FORWARD

Obviously, many of the above activities are incipient. They will require continued focus and resources in order to sustain momentum and realize completion. The following activities will comprise the Medical Staff Professional Development Initiative over the next 36 months.

Professional Education and Support

Six Month Objectives:

- Develop a continuing medical education (CME) committee
- Place a set of medical textbooks in clinic areas of each prison.
- Make the CDCR Drug Formulary available for download to PDAs in partnership with ePocrates.

Twelve Month Objectives:

- Develop CME programs held at local/regional sites and/or via distance learning including both didactic and case-based activities.
- Develop need-based CME options to address specific provider deficiencies noted on assessments and quality reviews.
- Improve access to health information and educational resources at all points of care delivery.
- Develop medical library resources and staff to assist clinicians in accessing the medical literature and clinical guidelines.
- Develop a medical leadership curriculum and multimodal deployment strategies in partnership with University of California.

Twenty-four Month Objectives:

- Collaborate with UC to establish specialized training programs using CDCR staff as clinical preceptors to residents and students (medical, NP, PA).
- Collaborate with UC to establish academic appointments for CDCR clinicians.

Thirty-six Month Objective:

- Win accreditation for CDCR as a CME provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education.

Professional Evaluation and Standards

Six Month Objectives:

- Require CPR and ACLS certification for all providers.
- Implement software program to track license and certificate renewals and continuing education.
- Expand proctoring to all new mid-level and physician hires.
- Continue QICM evaluations for a limited number of new hires, *e.g.*, new graduates without board certification and providers whose practice raises concern.

Twelve Month Objectives:

- Revamp the 10- and 60-day Clinical Evaluation Program.
- Implement universal use of annual practitioner performance evaluation form.

Twenty-four Month Objectives:

- Incorporate evidenced-based validation of a provider's knowledge, skills, ability, and behavior into provider re-credentialing.

Quality Infrastructure and Organizational Change

Six Month Objectives:

- Maintain Professional Practice Executive Committee (PPEC) commitment to ensuring patient safety, investigating incidents of potential clinical misconduct and conducting pattern-of-practice reviews when appropriate.

Twelve Month Objectives:

- Establish an Ethics Committee and develop ethics resources, building on the UC San Diego course developed for CDCR.
- Develop on-site and telemedicine pain management programs in collaboration with UC San Francisco.
- Encourage and clarify expectations for death reviews and other quality reviews at the local level.
- Institute sentinel event reviews and root cause analysis at the local level with assistance from CSU.
- Develop team training resources including use of SBAR communication, consistent with state-of-the-art crew resource management (CRM).
- Collect medical staff satisfaction data including targeted feedback from key groups, *e.g.*, recently-hired staff.

Twenty-four Month Objectives:

- Establish a Well-Being Committee to address the needs of impaired clinicians.
- Implement process improvement methodologies within the CDCR including use of quality measures, rapid-cycle quality improvement, high-reliability practices, sentinel event review, and root cause analysis.

Thirty-six Month Objective:

- Develop full spectrum of medical staff and interdisciplinary committees that are consistent with professional standards and that identify and address clinical system dysfunctions.

2. NURSING EXECUTIVE LEADERSHIP INITIATIVE

BACKGROUND AND INTRODUCTION

The background of the Nursing Executive Leadership Initiative is summarized in the Court's July 3, 2007, Order Re Receiver's Motion For Waiver of State Law Re Receiver Career Executive Assignments:

> The genesis for this motion is the severe void in qualified health care executive level managers within the California Department of Corrections and Rehabilitation ("CDCR"). Indeed, when this Court held evidentiary hearings in 2005, it became clear that the CDCR was content to operate without any functioning leadership in medical services – a startling 80 percent of higher level management positions in the CDCR Health Care Services division were vacant. *See* October 3, 2005 Findings of Fact and Conclusions of Law ("Findings of Fact") at 7. As this Court analogized, "[t]his is akin to having a professional baseball team with only a relief pitcher and no infielders." Id. Further, after hearing essentially uncontested evidence of serious systemic failings in virtually every area of health care management, the Court readily found that "[t]he leaders of the CDCR medical system lack the capability. . . . necessary to deliver adequate health care, much less fix the abysmal system that now exists." Id.

The Order goes on to quote the Receiver regarding a "pervasive lack of effective medical management throughout the CDCR system," "culture of incompetence and non-performance," and "utter disarray in the management, supervision, and delivery of [medical health] care."

The Nursing Executive Leadership Initiative, when expanded to include physicians and administrators, will create a pool of newly created positions in order to populate local, regional, and statewide leadership positions with qualified, responsive leaders. Refer to Clinical Initiative Appendix 2 – Nursing Executives Leadership Initiative.

Because the CDCR did not have an appropriate job classification for the Director of Nursing at local facilities, Supervising Registered Nurses (SRN) II and III, with or without management experience, were given the job designation. The Nursing Executive Leadership Initiative will establish a patient-focused nursing infrastructure with job descriptions that have set minimum qualifications and proposed compensation appropriately in order to attract the most qualified nursing executive candidates from the health care industry. Nursing leadership is a critical prerequisite to the success of other initiatives aimed to improve the delivery of patient-centered care throughout the prison system.

The Nurse Executive initiative aims to inoculate the current system with qualified nursing leaders by placing these leaders at all levels of the organization with potential capacity to function as change agents. The qualified Nurse Executives will provide mentorship to local nursing teams and develop new, emerging nurse leaders. The pilot sites will serve as future sites to mentor and train new Nurse Executives in a supportive culture. During the pilot, these new

positions will be posted internally and externally for qualified applicants. The incumbents will be eligible to apply for these new positions in a competitive process.

PROGRESS TO DATE

The Receiver's team has developed a new Nursing Executive civil services classification in collaboration with the State Personnel Board (SPB). The Nursing Executive (Safety) classification, which was adopted by the SPB on October 22, 2007, will define a set of minimum qualifications and requirements for all levels of Nursing Executives from the local institution to the headquarters. Appointees will start as two-year limited term (may be terminated with or without cause) civil service employees and be converted into permanent employees subject to a one-year probation period.

THE WAY FORWARD

The Nurse Executive Classification and salary range for each level requires approval by the Department of Personnel Administration (DPA). Refer to Clinical Initiative Appendix 3 - Nursing Executive Classification/Specification. Should DPA not approve appropriate, competitive salaries for these positions, the Receiver will request the appropriate waivers of State law to assure successful recruitment. This executive classification will first be piloted at the three regional levels and three institutions before extending to other institutions.

The pilot project will test three key components:

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

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

The Office of the Receiver will engage an external evaluation team to ensure objective review and feedback. Evaluation measures will be primarily qualitative, focusing on the process of hiring and incorporating Nurse Executives as change agents into the prison health care and custody culture using structured interviews with open-ended questions directed to the Nurse Executive as well as the Nursing and Custody Support Services management and staff. A prototype instrument from this evaluation will be used to implement the Nurse Executive program system-wide.

Six Month Objectives:

- Obtain approval for new salaries from DPA or obtain waiver from Court.
- Begin hiring Nurse Executives.
- Assign a mentor to each new pilot position.
- Hire external evaluator with organizational development and human resources expertise.
- Repeat SPB and DPA process for Physician Executives and begin hiring.
- Repeat SPB and DPA process for Administrators and begin hiring.

Twelve Month Objective:

- Complete evaluation.
- Create a pool of limited-term positions in order to populate local, regional, and statewide leadership positions with qualified, responsive leaders.

Twenty-Four Month Objective:

- Fill 90% of Nurse Executive positions at local regional and statewide levels.

3. HEALTHCARE ORIENTATION AND PRECEPTOR / PROCTORING INITIATIVE

BACKGROUND AND INTRODUCTION

In most health care settings, healthcare employees receive an introduction to the organization through a standardized orientation process starting on day one of employment. Ideally the initial orientation to the organization is followed by a comprehensive preceptor or proctoring program for clinical staff.

CDCR has had no consistent orientation program or practice, leaving new employees at the mercy of a dysfunctional system and resulting in dire consequences for patients in the prisons. Some employees, often new to correctional health care, may have been shown to a yard clinic and left to fend for themselves. Their subsequent assimilation into the CDCR culture has been caustic both to patients and to their own professionalism. The lack of initial guidance has led to disjointed communication, frustration of newly-hired individuals, high attrition rates, and most importantly, poor-to-lethal patient outcomes.

Orientation for new healthcare staff is currently directed by individual facilities using a variety of materials with no standardized curriculum or processes. A few facilities have strong nursing staff developers with creative nursing orientation programs, but there is no effective evaluation of whether the newly-hired nurses and other health care staff are oriented in a timely and effective manner. Currently individual facilities have no formalized preceptor or proctoring program.

The recent conversion of the Medical Technical Assistant (MTA) class to the Licensed Vocational Nurse (LVN) class has resulted in an influx of newly hired LVNs with various start

dates. The majority of the newly hired nurses did not begin orientation on the initial date of employment; indeed, many of the facilities were not equipped with the resources, *i.e.* nurse instructors and identified preceptors, to conduct an effective orientation program-or any program at all.

There is obviously a need for a new approach, one that will provide an introduction to the correctional health care system within CDCR, set the mark for learning best practices, and promote a positive and professional work environment.

PROGRESS TO DATE

The Office of the Receiver and CDCR staff members completed a standardized nursing orientation curriculum including a train-the-trainer component and utilization of a uniform facilitator's manual.

The curriculum has been expanded to include other health care staff including physicians and other allied health professionals, consistent with POA Objective A.8:

> Develop a human resources program focused on providing patient-centered health care services based on industry standards that effectively manage staffing, compensation, job descriptions, competency, performance evaluation, professional development, and training in collaboration with clinical teams or other subject matter experts.

Specifically, the objective aims to restore and standardize competency levels of clinical staff based on health care industry standards; review and revise orientation programs including appropriate health care information and specific orientation for providers, nurses, and ancillary clinical staff; and develop a centralized approach to education and training in collaboration with academic institutions. The orientation program will facilitate clinical transformation in the use of evidence-based, standardized processes that result in quality outcomes.

THE WAY FORWARD

New healthcare staff including Licensed Vocational Nurses (LVN), Registered Nurses (RN), Doctors of Osteopathy (DO), MDs, Physician Assistants (PA), and Nurse Practitioners (NP) will be oriented at the pilot sites starting on day one of employment, utilizing a standard curriculum based on adult learning principles. Start dates for new employees will coincide with day one of the orientation program. The training shall be completed prior to providing services to any inmate/patient.

The training incorporates mandated topics covered in the present 40-hour, Institution In-service Training (IST) New Employee Orientation and a comprehensive overview of the provision of healthcare within the correctional environment, thereby streamlining required training into a single health care orientation program.

The training shall include measurement and evaluation components to guide system improvement, accountability, and effectiveness and to ensure comprehension and retention of critical subject matter.

The selected pilot sites are: 1) Central California Women's Facility (CCWF), 2) California Substance Abuse Treatment Facility (SATF), 3) Richard J Donovan (RJD), 4) Solano State Prison (SOL), and 5) Mule Creek State Prison (MCSP). The pilot sites were selected based on the availability of demonstrably competent, dedicated nursing staff developers/nurse instructors at each of the chosen facilities. The evaluation results will be used to improve the program prior to executing statewide implementation.

This orientation and preceptor/proctoring program will start with one week of standardized general healthcare orientation, followed by 20 days of Preceptor Program for nursing and approximately 15 days of Proctoring Program for medical staff. The entire program will be introduced, evaluated and modified in the five pilot sites prior to system-wide implementation.

The Healthcare Orientation and Preceptor/Proctoring Initiative will standardize the orientation curriculum including a train-the-trainer component and utilization of a uniform facilitator's manual. The proposed orientation program necessitates cross-functional coordination between nursing and medical services, custody recruitment, and human resources departments to ensure timely, consistent start dates that coincide with day one of the orientation plan. The Healthcare Orientation and Preceptor/Proctoring Initiative will also explore the deployment of virtual learning sessions using IT-assisted learning modalities in Phase II of the pilot.

The program will initially focus on testing the aforementioned train-the-trainer program. The orientation will be scheduled in coordination with Personnel Department on the first Monday of the each month. An additional orientation session to start on the third Monday of each month will be scheduled if required to accommodate new hire volume. The first two pilots will be conducted sequentially with a period of evaluation and analysis. Detailed project materials include a Nursing Orientation Pilot Site Assessment, Implementation Worksheet, and orientation curricula.

The pilot program design consists of two components. The first component is orientation to the organization as a whole, including custody and healthcare, with respect to its purpose, mission and vision. As previously indicated, the scheduling of new employee orientation will be coordinated with the hiring process to ensure that orientation starts on day one of employment. The first week of orientation will occur in a classroom environment, introducing all employees to organizational governance, goals, operating policies and procedures. Although this proposal pilots orientation in a traditional classroom setting, future orientation will leverage distance learning for facilitating individually-paced sessions. The orientation during the first week of employment is frequently referred to as "general" or "core" orientation because the content is applicable to all healthcare employees within the organization.

The second component, a preceptor program for nurses and a proctoring program for physicians, nurse practitioners, and physician assistants, consists of unit- and role-specific orientation. The employee will be matched with a preceptor/proctor at his/her home facility. This component is frequently referred to as "clinical" orientation because it occurs in the patient care environment in which the employee will be assigned to work. A consistent preceptor/proctor will introduce the employee to patient care in the new work environment in a supportive, supervised manner. During this program, the new employee will demonstrate skills required providing safe, appropriate, and effective healthcare to the patients they serve.

Nurse preceptors and primary care proctors are vital to new employees for the successful completion of an orientation program in a health care organization. An effective preceptor/proctor demonstrates a high level of knowledge, clinical proficiency, and professionalism. The preceptor/proctor assists with the transition of the new employee to the clinical environment in order to maintain organizational standards and delivery of high-quality, efficient, and compassionate patient care.

The Primary Care Provider Proctoring Program will be flexible, based on the resources available from the Clinical Support Unit (CSU) and those at the facility. Training and orientation presentations and proctoring may be done by the Chief Medical Officer, Chief Physician and Surgeon, CSU providers, or institutional qualified rank-and-file providers. The pilot period will also allow provider management the opportunity to gather feedback from participants on how to optimally use the available proctoring resources.

The proctoring process for nurse practitioners and physician assistants begins with side-by-side observation of clinical encounters and assessment of skills. If the provider's performance is satisfactory, s/he will advance to participation in tiered clinical settings based on patient care acuity and level of direct supervision. The provider will be monitored by proctor review in each tier and can advance to higher acuity treatment settings if adequate skills have been demonstrated. Specific monitoring tools on which to base assessments have been developed to give objective information to management, provider, and peer-review bodies.

Detailed steps of implementation include:

Administrative

Establish a local interdisciplinary team workgroup including the Institution's Personnel Officer, In-service Training Manager, Regional Director of Nursing, Regional Chief Medical Officer, Local Director of Nursing, Local Chief Medical Officer, Associate Warden for Health Care Services, and the Nursing Staff Developer/Nurse Instructor to develop a working plan that accomplishes the goals and objectives outlined above. Work with Human Resources and Personnel representatives to provide input and recommendations regarding streamlining the hiring process and start dates.

Work Flow Redesign

Evaluate the current orientation processes at the pilot institutions including necessary points of interface between the IPO, IST, and Nursing Staff Developer/Nurse Instructor. Establish a flow of information and critical elements commencing from the point of

acceptance of employment through the training process, terminating with completion of orientation and data tracking.

Staffing
Request appropriate allocation of nurse instructor and clerical support positions. Ensure pilot institutions are staffed with positions prior to implementation to ensure adequate support for project success. Explore rotating nurse instructors to promote cross-training and sharing of best practices.

Technical Support
Ensure adequate audio visual support such as lap top and projector, computer access and establish a standardized tracking program. During the planning phase, the team will assess information system (IS) capacity for teleconferencing, web-base virtual learning, and/or computer assisted self learning module for consideration technology assisted orientation program.

Workspace
Ensure adequate space for education with appropriate equipment and supplies.

Personnel Management
Obtain participant evaluation of the program and identify any concerns and complaints during and immediately following implementation.

The orientation program will be designed with the consideration to accommodate virtual learning methodology in the future where the orientation can be conducted centrally with local facilitation using teleconferencing or web-base virtual learning technologies. The virtual learning approach is contingent on the timing of the information technology (IT) infrastructure deployment. An orientation program using virtual learning technology will be developed in collaboration with the IT department during the Phase II of the orientation design.

Six Month Objectives:

- Based on information gathered from the interdisciplinary team workgroup, design a training approach and mechanism for communication and tracking that will meet the needs of the Health Care Services Division, Employee, Institution Personnel Officer (IPO), and In-Service Training (IST) Manager.
- Begin the pilot Healthcare Orientation and Preceptor / Proctoring Initiative at five pilot prisons.

Twelve Month Objective:

- Complete the pilot Healthcare Orientation and Preceptor / Proctoring Initiative at five pilot prisons and revise curriculum based on evaluation results.

Twenty-four Month Objectives:

- Implement statewide Healthcare Orientation and Preceptor / Proctoring.
- Standardize orientation, training, and professional development programs through the prison health care system for employees of all levels in collaboration with clinical team and other subject matter experts.

Thirty-six Month Objective:

- Develop a human resources program focused on providing patient-centered health care services based on industry standards that effectively manages staffing, compensation, job descriptions, competency, performance evaluation, professional development, and training in collaboration with clinical teams or other subject matter experts.

METRICS

The training shall include measurement and evaluation components to guide system improvement, accountability, and effectiveness and to ensure comprehension and retention of critical subject matter.

% of healthcare staff starting orientation on day one of hire:
Numerator: # of new staff starting orientation on day one of hire
Denominator: # of new staff hired on the start date of the pilot

% of new LVN/RNs completing the full orientation:
Numerator: # of new staff starting orientation day one of hire and completing orientation
Denominator: # of new staff starting orientation on day one of hire

% of new LVN/RNs demonstrating comprehension and retention of critical subject matter through achieving > 85% on post testing components (Nursing only):
Numerator: # of LVN/RNs obtaining > 85% on post testing components
Denominator: # of new LVN/RNs starting orientation day one of hire and completing orientation

% of staff successfully completing new employee probation:
Numerator: # of new staff successfully completing new employee probation
Denominator: # of new staff starting orientation on day one of hire

4. NURSING MEDICATION DELIVERY PROCESS REDESIGN

BACKGROUND AND INTRODUCTION

Maxor is in the process of transitioning each institution to a uniform pharmacy information management system, GuardianRx. This system offers a verifiable data source for medication profiles and MARs statewide, a common formulary, a common pharmacy system of operations, and tremendous boost to inmate medication safety. The success of the pharmacy

system implementation is dependent on interdisciplinary proactive planning, process redesign, training and post go-live support. The nursing medication delivery process is linked to the Maxor GuardianRx system implementation because nurses depend on the system's timely output of data for medication dispensing. The Maxor system produces a Medication Administration Record (MAR) which is used to administer the right medication, to the right patient, at the right time, through the right route. Pharmacists also depend on providers to input new orders in a timely manner. This initiative describes the current pilot and the plan for subsequent Maxor sites.

PROGRESS TO DATE

Given the lessons learned from the initial GuardianRx system implementation at Folsom, the Maxor team recognized the importance of including the users during the planning and implementation phase. The project team is now operating under the following system implementation guiding principles:

- **Patient–Centered** -- Clinical care process requirements will drive the system redesign and technical configuration.
- **Interdisciplinary Process** -- It is essential to include all key stakeholders of the local institution utilizing a facility-wide group process.
- **Standardization** -- Aim to develop standardized policies, procedures and core processes with flexibility to accommodate appropriate institution-specific variations.
- **Data-Driven** -- Ensure measurement of important and appropriate results to drive sound decision making.
- **Realistic** -- Don't let the "perfect" get in the way of "good."
- **Fidelity to Scope** -- Promoting, monitoring, and guarding the project focus and activities to ensure that valuable project resources are directed towards completion of the project objectives/deliverables.

In response to the increasing project scope and long-term focused efforts required by the Maxor GuardianRx system implementation and nursing medication delivery process redesign, nursing leadership has developed a dedicated Clinical Process Improvement Team (Conversion Team) to provide ongoing support to local leadership teams. The Receiver approved the formation of a permanent Team that will include six full time positions -- one project manager, two nursing Quality Improvement (QI) Advisor/Consultants, one analyst, one Office Technician (OT), and one Custody Support Liaison. To date, one office technician (OT), one QI Nurse Consultant and one Custody Support Liaison position is filled with permanent employees. Delays in filling the other positions may be attributed to the unique combined qualifications of clinical and technical expertise required for this team

Mule Creek State Prison's Maxor Pilot Success

GuardianRx was installed in the Mule Creek State Prison (MCSP) pharmacy on Monday September 10, 2007 as planned. The installation in the pharmacy was a success with no adverse impact to patient care. The nursing medication delivery process went smoothly with no patient complaints or interruption to patients receiving the right medications timely.

Based on the lessons learned from the initial conversion challenges at Folsom, MCSP deployed a formalized project management and process improvement approach. MCSP activities for GuardianRx implementation in the pharmacy began the second week of July 2007. MCSP was selected as the pilot site based on the institution's leadership capacity and its pharmacy audit score. MCSP was the only state prison in California that passed the initial pharmacy audits. A collaborative project management and pre-implementation process was established and deployed by Maxor, the Office of the Receiver and MCSP leadership. In addition, MCSP utilized a GuardianRx Site Implementation Assessment Template which has been developed to standardize the medication delivery process. This redesign of the medication delivery process also includes medications for mental health and dental prisoner/patients. Based on the MCSP pilot experience, a "cook-book" or "how-to" manual has been developed to create a standardized approach for GuardianRx pre-implementation preparation and implementation at subsequent prison sites. Refer to Clinical Initiative Appendix 4 – Pharmacy Operating System Implementation Guide.

Post go-live, medical, mental health, dental, custody leaders and team members, as well as the Inmates Advisory Committee, all provided positive feedback. There was no disruption to patient care or custody services. As the result of proactive preparation, the local team was prepared to address the small glitches encountered that were part of the go-live process. The critical success factor was that the local MCSP team was prepared to problem-solve and able to activate contingency plans as needed to address the normal course of information system implementation. Other success factors are described in the Quality Measurement and Evaluation section of the Plan of Action.

California Men's Colony Gearing Up for GuardianRx System Installation

The MCSP experience helped to define a standardized collaborative approach to installing information systems such as the GuardianRx system. The improved pilot process is being tested again at the California Men's Colony (CMC), pilot site #2, to explore ways to shorten the implementation time. CMC will also serve as a test site for the use of the how-to manual to ensure a consistent implementation approach while providing flexibility to accommodate individual prisons' unique mission and space limitations.

Continuing Discovery of New Barriers

California Institution for Women (CIW) was originally selected to go-live on the GuardianRx system in January 2008 using the new project management and process improvement approach. CIW was chosen as the third pilot site because of its high rating in site readiness compared to other prisons in the Southern Regions. The project team was also hoping to gain additional perspectives related to medication delivery process for a female population. Despite the readiness of the local leadership and the pharmacy, deployment at CIW had to be delayed because of the discovery that the current building infrastructure lacks adequate electrical power and telecommunication lines to support the new hardware required for the installation. The new space construction will not be completed until February 2008.

THE WAY FORWARD

As an effort to accommodate the new discovery of the barriers while keeping the project on-track, the third pilot will test implementation approaches for co-located sites. Corcoran State Prison and Substance Abuse Treatment Facility have been selected to serve as the third Maxor pilot. In the meantime, Sacramento State Prison will start full implementation effort in February 2008, and Mule Creek will complete its phase II implementation in March 2008.

The Maxor Pharmacy system implementation and nursing medication deliver process redesign initiative aims to achieve the following objectives:

1. Pharmacy and nurse workflow will be integrated in two distinct and separate phases. The first phase will start with the GuardianRx transition process followed by the second phase of nursing medication delivery process standardization. The nurses will have access to the GuardianRx system using the new Receiver's Healthcare Network during the second phase;
2. Nursing staff will receive adequate training and response time; and
3. Maxor will continue towards achieving their goal without having to wait for full deployment of the new Healthcare Network.

Project Approach and Strategy

The lessons learned at Folsom and recently from CMC and CIW demonstrate the interdependency of the Receiver's Plan of Action initiatives. Before the pre-conversion team activities commence, a review committee including members of the Receiver's Facility Construction Team will provide input based on inspection of building infrastructure and feedback to inform the sequence of the implementation site selection. The complexity of initiatives such as these requires proactive project management, process improvement, and a phased-in strategy.

Details of the standardized project management and process improvement approach are as follows:

1. Establish local interdisciplinary Pharmacy Conversion Team at least 60 days prior to implementation, to meet weekly and to include at least the PIC, DON, HCM, AISA, AW Health Care, and Regional DON.
2. Analyze pharmacy data to determine average number of scripts/day, average number of refills/day, average number of STAT orders, and peaks. Determine workload associated with pharmacy volume.
3. Begin database population, prior to implementation.
4. Organize a "Go/No-Go" meeting/conference call with Maxor, Office of the Receiver, and the local pharmacy conversion team prior to the GuardianRx go-live date.
5. Evaluate local nursing medication delivery process, including the points of interface with pharmacy, and create process flowchart (including timeframes).
6. Identify current pharmacy database and methods of system access used by nursing during the medication delivery process.

7. Redesign nursing medication delivery process post-GuardianRx go-live including manual access to MARs and patient profiles.
8. Apply established process measures and baseline.
9. Create a manual process for providing pharmacy profile printouts to LVNs and clinics on a routine basis.
10. Using pharmacy data (refer to A.1.2.2.), evaluate adequacy of staffing levels in the pharmacy; CO's in medication distribution areas, and nursing. Augment staffing as necessary.
11. Train LVN's on new pharmacy and medication distribution processes prior to implementation.
12. Provide LVNs with a refresher after implementation.
13. Provide access to GuardianRx system through the DCHCS network for pharmacy, medical records, and clerical.
14. Evaluate number and location of existing computer terminals. Augment terminals necessary for GuardianRx access.
15. Evaluate medication distribution sites. Modify sites and local process as necessary.
16. Evaluate equipment/supply needs (i.e. carts/tubs for meds).
17. Evaluate pharmacy space (i.e. adequate table space, storage area).
18. Identify an individual (temporary) to field staff and inmate concerns and complaints during and immediately following conversion.
19. Distribute letter to inmates regarding conversion.

Six Month Objectives:

- Implement GuardianRx System Go-Live in the pharmacy (not in nursing) at Mule Creek, California Men's Colony, Sacramento State Prison, then simultaneously at Corcoran State Prison and Substance Abuse Treatment Facility (co-located facilities).
- Implement GuardianRx System in all nursing medication delivery areas using the Receiver's healthcare network at Mule Creek.

Twelve Month Objectives:

- Implement GuardianRx System Go-Live in the pharmacy (not in nursing) at High Desert State Prison and California Correctional Center (co-located facilities).
- Extend Medication Delivery Initiative to pharmacy in all 33 prisons.

Twenty-four Month Objectives:

- Extend Medication Delivery Initiative to nursing medication delivery areas in all 33 prisons.

5. ASTHMA INITIATIVE

BACKGROUND AND INTRODUCTION

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

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

On October 24, 2007, the Receiver issued a Request for Proposal (RFP) requesting an external team of clinical change and asthma experts to lead an asthma quality initiative within the CDCR.

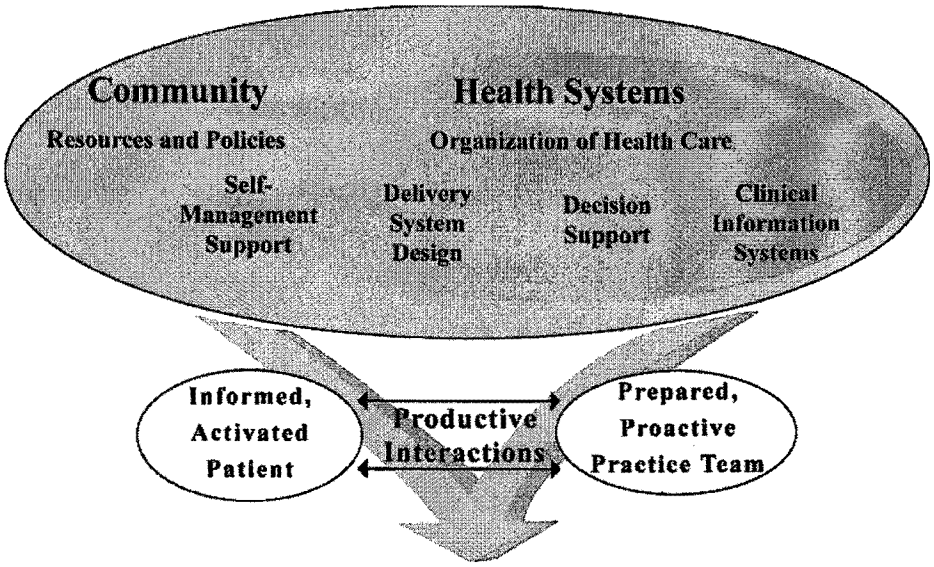
THE WAY FORWARD

The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. Refer to Clinical Initiative Appendix 5 – October 24, 2007 Asthma Initiative Request for Proposals. More than that, however, it will provide a testing ground for implementation of interdisciplinary quality improvement (QI) projects. It will engage all six of the organizational change strategies that the Institute of Medicine considers necessary to improve health care: (a) redesign of care processes based on best practices; (b) use of information technology for clinical information and support for caregivers; (c) increasing and deepening clinical knowledge and skills (d) development of a team-based, rather than a physician-centric, delivery system; (e) coordination of care; and (f) incorporation of performance and outcome measurements for improvement and accountability. The Asthma Initiative will demonstrate how to use data to inform the clinical care process while orienting our providers and management staff to patient safety issues. The end result of this specific disease management initiative will be a heightened awareness of chronic disease management leading to the improved care of other conditions and the beginning of a safety culture.

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

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

The Chronic Care Model



Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books

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

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

---

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

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

address these questions now—in a system with chaotic medical records, pharmacies and laboratories, in which nurses and physicians have rarely worked together in teams, and in which custody and healthcare staff have often worked at cross purposes?

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

The initial Asthma Initiative sites will be selected based on local leadership capacity, organizational resource availability, pharmacy stability, and prior implementation of a pharmacy information system, all factors that will also contribute to success in the Asthma Initiative. The pilot sites chosen will have been exposed to QI tools and process redesign; therefore, these sites are most likely to embrace a QI collaborative pilot and the chronic care model.

Six Month Objectives:

- Engage contractor team.
- Begin Asthma Initiative and finalize initial change package for practice redesign, clinical guidelines, policies, documentation tools, and staff education resources.

Twelve Month Objectives:

- Develop culturally and linguistically appropriate education resources and collaborate with CDCR on appropriate peer education programs for patients with asthma.
- Develop a chronic care team model appropriate for corrections, delineating roles, responsibilities, and measures of team function in the asthma context.
- Pilot an implementation plan for a quality measures, disease registry, care coordination, and case management for patients with asthma.

Twenty-four Month Objectives:

- Implement lessons learned in all 33 prisons.
- Complete evaluation of the Asthma Initiative.

6. EMERGENCY RESPONSE INITIATIVE

BACKGROUND AND INTRODUCTION

The California Department of Corrections and Rehabilitation (CDCR) currently utilizes a variety of internal medical emergency response systems in its facilities, which are not equivalent to the available community standard. As a result, CDCR facilities are not prepared to handle

basic medical emergencies resulting in lack of care, delayed transport, and poor patient outcomes. The emergency medical care of patients (staff or inmates) in prisons is woefully inadequate with significant gaps in pre-hospital and emergency care. (Utilizing county based pre-hospital care services by dialing 911 is a recent development. CDCR staffs in many facilities have not routinely initiated 911 calls until the event has been underway for 20-30 minutes.) Other health care areas are closed down or not covered when RNs respond to emergencies elsewhere in the prison.

The misperception that the Triage and Treatment Area (TTA) is not an emergency care area and that emergency care is not initiated until ambulance providers arrive creates a dangerous practice situation. Further, there is no requirement for the provision of emergency medical care consistent with community standards. Additionally, there are no specific training requirements or competencies for physicians or nursing staff who work in this area. Assignments to this area are based on the post-and-bid procedure without regard to the significant and specialized competencies required of those who provide emergency care. Although there is now a statewide policy for emergency response in prison facilities, there are no mechanisms in place to implement such a policy. Hence, the facilities continue to operate on local, misinformed procedures that vary widely, depending on geographic location, staffing and available resources. There is limited cooperation between medical and custody staff leading to inadequate, fragmented response increasing patient delays to emergency care.

Missing or broken basic emergency equipment and supplies, *e.g.*, Ambu bags and airways, are frequently noted in many of the unexpected death case reviews. There are no policies and procedures outlining the routine review of TTA supply content. There are no healthcare-focused drills in facilities for emergency response—only custody driven safety/security drills.

PROGRESS TO DATE

The Receiver has approved a statewide Emergency Medical Response System policy designed to standardize local emergency responses in every prison facility. This policy is based on American Heart Association (AHA) Chain of Survival, Emergency Cardiovascular Care, and California Emergency Medical Services Authority System standards and guidelines. The scope of Emergency Response pilot will be designed to include staff training programs and mechanisms to develop local preparedness through the creation of a local response team whose members are Advanced Cardiac Life Support (ACLS) certified.

The Emergency Medical Response System policy has been incorporated into the healthcare staff orientation curriculum that will be piloted as part of the healthcare orientation initiative.

THE WAY FORWARD

The Emergency Response Initiative aims to provide those within the California prison system with the same level and quality of emergency medical care as the community receives. The project goals are:

1. Improve emergency medical care and response within the prison setting as described in the statewide policy for emergency response in prison facilities.
2. Improve patient clinical outcomes and decrease unexpected deaths due to lack of EMS care.

Success factors for this project include availability of competent staff for pilot, complete design of internal processes, training of the eight pilot sites and a pilot support team.

Six Month Objectives:

- Identify equipment, supplies, security, location, transport methods by facility.
- Create standardized orientation for clinical providers and RN staff about EMRS policy and staff response.
- Evaluate existing equipment/supplies for TTA/ERs and emergency response bags.
- Standardize EMR equipment, supplies for TTA/ERs in all facilities.
- Create standardize EMR response bags for all facilities.
- Evaluate local facility transport vehicles for moving patients to TTA.
- Designate all clinical staff to have CPR certification within 10 days of hire.
- Establish / reestablish Emergency Response Review Committee (ERRC) at each facility to review all emergency response events.

Twelve Month Objectives:

- Coordinate custody officer emergency response functions with healthcare staff via meetings, education and drills.
- Create sally port log for community Emergency Medical Services (EMS) vehicles.
- Develop tracking system for ACLS annual certification for clinical providers and nursing staff.
- Coordinate with custody officer tracking of BLS annual certification.
- Establish method to obtain community EMS pre-hospital care field reports (PFRs) on ambulance transports of inmates to community facilities to track patient care.

Twenty-four Month Objectives:

- Designate TTA and R&R provider and nursing staff to have ACLS within 6 months of hire.
- Create EMR criteria for TTA, R&R nursing and medical providers-who should respond?
- Develop and implement emergency response training program for clinical and custody staff. (May POA, 2007, page 24)

Thirty-six Month Objective:

- Provide inmates and staff within the California prison system with the same level and quality of emergency medical care that the community receives.

METRICS

The evaluation plan for this pilot project will provide baseline data including volume of emergency patients in the correctional setting, patient complaint/condition assessment, average treatment time, and patient outcome.

The evaluation plan will include baseline data on clinical emergency response performance, in the form of a skills competency checklist, performance expectations in the form of job descriptions, a questionnaire about job satisfaction for the team participating in the pilot project, and a summary of patient outcome data already analyzed by DCHCS.

Data collected will be analyzed in a descriptive and observational format and will include feedback on patient volume, average treatment time, daily staffing matrix and costs and staff satisfaction data.

The Project Team will establish the following prospective, concurrent and retrospective evaluation processes to achieve clinical excellence and customer satisfaction:

1. Prospective – Employee hiring criteria, new employee orientation and training, continuing education, the purchase and use of new equipment, and new or revised policies, procedures, or protocols.
2. Concurrent – In this phase, employees and operations are monitored to ensure that established policies, procedures, and protocols are implemented in practice. Current correctional health care policies, practices, procedures, regulations and documentation for protecting patient safety. This occurs through daily supervision, field observation, and both internal and external audits.
3. Retrospective – Local EMSA data including time of initial notification, time on scene, care provided, equipment used, policies/procedures used, time of completion of care, time patient transferred to TTA or outside ambulance, time scene complete, time arrival in TTA, and/or time arrived at community hospital, and patient outcome.

Additional measurements of the success of this pilot project will be determined by the following criteria, measured prior to, during, and upon completion of the project:

1. Number of sentinel events and/or care quality issues during the duration of the project. Sentinel events will be defined to meet the current Department of Health Services (DHS) criteria. Care quality issues will be subjectively defined and documented by the institution Director of Nursing (DON), Chief Medical Officer (CMO) and the local county EMS medical director.
2. A questionnaire specifically designed to measure the criteria and outcomes of this pilot project's cohorts will be developed by the Project Director. Data will be shared with all participants in this pilot project.
3. Improved EMS response to patients within correctional setting as evidenced by decreased response time.
4. Documentation of non-emergency events that were true medical emergencies.
5. Decrease in preventable deaths.

The monitoring plan for this pilot project will be forwarded to the advisory committee for review. Facility pilot project staff will provide quarterly patient chart audits to monitor care outcomes, paramedic competency maintenance, and ongoing clinical oversight. The facility will be continually monitored by the Project Director to ensure compliance with employment and utilization criteria as listed previously. Quarterly meetings will be held by the designated project lead with all pilot project staff to discuss findings and distribute information to participants.

CLINICAL QUALITY MEASUREMENT AND EVALUATION INITIATIVE (POA OBJECTIVE C.2, C.6 AND C.8)

BACKGROUND AND INTRODUCTION

In the Findings of Fact and Conclusions of Law re Appointment of Receiver ("Findings") filed October 3, 2005 the Court found that "it is an uncontested fact, on the average, an inmate in one of California's prisons needlessly dies every six or seven days due to constitutional deficiencies in the CDCR's medical delivery system." *See* Findings at 1:26-28. The Court went on to find that "this unconscionable degree of suffering and death is sure to continue if the system is not dramatically overhauled." *See* Findings at 2:3-4. The Court found credentialing and peer review to be ineffective, noting that "historically the CDCR would hire any doctor who had 'a license, a pulse, and a pair of shoes." *See* Findings at 31:8-28; 16:1-12; and 8:14. Without question, one of causes that has created the unconstitutional shortfalls in the CDCR's medical delivery system has been an absence of clinical quality, as well as an absence of the infrastructure, policies, and clinical culture necessary to ensure adequate medical quality.

As expected by the Court, throughout the November 2007 Plan of Action the Receiver has proposed metrics and timelines for the progress of the Receivership in transforming the bureaucracy of California's prison medical care system. The focus of this section is not on the full range of the Receiver's organizational goals and objectives but on clinical quality: that is, on the Receiver's progress and plans (1) for a clinical quality infrastructure and (2) for using and reporting patient-level, clinical quality measures. All such clinical measures can be sorted using the Donabedian triad of structure, process, and outcome,[1] although standardized quality measure sets now tend to combine process and outcome measures. An example of a structural measure of quality is whether there is an adequate credentialing system in place. Examples of patient-level, clinical quality measures include (a) access-to-care measures appropriate for corrections, such as timely face-to-face triage by nursing, and (b) nationally-standardized quality indicators, such as use of aspirin for one year after heart attack after heart attack.

STATUS OF THE RECEIVER'S CLINICAL QUALITY MEASUREMENT AND EVALUATION PROGRAM AS OF NOVEMBER 15, 2007

A. The Creation of the Clinical Operations Branch

Although the Receiver originally planned to establish an Office of Evaluation, Measurement, and Compliance, the need to integrate other quality functions with measurement under a single management authority has led to an alternative structure and name. The Receiver has created a Clinical Operations Branch and recruited an administrator

[1] Donabedian, A. 1966. "Evaluating the Quality of Medical Care." *Milbank Memorial Fund Quarterly* 44 (1): 166-203.

with appropriate experience to lead it. The Clinical Operations Branch now encompasses the following:

1. Credentialing and Privileging
2. Peer Review
3. Death Review
4. Medical Oversight (new)
5. Measurement and Evaluation (new)

Credentialing, peer review, and death review are statewide medical staff functions that are currently in place. As discussed in the Medical Staff Professional Development Initiative, the medical staff have struggled with the volume of work in credentialing, peer review, and death review because of insufficient support staff and dysfunctional reporting relationships. The CDCR lacks many of the organizational components that even a small community hospital would take for granted, such as a continuing medical education programs or an ethics committee. The Clinical Operations Branch will provide appropriate structure and administrative support for these functions and an expanding spectrum of statewide medical staff and interdisciplinary committees. The Receiver has created new support staff positions and has brought these functions together in a coherent management structure.

The functions of the originally planned Office of Evaluation, Measurement, and Compliance now fall to the Measurement and Evaluation Unit, reporting to the Chief of the Clinical Operations Branch. The Receiver has authorized and begun recruitment for a CEA position at the PhD level to head the Quality Measurement and Evaluation Unit in the Clinical Operations Branch.

B. Quality Programs Established By the Receiver as of November 15, 2007

INTRODUCTION

Following brief discussions of credentialing and peer review, this section will describe progress on death reviews; then the Receiver's new Medical Oversight Unit; then the diverse measurement activities and plans, including current and future use of *Plata* remedial plan (QMAT) measures and external institutional inspections by the Office of the Inspector General.

CREDENTIALING AND PRIVILEGING

Representatives from medical, mental health, and dental services have formed a new Credentialing Committee. The Receiver has negotiated purchase of an online software program to support credentialing of all three services as required by the *Plata, Coleman* and *Perez* courts. This software will make the original credentialing process faster and more reliable. It will also facilitate tracking of required licenses, certification, and continuing education.

Achieving an adequate two-year re-credentialing process, however, will require significant new quality and peer review resources. The 2007 Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards make it clear that re-credentialing should involve evidenced-based validation of a provider's knowledge, skills, ability, and behavior. Reorganization of credentialing, peer review, and performance measurement functions with additional support staff under the Chief of the Clinical Operations Branch will facilitate achievement of this re-credentialing standard.

Six Month Objective:

Implement credentialing software program to facilitate initial credentialing and ongoing tracking of required licenses, certification renewals, and continuing education.

Twenty-four Month Objective:

Incorporate evidenced-based validation of a provider's knowledge, skills, ability, and behavior into provider re-credentialing.

PEER REVIEW

The Professional Practice Executive Committee (PPEC) has sustained a high level of activity with regard to ensuring patient safety, investigating incidents of potential clinical misconduct and conducting pattern-of-practice reviews when appropriate. Equally important, PPEC has launched a series of activities—summarized in the Medical Staff Professional Development Initiative—that focus on professional education and provider support. PPEC's Mid-Level Provider Subcommittee, for instance, will address issues of recruitment, privileging, proctoring, supervision, and best practices with regard to nurse practitioners and physician assistants. These objectives for peer review are detailed in the Medical Staff Professional Development Initiative.

A motion to reform the PPEC disciplinary process while preserving physicians' due process rights is pending before the Court, and the Receiver has received approval from the Court to contract with consultants to implement the new process, as appropriate, after the Court rules on the pending motion.

Six Month Objective:

1. Modify the PPEC disciplinary process after the Court ruling.
2. Implement the modified PPEC disciplinary process.

DEATH REVIEW

Given the earlier testimony about preventable deaths in the CDCR, an obvious question is whether that number of deaths is continuing. To explore this question, the Receiver commissioned a consultant "to categorize each of the 2006 deaths as non-

preventable, preventable, or possibly preventable, to summarize the major lapses in care (both individual and systemic) contributing to the patient deaths, and to make recommendations for quality improvement." The full analysis[2] describes the methodology used. Refer to Clinical Quality Measurement and Evaluation Initiative Appendix 1 – August 20, 2007 Analysis of CDC Death Reviews 2006.

Of 426 deaths in 2006, 66 of them were preventable (18 deaths) or possibly preventable (48 deaths). Among the 315 non-preventable medical deaths, more than half reflected lapses in care that may have contributed to premature death or unnecessary suffering. Asthma was the most common cause of preventable death. A total of six inmates died because of "failure of clinicians to follow published guidelines and standards of care in the evaluation and management of asthma, failure of RNs to appropriately triage sick asthmatics to an MD, failure to ensure timely follow-up after treatment of an acute exacerbation, failure to recognize the volatility of symptoms, failure to refer refractory asthma to a pulmonologist, and a botched handoff in which a steroid dependent asthmatic did not receive steroids for two days following transfer from a county prison to a CDCR facility."

As described in the death review analysis, the exact numbers of preventable or possibly preventable deaths should be considered with caution:

> There are no established criteria for attribution of "preventability." Research in this area is primarily epidemiological, comparing actual versus expected deaths in large populations over time. A search of the medical literature revealed no case-based studies for preventable deaths in adult primary care. Such studies would be difficult precisely because creating rigorous criteria for preventability would be difficult. Another limitation of this analysis is that it depends wholly on the judgment of a single reviewer. For example, several of the sudden cardiac arrests were judged to be possibly preventable because of a failure of clinicians to evaluate symptoms of syncope or chest pain in the weeks or months prior to the patient's death. Another reviewer might have judged these deaths to have been non-preventable, because there is no assurance that a proper evaluation of these red flag symptoms would in fact have prevented the patients' deaths.... In short, there is no easy methodology that can reliably quantify preventable deaths.

The analysis found that, "[d]espite the limitations in the death review process, it has proven useful in identifying many egregious examples of individual errors in judgment and failures to perform commensurate with community standards." The analysis describes this utility as follows:

> The death reviews were valuable in identifying potentially unsafe practitioners. As one step in its practitioner assessments, PPEC conducted pattern of practice reviews for these individuals. Typically, the reviewer assessed a large sample of patient care interactions (usually 40-60 patient charts, including the index death case and any other

[2] Imai K. Analysis of CDCR Death Reviews 2006. August 20, 2007. Found at: http://www.cprinc.org/resources_other.htm.

deaths involving the clinician) for adherence to a community standard of care. After considering evidence from multiple sources, PPEC took one of several actions:

1. Temporary restriction from practice in the CDCR, pending a complete review of the clinician's pattern of practice
2. A program of remediation, e.g., taking a course in an area of deficiency, followed by close monitoring
3. Suspension of privileges
4. No adverse action.

As of July 2007, 62 CDCR practitioners (56 MDs and DOs and 6 Nurse Practitioners) have had adverse action taken by the PPEC. Of these, 41 were initiated by the death reviews.

While the individual death reviews have obvious utility, comprehensive analysis adds additional value. However cautious we should be about the exact numbers of preventable deaths, the imperatives drawn from this analysis are compelling:

> The CDCR must create a culture of patient safety, in which clinicians readily identify mistakes and system vulnerabilities and in which all staff share in the responsibility for optimal patient outcomes...
>
> To that end, the Death Review Committee should continue in on-going fashion the analyses piloted in this analysis, identifying not only individual performance issues but also the most common systemic lapses in care. The Committee should begin to standardize a list of the lapses and vulnerabilities that contribute to preventable deaths. The Joint Commission provides examples of how to proceed in this area, *e.g.*, in categorizing the causes of sentinel events or specifically the causes of delays in treatment (see the Sentinel Event Alert of June 17, 2002). The Committee should continue its efforts to standardize its methodology for classifying preventable deaths.

The analysis goes on to make specific recommendations regarding PPEC, communicating the lessons derived from death reviews, asthma management, mid-level practitioners, abnormal test reporting, appeals, specialty services, emergencies, health information, and ethics. All of these concerns are reflected in the Receiver's Plan of Action, and the Death Review Committee has begun to improve and standardize its processes.

While still in early pilot phase, this death review process and analysis have had a significant impact in focusing attention on asthma and on system failings overall. Mortality data per se have a limited role in tracking performance and guiding improvements because the numbers involved are often too small and change too slowly for valid statistical comparisons. Be that as it may, the Receiver is convinced that the benefits of vigorous death review and analysis are significant and plentiful.

Specifically, the Receiver will commit resources to the Death Review Committee in order to standardize the determination of preventable *vs.* non-preventable deaths. While such

determinations in ambulatory care may not meet rigorous standards, they serve to focus attention on meaningful questions and issues. In combination with performance measures, peer review, sentinel event reviews, and the lessons learned from the Medical Oversight Unit, the death review process will continue to guide improvement initiatives.

Six Month Objectives:

1. Standardize the Death Review Committee criteria for preventability of deaths.
2. Implement policies and practices to ensure coordination between the Death Review Committee and the Medical Oversight Unit.

Twelve Month Objectives:

1. Standardize the list of the lapses and system vulnerabilities that contribute to preventable deaths.
2. Produce another death review analysis with improved methodology for determining preventability and with expanded lessons learned.

MEDICAL OVERSIGHT UNIT

Introduction

Unfortunately, although the Death Review Analysis praised the "many conscientious providers and RNs who are doing a good job despite the environment," individuals still make egregious deviations from good care. In addition, some clinical and support staff employees of CDCR, as in other organizations, routinely commit deliberate and serious violations of organizational policy, at times of a criminal nature. The CDCR culture of silence, collusion, and low expectations and the paucity of trained local managers have made it difficult to identify and document such behaviors. Furthermore, California's State employment practices often make it difficult to extricate deviant individuals from the workplace. The problem with CDCR medical care is not the unusual number of its "bad apples;" rather, the problem is that getting rid of even a single bad apple from the bureaucratic barrel can sometimes require massive efforts on a scale appropriate to the Army Corps of Engineers. CDCR management has had neither the time nor the wherewithal to mount such efforts on a routine basis. Furthermore, even after massive efforts to dismiss incompetent or derelict staff, the State Personnel Board has all too often returned these rotten apples to the barrel.

Court-ordered CDCR reforms over the past decade, triggered by inappropriate use of force, have led to significant improvements in investigations and discipline within custody. The Office of Internal Affairs (OIA), which has authority to investigate allegations of CDCR employee misconduct, has developed a Central Intake Unit to process and track these allegations. Participating in the Central Intake Unit are the (1) Employment Advocacy and Prosecution Team (EAPT), which is a unit within CDCR's Office of Legal Affairs responsible for the Vertical Advocacy Model, and (2) the Bureau of Independent Review (BIR), which is a unit within the Office of the Inspector General responsible for public oversight of CDCR's investigative and disciplinary processes.

Without healthcare input, however, the OIA's Central Intake Unit has often been flummoxed by allegations of misconduct concerning healthcare staff and by medical terminology, medical charts, and medical processes. In 2006 the OIA reviewed 270 requests for investigations (RFIs) involving healthcare and custody staff, of which 101 involved only healthcare classifications.

a. Changing the CDCR Culture

The difficulties of this situation with California prison healthcare are not unique. Rather, they dovetail with major issues within mainstream healthcare. Patient safety has been the most significant clarion call and movement in American healthcare over the past decade. Within patient safety, the most significant development has been the "just culture" movement. An influential paper in 2001[3] introduced the issues as follows:

> Today, most corporate disciplinary systems literally prohibit human error. That is, mere human error, when coupled with harm to a patient, will raise the specter of social condemnation and disciplinary action. Advances in patient safety, especially when involving the management of human error, depend upon our collective ability to learn from our mistakes – whether they are near misses or mistakes resulting in actual harm to a patient. To promote a culture in which we learn from our mistakes, organizations must re-evaluate just how their disciplinary system fits into the equation. Disciplining employees in response to honest mistakes does little to improve overall system safety. Yet, mishaps accompanied by intoxication or malicious behavior present an obvious and valid objection to today's call for blame-free error reporting systems.
>
> It is through the lessons of our everyday errors that we can design our work environment to be less error prone and more error tolerant. Few people are willing to come forward and admit to an error when they face the full force of their corporate disciplinary policy, a regulatory enforcement scheme, or our onerous tort liability system. To collect productive investigative data, we must promote a culture in which employees are willing to come forward in the interests of system safety. Yet, no one can afford to offer a "blame-free" system in which any conduct can be reported with impunity – as society rightly requires that some actions warrant disciplinary or enforcement action. It is the balancing of the need to learn from our mistakes and the need to take disciplinary action that this report addresses. Ultimately, it will help you answer the question: "Where do you draw the disciplinary line?"

Federal agencies and the Joint Commission have promulgated just culture principles. Key to implementation is distinguishing "knowing violations" from three classes of human fallibility: human error (inadvertent), at-risk conduct (taking shortcuts leading to increased risk), and reckless conduct (choosing to put someone in harm's way).

---

[3] Marx D. Patient safety and the "just culture": a primer for health care executives. April 17, 2001. Prepared for Columbia University under a grant provided by the National Heart, Lung, and Blood Institute. Available at: www.mers-tm.net/support/marx_primer.pdf.

Healthcare delivery systems have begun implementation of just culture principles not from some sense of fair play but because the alternatives have not worked. Finding someone to blame after each bad outcome, also known as "hanging a carcass on the door," has not reduced bad outcomes. Sentinel event investigation practices that looked only for system vulnerabilities, not human behavior, have likewise failed.

The death review analysis described above and the new PPEC-generated activities described in the Medical Staff Professional Development Initiative signal a new level of understanding about staff behavior and outcomes and a shift toward a culture of appropriate accountability.

b. Medical Oversight Unit Accountability

The Receiver's pilot of the Medical Oversight Unit will integrate the CDCR accountability processes developed in the Central Intake Unit with the principles and practices of just culture. The assigned CDCR medical and nursing leaders will learn and teach proper investigation techniques and the sometimes arcane regulations of employee discipline. They will modify the CDCR Employee Disciplinary Matrix[4] to be clinically relevant. They will help the Office of Internal Affairs reduce the burden and backlog of allegations regarding healthcare staff. And they will learn and disseminate patient safety principles and practices.

Preparatory work has already begun on the pilot. In May 2007 CPR/CDCR medical and custody representatives participated in formative discussions of California's "Bright Line Project," which aims to create and disseminate a set of patient safety guidelines and scenarios and help health care leaders determine when to report professionals to their respective boards. The Medical Board of California, the California Board of Registered Nursing, and the California State Board of Pharmacy have been participating in these discussions.

In June 2007 the Receiver hired an Investigation and Discipline Coordinator to monitor healthcare investigative and disciplinary activity. The Coordinator has organized both statewide and local trainings for medical, nursing, and administrative leadership, including Maxor. In addition, he has held meetings with employee relations officers, Investigative Services Unit lieutenants, sergeants, and investigators to discuss criminal misconduct, emergency investigation requests, administrative time off, and specialty investigations, *e.g.*, involving computer forensics. One major investigation has already paired a Regional Chief Medical Officer and Regional Director of Nursing with OIA investigators in planning and carrying out the investigation.

In order to better understand the frequency and type of misconduct occurring at CDCR institutions, the Receiver has implemented a statewide system to track the healthcare-related investigations of misconduct by healthcare and correctional staff. The tracking system requires institutions to provide a monthly Investigation and Discipline Audit Report (IDAR)

[4] CDCR Department Operations Manual, Chapter 3, Article 22, page 19

on all cases involving medical employees, providing information concerning the number, type and outcome of investigations, as well as any discipline associated with those investigations.

c. Goals of the Medical Oversight Unit

The goals of the Medical Oversight Unit in this pilot initiative are as follows:

1. Improve patient safety by identifying and addressing misconduct among staff in the CDCR medical care system, distinguishing knowing violations, at-risk conduct, reckless conduct, and human error.
2. Derive and disseminate lessons learned from investigations regarding employee behavior, system vulnerabilities, and patient safety.
3. Enhance legal support and communication for each hiring authority.
4. Increase CDCR's and Receiver's ability to control and monitor investigative activities statewide by centralizing tracking of medical employee disciplinary matters.
5. Reduce the potential of lawsuits by employees, prisoner/patients, and the public by addressing misconduct in a thorough, timely, and judicious manner.
6. Increase the success of appropriate employee discipline, reducing the number of appeals overall and the number of successful appeals in particular, enhancing settlement prospects, and reducing civil litigation.
7. Standardize settlement guidelines for cases involving medical employees.

d. Staffing and Process

The Medical Oversight Unit will be led by a Chief Medical Officer working in concert with a lead nurse and reporting to the Chief, Clinical Operations Branch, who reports directly to the Receiver's Chief Medical Officer. These lead clinicians will be responsible for initial "scoping" of potential misconduct, for leading Central Intake Unit discussions involving clinical incidents, and for coordinating clinical staffing of the investigation teams.

For the initial pilot, three to six physicians and three to six nurses will be trained to do investigations. The physicians or mid-level practitioners will be drawn from the Clinical Support Unit (formerly known as QMAT) and the nurses will be drawn from the Nurse Consultant Program Review ranks or other specialized positions. While these clinicians will have other duties as part of their regular job assignments, when they are called for investigations they will commit 100% of their time to their investigatory role as needed until the investigation is complete. In addition to their investigatory work for the Medical Oversight Unit, these clinicians will also be responsible for learning and teaching the science of safety and human factors, the principles of just culture, and the techniques of sentinel event review and root cause analysis.

Representatives from the OIA and the EAPT will participate in the weekly Central Intake Unit discussions of potential misconduct by clinicians. The OIG's BIR has agreed to conduct independent oversight of the new OIA and EAPT units using the same model (real-time monitoring) that the BIR now employs for CDCR investigatory and disciplinary matters pursuant to the *Madrid* Remedial Plan. EAPT will dedicate staff to performing expedited

disciplinary actions against staff if warranted. BIR will report its assessment of the above components on a semi-annual basis.

On October 9, 2007, the Receiver approved the OIA, EAPT, and BIR's staffing proposals and instructed the offices to begin hiring. Recruitment for the Chief Medical Officer has begun. The Receiver has directed that the pilot project begin as soon as January 1, 2008.

For the pilot, the Medical Oversight Unit will focus particularly on OIA investigation requests regarding CDCR employees involved in unexpected deaths. The lead clinicians, in concert with the other representatives in Central Intake, will decide whether an investigation is appropriate and whether the case should be referred to peer review and/or the hiring authority. They will define the focus, range, and urgency of initial investigations.

Whereas the average investigation completed by OIA currently takes approximately 174 days, the Medical Oversight Unit will generally operate on a 90-day timeframe with 60 days allotted for the investigation and an additional 30 days to consult with the hiring authority and to draft and serve the employee with adverse action, if necessary.

When an investigation is potentially appropriate, agents, clinical staff, and the Vertical Advocate will travel to the site for initial review and begin investigation if appropriate. The staff will provide a detailed case briefing to the Receiver within the first 21 days of the case initiation or receipt of the request for investigation. The briefing will recommend continuing the investigation or yet another disposition.

The Medical Oversight Unit will be responsible for training staff in the institutions relative to initial response to the incident and communication with other responding personnel. The Medical Oversight Unit will also facilitate coordination of criminal investigations and any subsequent prosecution with other criminal justice agencies, including local law enforcement and District Attorneys' offices, the California Office of the Attorney General and the Federal Bureau of Investigation, when appropriate.

Six Month Objectives:

1. Hire initial Medical Oversight Unit clinical and non-clinical staff and begin pilot.
2. Modify the CDCR Employee Disciplinary Matrix to be clinically relevant.
3. Train clinicians assigned to Medical Oversight Unit in investigation techniques, the science of safety and human factors, the principles of just culture, and the techniques of sentinel event review and root cause analysis.

Twelve Month Objectives:

1. Develop a train-the-trainer program to be led by the assigned clinicians assigned to Medical Oversight Unit.

2. Submit a formal evaluation of the Medical Oversight Unit pilot to the Receiver, including quantitative and qualitative assessment of progress toward the stated goals.

MEASUREMENT AND EVALUATION IN QUALITY IMPROVEMENT

Introduction

In 2001 the Institute of Medicine (IOM) identified one of its six essential strategies for health care transformation as "the incorporation of performance and outcome measurements for improvement and accountability." The scoring system of the Baldrige Health Care Criteria for Performance Excellence[5] grants 540 of its 1000 points to either "Results" or "Measurement, Analysis, and Knowledge Management." Baldrige describes the value of "management by fact" as follows:

> An effective health care service and administrative management system depends on the measurement and analysis of performance.... Performance measurement should include information on health care outcomes; community health; epidemiological data; critical pathways, care bundles, and practice guidelines; administrative, payor, workforce, cost, and financial performance; competitive or collaborative comparisons; customer satisfaction; and corporate governance and compliance....
>
> Analysis refers to extracting larger meaning from data and information to support evaluation, decision making, and improvement. Analysis entails using data to determine trends, projections, and cause and effect that might not otherwise be evident. Analysis supports a variety of purposes, such as planning, reviewing your overall performance, improving operations, accomplishing change management, and comparing your performance with competitors', with similar health care organizations', or with "best practices" benchmarks.

While the necessity for functional data systems is undisputed, achieving that goal within CDCR is a daunting challenge. In addition to all the other dysfunctions, the October 3, 2005 Findings found that "Data management, which is essential to managing a large health care system safely and efficiently, is practically non-existent." *See* Findings at 6: 18-19.

Prior to the Receivership, the clinical quality measurement strategies of the *Plata* remedial plan, while well-intended, were doomed to an early demise. The June 2002 Stipulation for Injunctive Relief called for monitoring compliance with an extensive set of new policies and procedures using an audit instrument. Quality Management Assistance Teams (QMAT) of physicians, nurses, and support staff were assembled to descend upon individual prisons for a weeklong inspection and audit. The QMAT audit instrument was designed to generate over 200 indicators, some from an electronic tracking system, most from manual chart reviews.

---

[5] Baldrige National Quality Program. *Health Care Criteria for Performance Excellence*, 2007.

The *Plata* remedial measurement strategy suffered from multiple flaws. The electronic tracking system consisted of unconnected, unsupported Access databases that soon varied from location to location and contained unreliable data. In addition to being overwhelming in number, the individual measures were unvalidated and yielded results that often flew in the face of direct observation. The attempt to average all the measures into a composite score was wholly uninformed and misguided. Most critically, the findings, even had they been trustworthy, were not actionable. The available infrastructure, even when headed by competent managers, was utterly incapable of supporting the development and implementation of appropriate interventions. The QMAT audits collapsed under their own weight in 2005, offering scant contribution toward improving care.

Until the Receiver's plans for new information systems come to fruition, measurement efforts must continue to operate in this data wasteland. Abt Associates, commissioned by the Receiver to do a needs assessment for chronic and long-term care,[6] launched heroic attempts to gather electronic demographic and clinical data on prisoner/patients, then concluded that CDCR faces "an urgent need... to improve information technology infrastructure and replace obsolete and homegrown data systems with systems that support case management and quality measurement across the state."

> The health-related data systems throughout CDCR suffer from (1) a lack of standards, policies, and procedures for data management, (2) a lack of infrastructure for integration and interoperability among facilities across the state, and (3) an over-reliance on ad hoc, labor-intensive efforts to extract information and reconcile discordant information across multiple legacy data systems, all of which results in poor data quality, overworked staff, and a missed opportunity to provide quality health care.

While these realities are sobering, the Receiver's team will pursue multiple measurement strategies even before new information systems are functional. The Receiver has authorized a CEA position at the PhD level to head the Quality Measurement and Evaluation Unit in the Clinical Operations Branch. Trained in epidemiology, this person will be responsible for developing and sustaining organizational capacity for fact-based management, supervising scientific and non-scientific staff to support a spectrum of sorely-needed quality measurement and evaluation programs. Recruitment for this position has begun.

a. Data for Improvement

Improvement efforts can succeed using "quick-and-dirty" data that may lack the requisite rigor to yield reliable comparisons over time or between institutions. The IOM quotation above makes a distinction between data for accountability versus data for improvement. The rule of thumb used to guide day-to-day decisions in quality initiatives is

[6] Abt Associates. Chronic and Long-Term Care in California Prisons: Needs Assessment. August 31, 2007. Found at: http://www.cprinc.org/resources_other.htm.

that one needs only enough data to convince a benevolent skeptic. The Nursing Medication Delivery Process Redesign Initiative offers one illustration.

As Maxor converts CDCR's inadequate pharmacy information system to GuardianRx, nursing staff must dispense with the work-arounds previously used in their medication delivery process. From one day to the next, as the system goes live, nurses must change dozens of steps in their work flow. The Receiver's team has organized a conversion team to prepare each institution and facilitate the change process. The nurses developed three simple measures to track their progress in real time:

1. Perceived missing Medical Administration Records (MARs)
2. Perceived missing medications
3. Perceived incorrect MARs

Front-line nurses create these data by making hash marks on a form throughout their work day. The pharmacy staff, assisted by their information system and working with established protocols, collect different and more rigorous data regarding medication errors.

One month after implementation at Mule Creek State Prison, the nursing data showed 84% improvement. In the context of other observations of local and regional managers, these data were credible. It is important to note that the measures were developed for a specific purpose by clinicians directly involved in a planned organizational change, a change facilitated by a dedicated, competent, and enthusiastic external team. It is particularly important to note how the data collection was interwoven with and supportive of the change effort. The following is a verbatim list of success factors informally noted by a member of the Conversion Team in anticipation of the going to the next site:

- Strong clinical, administrative, and custody leadership at Mule Creek.
- Lots of communication.
- Continued nurse manager ownership of results for their assigned areas
- Maxor dedication of a problem-solving staff position to handle reports of missing meds and MARs.
- Positive, team-oriented, "can-do" attitude—unconditionally my #1 vote for greatest contributing element to project success.
- Consistent, ongoing local CQI efforts.
- Using ongoing data measures to provide decision-informing and progress-confirming feedback (the strength of the feedback loop).
- Support and guidance from headquarters.
- Diligence, persistence, and belief that with continued hard work and focused attention the strength of the system itself (GuardianRx software plus new processes and infrastructure) will begin to work through some of the earlier bugs and inefficiencies.

The nurses developed and owned this data strategy and made it work in service of better performance and better outcomes.

b. Data for Improvement and Accountability in Management Context

Nurse Consultants[7] in the Central Region have been using a periodic data-gathering strategy that makes use of selected QMAT audit indicators. They performed audits of Receiving and Release at all 12 Central Region institutions between November 2006 and February 2007, recording the following indicators:

- Whether new arrivals:
  - Came with a Unit Health Record
  - Came with an Information Transfer Form
  - Had a screening form in chart and appropriately completed
  - Had a screening form appropriately completed
  - Were seen by RN if so triggered during LVN/LPT screening
  - Got a history & physical exam within 14 days
  - Had appropriate TB screening documented
  - Had appropriate disposition by RN
  - Had appropriate intervention by RN
  - Got provider-ordered interventions within required time
  - Got any urgent or emergent referrals within required time

- Whether the facility:
  - Had a functioning intake tracking system
  - Had a private screening process

The Nurse Consultants did an exit conference with the supervisory nurses following each audit and reiterated the importance of the findings in later Regional Meetings, with good impact. However, they did formal follow-up audits in June/July and found slippage on some items. This time they trained the supervisory nursing staff how to do their own audits, and they invited the supervisory nurses, Director of Nurses, Chief Medical Officer, and Health Care Manager to each exit conference.

In June and July the Central Region Nurse Consultants turned their attention to the primary care clinics and did similar audits using the following indicators:

- Whether patients prioritized as urgent during face-to-face encounter were seen by PCP on the next calendar day.
- Whether patients prioritized as routine during face-to-face encounter were seen by PCP within 14 calendar days
- Whether the RN face-to-face encounter:
  - Had documentation of an adequate history
  - Had appropriate vital signs and other relevant data
  - Had an assessment reflecting the patient's complaint and including appropriate nursing diagnoses

[7] Nurses in the classification of Nurse Consultant Program Review were formerly in QMAT.

    - Had nursing plan with consultation with or referral to a physician, scheduling a clinic appointment, and/or providing care per nursing protocol, as appropriate
- Whether chronic medications scheduled to expire or recently expired got renewed, discontinued, or substituted by a comparable medication, or whether an explanatory note was written
- Whether sick call visit vital signs were recorded
- Whether patients returning from offsite specialty service appointments were seen by a PCP within 14 calendar days
- Whether specialty services appointments were completed within a 30-day period
- Whether patients seen in TTA were seen in follow-up by a PCP within 5 days

Taken in isolation, the value of quantitative date such as these would be quite limited. But their reports make it clear that they were doing much else in addition to collecting quantitative data. Their reports contain abundant qualitative observations. The nurses were clearly doing management by walking around, interviewing staff and patients, and making observations, suggestions, and plans for future intervention. The summary of the Central Region Nurse Consultants' accomplishments and goals places these audit activities in the context of all their other management, consulting, and educational activities. The value of the data is enhanced in this context. Training the onsite supervisory nurses to do their own audits further enhances the value. Critical to the benefit of this effort was that a small number of the QMAT indicators were chosen as the most relevant, and at least some of them were actionable.

The weaknesses of the data themselves lie in their often small sample sizes, their retrospective rather than concurrent nature, and the infrequent collection. In addition, while some of the indicators are well-defined, most are not, some lack face validity, and many depend on subjective judgment. Finally, the burden of this data collection is significant, burying Masters-prepared Nurse Consultants in chart reviews at considerable opportunity cost.

The Receiver's Quality Measurement and Evaluation Unit will provide support staff and technical assistance to facilitate data collection efforts such as these, used in the context of ongoing education and management. As discussed below, the Receiver will also improve the access-to-care measurement strategy.

c. Access to Care Measurement

The Receiver's most focused efforts to measure access to care have occurred in the Specialty Services Pilot Project Initiative at California State Prison – Los Angeles County (LAC) and California Correctional Institution (CCI). A snapshot of the statewide specialty referral backlog on December 1, 2006, found a total of 17,458 uncompleted specialty referrals of which 4,837 were over 90 days old and therefore out of compliance with policy and 635 were "urgent" and yet not completed within 14 days. The problem with this snapshot is that none of the data is reliable, given that the 33 prisons have widely varying practices of collecting and tracking data. Defining and implementing a standard reporting methodology at

the two pilot prisons (LAC and CCI) has itself been a Herculean task because of the barriers described.

The Receiver's team is working with *Coleman* and *Perez* representatives to develop an electronic scheduling and tracking system that will facilitate getting prisoner/patients access to care and will provide meaningful reports. What is already clear from the Specialty Services Pilot Project Initiative at LAC and CCI is that standardizing workflows will be an enormously challenging pre-requisite, and that getting meaningful access-to-care measures from this electronic system is more than a year away.

Part of the challenge in developing the electronic scheduling and tracking system lies in defining the data elements it will generate. These data will be used for accountability purposes by multiple external stakeholders, not just for improvement purposes by clinical staff, so they merit careful definition. Furthermore, once programmed into the system, they will not be easily altered. The IOM's 2006 volume, *Performance Measurement: Accelerating Improvement*,[8] lists the definition requirements as follows:

> Measures of clinical quality are specific quantitative indicators to identify whether the care provided conforms to established treatment goals and care processes for specific clinical presentations. Clinical quality measures generally consist of a descriptive statement or indicator..., a list of data elements that are necessary to construct and/or report the measure, detailed specifications that direct how the data elements are to be collected (including the source of data), the population on whom the measure is constructed, the timing of data collection and reporting, the analytic models used to construct the measure, and the format in which the results will be presented.

While such standardized specifications already exist for a host of free-world clinical quality measures, there are none for access-to-care measures appropriate for corrections. CDCR access-to-care standards include face-to-face nurse triage for prisoner/patients with symptoms within 24 hours; an appointment with a primary care provider within 5 days for patients classified as urgent or within 14 days for prisoner/patients classified as routine; and high-priority outpatient specialty services within 14 calendar days or routine services within 90 calendar days. Most states have variations on such themes, often distinguishing weekdays from weekends for non-urgent complaints. Many states have built their standards into enterprise-level information systems that generate reports on access-to-care compliance.

The Receiver will carefully review CDCR policies regarding access to medical care prior to developing software systems that track compliance with these policies. California's standard for urgent primary care visits within 5 days lies well beyond what many other state correctional systems require. The standards for TriCare, the system serving military beneficiaries, include urgent primary care within 24 hours, routine primary care within 7 days, and routine specialty care within 30 days. The Receiver's efforts in the Specialty Services

[8] Institute of Medicine. *Performance Measurement: Accelerating Improvement*. Washington, DC: National Academy Press; 2006.

Coordination Pilot have already revealed multiple problems with "urgency" designations, all of which need to be addressed prior to implementing an electronic measurement strategy.

The Receiver will also contract with external consultants to work with the rest of his team and CDCR clinical staff to develop meaningful and valid access-to-care measures. According to the National Quality Forum,[9] to be worthy of use in accountability and public reporting, a measure should address one or more key leverage points for improving quality. It should be valid, precise, and reliable, yielding consistent and credible results when implemented. The benefit should outweigh the burden of measurement. The results should be useful in making decisions. In its volume on the science of clinical measurement,[10] the IOM expands on these criteria as follows:

> Most would agree that a measure is good enough when acting upon it results in a net improvement in quality. Thus, the direct benefits of implementing a particular measure cannot be outweighed by the indirect harms, *e.g.*, resource and opportunity costs, antagonizing providers, incentivizing perverse behaviors, or negatively affecting other domains of quality.

Complementing the Receiver's efforts to develop valid measures and electronic reporting, the Office of the Inspector General has agreed to establish a program for inspecting California prison medical care. The Receiver's team and the Quality Measurement and Evaluation Unit are committed to sharing knowledge and resources and coordinating with the OIG program. The OIG proposal is described in the Clinical Operations Initiatives.

d. The Asthma Initiative and Free-World Quality Measures

In wake of the death review analysis that found asthma to be the leading cause of preventable deaths, the Receiver is committed to launching a quality initiative focused on eliminating additional asthma deaths with the help of external asthma and organizational change experts. The Request for Proposals (RFP), released October 24, 2007, describes the initiative as follows:

> The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. More than that, however, it will provide a testing ground for implementation of interdisciplinary quality improvement (QI) projects. It will engage all six of the organizational change strategies that the Institute of Medicine considers necessary to improve health care: (a) redesign of care processes based on best practices; (b) use of information technology for clinical information and support for caregivers; (c) increasing and deepening clinical knowledge and skills (d) development of a team-based, rather than a physician-centric, delivery system; (e) coordination of care; and (f) incorporation of performance and outcome measurements for improvement and accountability. The Asthma Initiative will demonstrate how to

[9] National Quality Forum. www.qualityforum.org.
[10] Institute of Medicine. *Performance Measurement: Accelerating Improvement*. Washington, DC: National Academy Press; 2006.

use data to inform the clinical care process while orienting our providers and management staff to patient safety issues. The end result of this specific disease management initiative will be a heightened awareness of chronic disease management leading to the improved care of other conditions and the beginning of a safety culture.

The Receiver's team held a bidders' conference November 8, 2007. Responses to the RFP are due December 8, 2007, with an anticipated project start date of January 21, 2008 and a duration of 12-18 months. Refer to Clinical Initiative Appendix 5 – October 24, 2007 Asthma Initiative Request for Proposals.

The Asthma Initiative offers excellent examples of the challenge and promise of bringing free-world, nationally-standardized quality measures into the CDCR. For asthma, hyperlipidemia, seizures, HIV, hepatitis C, and diabetes, the statewide Pharmacy and Therapeutics (P&T) committee and Maxor have committed to tracking quality indicators - about 10 indicators for each condition. The problems of operationalizing these intentions, however, are significant. The burden of doing chart reviews severely limits the number of data points and the frequency of data collection, as discussed above regarding the Central Region Nurse Consultant audits, thus decreasing the reliability of comparisons across sites or over time.

There is also the "denominator problem:" in order to know how many people are getting appropriate treatment for a condition, one needs to know how many people have the condition. In the example of HIV, because the CDCR does not do universal screening, staff may have identified only half the population who are infected. Even for those who have tested positive, tracking is inadequate. In October 2007 the HIV Steering Committee cross-referenced the central CDCR database that is purported to track HIV-infected inmates (Distributed Data Processing System) with lists kept by medical staff in each facility. Predictably, the results did not jibe. There were 1,273 inmates on the facility lists and 764 in DDPS with only 584 on both lists. So even if we know who is getting a particular prophylactic treatment, we still do not know how well we are doing.

The Asthma Initiative will address the information challenges by taking full advantage of the Receiver's other quality initiative, the Maxor GuardianRx and medication management rollout discussed above. Earlier this spring, Maxor's centralized pharmacy management system began to offer a facility-level data dashboard specific to medication type and volume. With the introduction of GuardianRx, Maxor will be able to provide reliable patient-level data. Because most asthmatics succeed in getting asthma medications of some sort, even in the CDCR, analysis of the GuardianRx data will provide a relatively comprehensive list of asthmatics and thus address the denominator problem.

Another reason to select Asthma Initiative pilot sites based on GuardianRx deployment is obvious from the list of success factors noted above by the medication management Conversion Team. Success breeds success. Once the staff is excited and knowledgeable about the potential for process redesign, they are better prepared for the next project. As stated in the Asthma Initiative RFP:

> The initial Asthma Initiative sites [will] be selected based on local leadership capacity, organizational resource availability, pharmacy stability, and prior implementation of a pharmacy information system, all factors that will also contribute to success in the Asthma Initiative. The pilot sites chosen will have been exposed to QI tools and process redesign; therefore, these sites are most likely to embrace a QI collaborative pilot and the chronic care model.

The Asthma Initiative will make rich use of non-rigorous data in the clinics to guide rapid-cycle process redesign, just as the nurses in the medication management initiative are using hash marks to track perceived missing medications. But the Asthma Initiative will also offer the first opportunity to introduce more rigorous free-world measures. A recent Agency for Healthcare Research and Quality (AHRQ) study[11] offers this guidance for measure selection in asthma:

> With a specific population in mind, a quality improvement program should consider the dimensions to be measured before embarking on data collection. What is to be measured? What change will be instituted? What quality measure will track the spread of that change? What is the ultimate outcome to be improved and how is that changed measured? What special populations are to be targeted and how will their improvement be documented?
>
> Quality measures cover a large range, from crude measures (for example, unadjusted mortality rates) to more refined measures (for example, percent using asthma medications to achieve better asthma control). Although a full range of measures is essential for a complete picture of health care quality, specific process measures are needed to guide a health care team in improving quality of care. For example, the number of deaths related to asthma at a hospital can suggest poor quality of treatment at that hospital and in the community, but knowing the number of deaths does not tell the hospital staff or community providers how to improve. Metrics that measure processes of care that reduce deaths or improve other medical outcomes help medical staff know how to change care so that they provide better care.

While the AHRQ study lists more than 100 asthma quality indicators that have been recommended by federal agencies or professional organizations, there is one that has been deemed a "high-leverage" measure by the IOM:[12] appropriate treatment with anti-inflammatory (steroid) medication. The Institute for Healthcare Improvement[13] offers this definition of the measure:

> The number of patients with a National Heart, Lung, and Blood Institute (NHLBI) classification of persistent asthma who are on anti-inflammatory medication, divided

---

[11] Coffey RM, et al. *Asthma Care Quality Improvement: A Resource Guide for State Action.* AHRQ; April 2006.

[12] Institute of Medicine. *Performance Measurement: Accelerating Improvement.* Washington, DC: National Academy Press; 2006.

[13] Institute for Healthcare Improvement (IHI). www.ihi.org.

by the number of patients with an NHLBI classification of persistent asthma. Multiply the result by 100 to express as a percentage.

The steroid measure is attractive because analysis of the patient-level GuardianRx data will facilitate moderately-accurate designation of numerators and denominators for each facility that has the new system online.

Just as the medication management initiative is preparing the way for asthma, the asthma work will prepare for the next quality initiative. Each subsequent chronic care initiative, *e.g.*, diabetes and HIV, will reinforce the chronic care model and rapid-cycle quality improvement using strategic quality measures. Most systems, both in free-world and corrections, launch no more than two-four such initiatives per year. While the urgency of reform in CDCR would argue for a higher number, the extraordinary barriers to implementation argue for more modest ambitions. With improvements in information technology and leadership, in particular, the capacity for transformative change will accelerate.

e. Other Quality Improvement Activities

Management by fact, as noted in the Baldrige quotation above, also requires analysis and integration of prisoner/patient and staff satisfaction data. Several state prison systems have successfully conducted patient satisfaction surveys. The IOM has endorsed the AHRQ-funded Consumer Assessment of Healthcare Providers and Systems (CAHPS) Program as its recommended patient satisfaction instrument. CAHPS has not yet been validated for corrections, but it gathers data on important domains such as timely access to care, staff communication, and health education. The Receiver will explore use of CAHPS within the CDCR. These patient-centered measures complement complaint and appeal systems and indeed, if used correctly, should decrease complaints and appeals.

The Receiver will also develop measures of organizational culture and change, including staff satisfaction surveys. The Centers for Medicare and Medicaid Services (CMS) has begun to use staff turnover rates as a marker for organizational culture, and several state prison systems have begun to explore this use as well.

As the Receiver's new information and managerial systems begin to mature over the next two years, his team will develop balanced scorecards for each prison, eventually to be available on a monthly basis. These one-page scorecards will include measures of population health, clinical quality, utilization, financial performance, and management. Balanced scorecards facilitate transparency and accountability, bridging long-term goals and immediate challenges. They focus attention on organizational initiatives and provide early alerts regarding trouble areas. Showing the disease burden and staffing resources in a prison can put into context that facility's access, utilization, and clinical indicators.

Six Month Objectives:

1. Fill CEA position at the PhD level to head the Quality Measurement and Evaluation Unit.
2. Begin Asthma Initiative.
3. Begin contract with external consultants to develop meaningful and valid access-to-care measures.
4. Coordinate with the Office of the Inspector General on a pilot program for inspecting medical care at California prisons.
5. Develop dedicated project management infrastructure to support major quality initiatives.

Twelve Month Objectives:

1. Provide support staff and technical assistance to facilitate data collection efforts such as those led by the Central Region Nurse Consultants, to be used in the context of ongoing education and management.
2. Pilot use of prisoner/patient satisfaction surveys.
3. Implement electronic tool for reporting incidents and near-misses.

Twenty-four Month Objectives:

1. Implement process improvement methodologies within the CDCR including use of quality measures, rapid-cycle quality improvement, high-reliability practices, sentinel event review, and root cause analysis
2. Complete the Asthma Initiative, encompassing chronic care model, practice redesign, clinical guidelines, policies, documentation tools, and staff education resources.
3. Develop culturally and linguistically appropriate patient education resources and peer education programs for patients with asthma.
4. Design and pilot an implementation plan for a disease registry, care coordination, and case management for patients with asthma.
5. Complete three other chronic care quality initiatives.

Thirty-six Month Objective:

Develop balanced scorecards showing each institution's disease burden, utilization, staffing, access-to-care measures, clinical quality indicators, and financial performance.

BARRIERS TO THE SUCCESS OF THE RECEIVER'S CLINICAL QUALITY MEASUREMENT AND EVALUATION SIX TO THIRTY-SIX MONTH OBJECTIVES

1. Longstanding absence of a quality management infrastructure in CDCR.
2. Longstanding impoverishment of professional development resources for clinicians.

3. Lack of familiarity with quality improvement and patient safety.
4. Bureaucratic roadblocks to employee discipline.
5. Lack of standardized measurement strategies for access to care in corrections.
6. Premature commitment to poorly developed measurement strategies.
7. Lack of adequate external expertise and support for local quality improvement initiatives.
8. Inadequate commitment to training and education.
9. Lack of functional information technology.

CLINICAL OPERATIONS INITIATIVE
(POA OBJECTIVE C.2, C.6, C.8 AND OBJECTIVE B.12)

BACKGROUND AND INTRODUCTION

In the Third BiMonthly Report filed December 2006, the Receiver reported as follows:

> In April 2006, when the Receivership began, the decision was made to allow the State to retain direct management over the daily operation of the prison medical delivery system. Near the end of this bi-monthly reporting period, however, the Receiver made the decision to begin to assume direct management over several elements of the CDCR medical delivery system, including direct management of CDCR physician and nursing operations. Numerous factors precipitated this change of management responsibility, including the following:
>
> 1. It is increasingly apparent, given existing bureaucratic, political, and fiscal restrictions that no one individual, no matter how talented and dedicated, can manage the CDCR's medical, mental health, and dental programs under the existing state of disrepair. (footnote omitted)
> 2. Conflicts between the orders of numerous pending class actions and the human resources needed to comply with those orders (as well as the resulting lack of long range planning and lack of focus) impede the Receiver's efforts to effectuate changes in the prison medical delivery system.
> 3. Day to day crisis situations have increasingly required time consuming attention from Office of the Receiver personnel; therefore, the assumption of direct management over certain elements of the CDCR's medical delivery system has to some degree already taken place.
> 4. Many critical medical system programs, including medical contracts processing, recruitment, hiring, and human resource transaction processing have in the past been provided by CDCR divisions other than Division of Correctional Health Care Services ("DCHCS"), resulting on occasion in poor service, inadequate staffing, and a lack of responsiveness to remedial plan requirements. The Receiver is convinced that unless and until the Office of the Receiver assumes direct control over the day to day operation of these critical functions, the remedial programs that he implements will not be effectuated in a timely and cost effective manner.
>
> *See Third Bimonthly Report* at 7-8.

In less than a year the Receiver's Plata Support Division has expanded to provide not only a wide range of services which support the Receiver's medical care operation. In addition, it has also assumed, through various coordination agreements, direct management over several critical elements of the CDCR's mental health, Americans with Disabilities Act, and dental operations, including registry contracting, credentialing, and information technology services. While it was not part of the Receiver's original remedial program, the direct management of CDCR operations as they pertain to medical care is now an integral part of the corrective actions initiated by the Receivership. Therefore, while this POA focuses on substantive programs

designed to bring the California prison system's medical delivery up to constitutional standards, it is also necessary to include, in the POA planning process, changes that will be needed to ensure effective operation of the underlying central office support, staffed primarily with State employees.

During the next six months the Receiver will implement three significant organization changes to the CDCR operation which support his remedial programs. Those changes are summarized as follows:

1. Creation of a unit to monitor and manage clinical quality and metrics.
2. Creation of an organization to monitor the transfer of Plata class members out of state, into Community Correctional facilities (CCFs), and re-entry facilities.
3. Creation of an organization that will manage clinical support services including radiology, laboratory, telemedicine, and pharmacy.

Some of this re-organization has commenced, as explained below. All three projects will be underway within the next six months.

Projects 1 and 3 are necessary for the same reasons stated by the Receiver in his Third Bimonthly Report. To summarize, the CDCR has proven incapable of performing the day-to-day operations needed to support a constitutionally adequate medical delivery system. Therefore, staff from the Office of the Receiver now direct the operation of the CDCR's medical delivery system.

Project 2, however, is necessary at this time because of three different factors. First, in 2007 the State began to transfer hundreds of *Plata* class members to private prisons in other states, necessitating that the Receiver and his staff become involved in a number of time consuming and expensive operations including the screening of prisoners to be transferred, re-writing and approving the contracts with the private prisons, and inspecting the private prisons [designated by the State as "California Out of State Correctional Facilities" (COCFs)]. Second, the Receiver has uncovered a number of serious problems with the delivery of medical services in California CCFs which house thousands of Plata class members, again necessitating that the Receiver and his staff become involved in a number of additional time consuming and expensive operations including screening prisoners to be transferred to CCFs, approving the contracts with CCFs, and inspecting CCFs. Third, the State has announced plans to build numerous local re-entry facilities. Given the track record with CCFs, and given the fact that Plata class members with a wide range of medical problems will not be excluded from transfer into re-entry facilities, it is necessary to monitor the re-entry program as it rolls out.

THREE NEW ORGANIZATIONS TO BE CREATED BY THE RECEIVER IN THE NEXT SIX MONTHS

A. Clinical Quality Measurement and Evaluation Unit.

This organization is described in the section regarding the Receiver's Clinical Quality Measurement and Evaluation Initiative.

B. "COCF, CCF and R-entry Oversight Unit," the Receiver's organization to monitor the transfer of Plata class members out of state, into Community Correctional facilities, and into Re-entry Facilities

The COCF, CCF, Re-entry Oversight Unit is managed by Teresa Reagle, the Receiver's Acting Director of Field Support. It will have two primary initial functions:

1. The Unit will establish clinical standards for out-of-State and community prison beds and will conduct the necessary reviews and inspections to ensure compliance with the standards.

2. The Unit will serve as an interface and coordinating agency for the Inspector General's pilot project for monitoring quality of prison medical care.

With consultation from the Office of the Receiver, the Office of the Inspector General (OIG) has proposed a three-phase implementation of the monitoring program. In phase I, the OIG will develop audit instruments for some 26 healthcare functions described in the Court-mandated Health Care Services Division Policies and Procedures. The OIG team will pilot test the instruments at five CDCR facilities and issue a public report following inspections. In phase II, with the consent of the Court, the OIG will assume inspection responsibilities for all CDCR facilities affected by the *Plata* lawsuit. In phase III, at an unspecified time in the future, the OIG would turn over inspection responsibilities to the Receiver/CDCR.

The Receiver will ensure that the OIG has access to all relevant medically-related documents, records, logs, and complaints. The Receiver's staff will share information about their own quality measurement efforts, examples of quality data collected, and plans for future quality initiatives. The Receiver's staff will facilitate efficient data-gathering by the OIG team during on-site inspections. Ms. Reagle's Unit will take the lead concerning these processes.

COCF, CCF AND RE-ENTRY OVERSIGHT UNIT INITIATIVE: NOVEMBER 2007 TO NOVEMBER 2010

Six Month Objectives:

1. Establish an initial baseline or "core," expectation for field compliance with Plata standards for delivery of medical care.
2. Work with the Receiver's legal staff to ensure that COCF, CCF and re-entry contracts contain provisions necessary to ensure compliance with *Plata* mandates.

3. Conduct an initial series of inspections and reviews of all COCFs and 50% of CCFs. Review operating policies, procedures, and practices to ensure the adequacy of the staffing necessary to provide Plata compliance (both clinical and correctional), to ensure the adequacy of facility design, treatment space, access to supplies and maintenance, to verify the adequacy of policies and procedures, to ensure compliance with policies and procedures, etc.
4. Provide initial assistance as necessary to all COCFs and those CCFs inspected concerning policies and procedures which support the delivery of adequate medical care as called for by *Plata* mandates.
5. Receive and manage the medical records of prisoner/patients housed in COCF facilities. Develop policies and procedures to appropriately manage the medical records of prisoner/patients housed in CCFs and re-entry facilities.
6. Establish an audit tool to accurately reflect compliance with medical standards. Implement a program to document deficiencies and require timely corrective action or contract cancellation.
7. Hire initial Unit personnel, including one physician, two registered nurses, one associate Government Program Analyst, two correctional managers, one Office Technician, one Health Records Technician II, and two Health Records Technician I's.
8. Establish agreements with the Court representatives in *Armstrong*, *Coleman*, and *Perez*, and the CDCR officials responsible for A.D.A., mental health, and dental services delivery to conduct inspections and review in a coordinated, cost-effective manner.
9. Establish liaison with the pilot OIG prison monitoring program and participate in data collection and inspections as necessary.

Twelve Month Objectives:

1. Hire secondary staff, two registered nurses, one Associate Government Program Analyst, and four Health Record Technician I's.
2. Audit the remaining 50% of CCFs.
3. Conduct a second, follow-up audit of all COCF facilities.
4. Continue remediation action as necessary.
5. Commence inspection program of re-entry facilities as necessary.

Twenty-Four Month Objectives:

1. Physically audit all COCFs, CCFs, and re-entry facilities annually, and on an unannounced basis as deemed appropriate.

COCF, CCF and RE-ENTRY OVERSIGHT UNIT METRICS

The COCF, CCF and Re-entry Oversight Unit commenced operation on November 5, 2007, nine days before the filing of the November 2007 POA submission. While an initial pilot version of an inspection template has been developed in conjunction with earlier surprise inspections of CCFs conducted at the Receiver's request, it is premature to produce a complete

set of relevant metrics for this iteration of the POA. Refer to Clinical Operations Initiative Appendix 1 – CCF/Out-of-State and Re-entry Inspection Template. However, a vigorous inspection plan has been established, as explained above, and the inspection tool, as well as baseline requirements, will be set in place during the next six months. The Receiver will provide more detailed information concerning the COCF, CCF and Re-entry Oversight Unit metrics in his Quarterly Reports and future iterations of the POA.

BARRIERS TO THE SUCCESS OF THE COCF, CCF AND RE-ENTRY OVERSIGHT UNIT

1. Aggressive Inspection Schedule

The schedule of inspections set forth above has been set in an aggressive manner because of the Receiver's concern about Plata class members housed out of state and in CCFs. Meeting this schedule will require careful planning, the timely hiring of key personnel, and the prompt implementation of an adequate inspection template.

2. Cooperation with CDCR

An effective medical inspection program of all facilities where Plata class members are confined will require close coordination with, and cooperation by the CDCR. Thus far, the CDCR's cooperation concerning out-of-state and CCF inspections has been good.

3. Coordination with *Armstrong*, *Coleman*, and *Plata*

The cost effective monitoring of out-of-state and CCF facilities, inspections which deal with all of the health concerns of prisoner/patients, will require coordination with the Court representatives in *Armstrong*, *Coleman*, and *Perez*, and the CDCR officials responsible for A.D.A., mental health, and dental services delivery. Thus far, cooperation and coordination concerning mental health care has been good. Cooperation and coordination concerning dental care has been problematic.

C. Clinical Support Services: The Receiver's unit to manage clinical support services including radiology, laboratory, telemedicine, and pharmacy

1. *Background and Introduction*

Many California prisoners suffer from very serious medical problems. Others are aged, and suffer from long term serious and less serious chronic diseases. Given these patient demographics, it will not be possible to deliver constitutionally adequate care unless and until the appropriate clinical support services including radiology, laboratory services, telemedicine, and pharmacy services are available. Prior to establishing the Receivership, all of the above referenced services were suffering from very serious problems. For example, as noted by the Court in the Findings of Fact and Conclusions of Law re Appointment of Receiver ("Findings") filed October 3, 2005:

> The medical records in most CDCR prisons are either in shambles or non-existent ...This makes even mediocre medical care impossible. Medical records are an essential component of providing adequate patient care and should contain comprehensive information about a patient that can assist a physician in determining the patient's history and future treatment ...The amount of unfiled, disorganized, and literally unusable medical records paperwork at some prisons is staggering... three and one-half feet of loose filing at San Quentin . . .twelve to eighteen inches of loose filing at Salinas Valley...six to eight feet of loose filing at CSP-Sacramento...At CIM, the records were kept in a 30 foot long trailer with no lights except for a small hold cut into the roof and were arranged in piles without any apparent order...Conditions are some at other prisons as well. At some prisons medical records are completely lost or are unavailable in emergency situations...the CDCR medical records system is "broken" and results in dangerous mistakes, delays in patient care, and severe harm."

See Findings at 20:17 to 21:16.

As found by the Court, healthcare providers do not operate in a vacuum. Without essential clinical support services, physicians and nurses are unable to provide diagnoses and treatments to their patients. Functional healthcare systems have a set of ancillary support services that are core to delivery of patient care. These services include pharmacy, clinical laboratory services, enterprise imaging (radiology), and health information management (HIM). Competent healthcare administrators recognize that these clinical operations drive utilization and quality, have a significant effect on morbidity and mortality, and that they require careful management in coordination with clinical leadership.

Unfortunately, consistent with all other matters regarding healthcare in California's prisons, these clinical operations and, consequently, prisoner/patients, have suffered from years of neglect, incompetence, and mismanagement. In most cases, each institution has been left to fend for itself in these areas without any leadership from Sacramento. Meanwhile, patients continue to suffer and die because clinicians cannot obtain timely lab results, radiology studies, or medical records. At the same time, countless taxpayer dollars are probably being wasted as expensive imaging and lab studies are repeated because the originals cannot be found.

One aspect of clinical operations, pharmacy operations, was found to be in crisis early in the Receivership, and is the subject of a separate section of this report. *See* Maxor Pharmacy Services Initiative. However, since the last iteration of the Plan of Action in May, the Receiver has grown increasingly concerned that operations of clinical laboratory services, radiology, and health information management may also be near the breaking point. Now that the Receiver has established his remedial team and hired experts to direct the remedial programs that will be necessary to address problems with clinical support services; and now that remedial programs are underway concerning certain more severe problems (such as the hiring of clinical staff and the improvement in the controls over contract processing and invoice processing)have been addressed with remedial programs that are proving to be effective to some degree, the Receiver has established as a new priority related to new clinical support remedial programs. To manage this process, he will, over the course of the next six months, establish a Clinical Support Services Division.

It must also be emphasized that before establishing a proposed remedial plan, the Receiver needed to determine the specifics of the problem. If no one knows exactly what is wrong, it will not be possible to develop a fix. In fact, the depth and scope of medical delivery problems in the CDCR are so serious that no one with the State of California could inform the Receiver with any accuracy about the nature of the problems themselves. Therefore, prior to launching any remedial effort that relates to clinical support services the Receiver was forced to utilize his staff of experts to examine the nature of the underlying problems. The level of administrative disarray and the resulting waste of public funds has proven to be far worse than anticipated, as explained below.

2. *Summary of Receiver's Initial Findings Re Clinical Support Services*

Radiology

The scope of imaging services required by the CDCR patient population includes plain 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/year), followed by MRI (7,123), ultrasound (7,098), CT (4,753), and mammography (4,142). Also, CDCR estimates that 3 million dental radiographs are taken each year (an astronomical figure subject to verification).

Each institution, however, has been responsible for managing its own radiology program, resulting in widely varying methods of service delivery, operation, and cost. 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 some lack the expertise, space, and ancillary equipment necessary to install them. Several prisons have purchased and installed new computed radiography imaging systems that may be mutually incompatible with one another. Prisons literally across the street from each other are unaware of and do not share high cost technologies available at one of them. It should be emphasized that the negative effects of the lack of central management and planning are not limited solely to the institutions themselves. Because the CDCR's healthcare information technology infrastructure has suffered from decades of neglect, the current network is insufficient to support a Picture Archiving and Communication System (PACS), and all digital images must be printed 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.

Clinical Laboratory

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. Eleven prison laboratories are licensed and providing on-site testing services, including chemistry, coagulation studies,

endocrinology, hematology, serology, toxicology, urinalysis and blood banking. These eleven laboratories provide almost 2.2 million individual (non-bundled) tests annually. Five more laboratories provide limited testing of simple tests and point of care tests. The seventeen remaining 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.

Each institution has been responsible for developing its own clinical laboratory program. Consequently, yet again 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. Multiple labs provide lab results to clinicians on hand-written scraps of paper, with all the attendant potential for errors due to mistakes in transcription or poor handwriting. There are no standards for testing panels, reference ranges, or alert or panic values. 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.

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, as found by the Court, that the health information management (HIM) system is inadequate to meet the needs of the confined adult population.

Furthermore, the Receiver's staff, as well as the Court representatives in *Coleman* and *Perez,* have expressed the following additional concerns, all of which appear valid:

- 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 16 feet!

Yet again, the CDCR has 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 the following:

- lost or missing charts;

- misfiled documentation;
- stacks of unfiled paper documents dating back months to years, including over 8 million "orphan documents" collected from various prisons and parole offices;
- 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 health 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.

Dictation and transcription, one component of the medical record problem, is particularly problematic. CDCR employs approximately 78 full-time, on-site medical transcriptionists, and has approximately 43 more unfilled positions. Because there is no organized management or oversight of this important function, most facilities are unable to provide precise documentation as to their usage of transcription (in transcribed lines/day), but report their average number of monthly documents transcribed as anywhere between 9 and 850. In some cases, CDCR appears to be employing full-time transcriptionists, taking up valuable office space inside prisons, to produce documents at a rate of only 8-10 per month. Meanwhile, there are a number of prisons where the backlog of dictated but un-transcribed notes extends back weeks to months.

On October 16, 2007, the Receiver approved the engagement of a private transcription consultant to assess and redesign the department's approach to dictation and transcription. The consultant is performing a needs assessment, including gathering information on existing transcription requirements and services at each facility. Although her engagement is only just underway, the following preliminary findings have resulted:

- A number of institutions have been routinely in violation of Federal and State patient privacy regulations by emailing confidential patient health documents without appropriate protections such as encryption or password protection;
- Several institutions have full-time transcriptionists but no transcription equipment or transcription services offered;
- Transcriptionists in some institutions are averaging 165 lines transcribed per day (as opposed to an industry average of 300 lines per hour!);

- At San Quentin, where the Receiver authorized outsourcing of transcription as part of emergency remedial efforts, the external transcription provider is not meeting their contractual turn around time of 24 hours 70% of the time;
- Dictation/transcription equipment in many institutions is very outdated and inadequate for its intended uses.

To summarize, the CDCR system of health records management is not efficient and standardized according to best practice and industry standards, and the current allocation of health records staff is inappropriate 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.

Telemedicine Services

CDCR currently operates a telemedicine program that connects inmates in up to 29 prisons with one of three contracted specialty physician groups as well as a telemedicine hub in downtown Sacramento. Since the program's inception in 1996, there have been about 60,000 telemedicine visits, with approximately 6,200 occurring in Fiscal Year 2006-2007. In comparison, the UTMB telemedicine program provides over 60,000 telemedicine visits per year!

Nevertheless, a cursory review of CDCR Telemedicine by the Receiver's team suggests the program is not providing anywhere near its full capabilities. Less than half of all telemedicine visits are medical in nature (as opposed to mental health). Just 6 prisons (out of 33 managed by CDCR) accounted for more than 80% of all telemedicine medical visits in Fiscal Year 2005-2006. The current system appears to be inadequately staffed, with only one technician available to service 29 widely-dispersed facilities. The technology in use is also outdated, as the system is exclusively dependent on ISDN paired copper wires and analog video equipment.

In July 2007, the Receiver contracted for a telemedicine assessment and road map from consultants with the University of Texas Medical Branch (UTMB) in Galveston's Electronic Health Network, who operate the largest operational telemedicine network in the world. The UTMB engagement is still underway, and a final report is not expected until January 2008. However, some preliminary, informal findings from their assessment so far include:

- Referrals to telemedicine (rather than expensive and difficult transport to off-site specialty providers) are entirely at the mercy of local utilization management staff who, in most cases, have no training, protocols, or criteria to guide them.
- Local telemedicine coordinators often have inadequate training and skills to do their jobs.
- Contracting for specialty services and payment methodologies are not standardized and performance of contracted providers is not appropriately monitored.
- Because CDCR telemedicine equipment uses outdated ISDN connections, it is subject to bureaucratic ineptitude (such as shut down of telemedicine services when a phone bill goes unpaid) and abuse (such as when providers use telemedicine lines to make personal international calls).

- Action on recommendations from specialists seen by telemedicine can be delayed many weeks because no local providers will take responsibility for immediate follow-up.

CLINICAL SUPPORT SERVICES INITIATIVE: NOVEMBER 2007 TO NOVEMBER 2010

The Receiver and his staff have concluded that there is no one within CDCR or State service with the knowledge and experience to provide appropriate advice and consulting services to develop the statewide strategies and programming necessary to correct these serious problems. Therefore, he has embarked on the following remedial program, the first stage of which will be implemented during the next six months. As explained below, the necessary consulting services efforts are already underway.

Six Month Objectives:

1. 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. On November 6, 2007, Navigant Consulting kicked off its consulting engagement to do the following:

    - Conduct an operational and risk assessment of the existing laboratory network in which facilities will be evaluated individually in terms of their overall operational infrastructure, and collectively as a network;
    - Render recommendations on the strategic restructuring of the laboratory program in accordance with the mission of the CDCR (and the CDCR's planned enhancements in healthcare, including an overhaul of information systems); and
        - Create a plan with clear priorities, accountabilities and metrics for implementing the project's recommended improvement interventions and for monitoring progress going forward.

    Based on the Navigant recommendations due March 30, 2008, the Receiver expects to propose a plan for remediation of lab services in April 2008.

2. The Receiver intends to improve and enhance the existing telemedicine program and integrate it into the continuum of inmate medical care to provide primary, emergency and specialty care to allow for greater access to inmates while reducing cost of care as well as custody inmate transportation to outside clinical care locations. In July 2007, the Receiver contracted for a telemedicine assessment and road map from consultants with the University of Texas Medical Branch (UTMB) in Galveston's Electronic Health Network, who operate the largest operational telemedicine network in the world. By January 2008, UTMB will complete an assessment of CDCR telemedicine services and a road map to the future with an eye toward telemedicine infrastructure, facilities, staffing and personnel, workflow, operations, and perception of telemedicine. In the interim, the Receiver is taking the following initial steps:

a. Creating a pilot program to maximize telemedicine utilization at all prisons for one particular clinical specialty (such as dermatology or cardiology);
b. Hiring a Director of Telemedicine Services to implement the UTMB recommendations;
c. Beginning the transition from telephone-based ISDN to Internet-based telemedicine video services in concert with the Receiver's IT Initiative;
d. Allowing a few facilities to pilot usage of telemedicine to provide pre- and post-procedure telemedicine visits for patients requiring off-site hands-on procedures such as surgery or endoscopy;
e. Beginning to re-evaluate telemedicine contracting methodologies.

Twelve Month Objectives:

1. On October 16, 2007, CDCR engaged Sandra Hirsch, a private transcription consultant, to assess and redesign the department's approach to dictation and transcription. The consultant is performing a needs assessment, including gathering information on existing transcription requirements and services at each facility. She will analyze existing processes and create a series of business cases for potential future dictation/transcription alternatives. All of the alternatives will be analyzed with regard to effectiveness, quality, impact on care, elimination of backlogs, standardization of document data, and efficiency. Ms. Hirsch will present CDCR with a strategic plan in April 2008. Based on the contractor's recommendations, the Receiver will create a plan for remediation of dictation and transcription within CDCR no later than June 1, 2008.

2. To improve the quality, efficiency, and timeliness of radiology services delivered to the CDCR's patient population, the Receiver released a Request for Proposals in September to create a statewide strategy for centralizing the oversight, management, and delivery of imaging and radiology services. A vendor finalist has been chosen whose name will be made public once contract negotiations have been completed. If the vendor starts the engagement in January 2008, we expect to have an assessment and strategic plan from our consultants by June 2008. Based on these recommendations, the Receiver will create a plan, with metrics, for remediation of enterprise radiology and imaging services, including dental radiology, by July 2008.

3. To improve health information management, the Receiver released a Request for Proposals on September 24, 2007, to commission a HIM study based on best practices and standards in the industry applicable to our environment, including medical, dental, and mental health records. The selected contractor will 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. The assessment and plan will focus on the following areas: medical record continuity; filing systems; chart structure and forms; chart retrieval and movement; chart analysis/chart deficiency; release of records; metrics; HIM organization and staffing; information technology and HIM software;

policies and procedures; and HIM leadership and governance. Semi-finalists for this engagement have been selected, and vendor should be chosen by December 1, 2007. Based on the contractor's recommendations, the Receiver will create a plan for remediation of health information management within CDCR no later than August 1, 2008.

4. Following the Receiver's review of these reports and agreement among his staff concerning the most effective, timely, and cost efficient manner by which to implement the remedial actions recommended by the consultants, the Receiver will form the Clinical Support Division.

Because the consultants who have been retained by the Receiver have not completed their reviews, it is premature to provide POA projections past twelve months. The Receiver will inform the Court concerning the development of more detailed long term clinical support planning efforts in his Quarterly Reports and future iterations of the POA.

CLINICAL SUPPORT SERVICES DIVISION METRICS

Because the consultants who have been retained by the Receiver have not completed their reviews, it is premature to provide clinical support metrics; however, an extensive array of metrics will be required elements of the remedial plans to be implemented. The Receiver will inform the Court concerning the development of metrics for the clinical support operation in his Quarterly Reports and future iterations of the POA.

BARRIERS TO THE SUCCESS OF THE CLINICAL SUPPORT SERVICES SIX AND TWELVE MONTH OBJECTIVES

1. Aggressive Implementation Schedule

As apparent, there are several major consulting reviews occurring simultaneously. Once the reports are received and analyzed, the Office of the Receiver will be faced with the task of implementing a number of major remedial programs. Implementing these programs will require significant planning, staff resources, and extensive follow-up give that the ultimate fix involves 33 separate institutions.

2. Coordination with *Armstrong*, *Coleman*, and *Plata*

The cost effective implementation of clinical support remedial programs, services that affect the delivery of mental health and dental services will require coordination with, and cooperation by the with the Court representatives in *Armstrong*, *Coleman*, and *Perez*, and the CDCR officials responsible for A.D.A., mental health, and dental services delivery. Thus far, cooperation and coordination regarding clinical support services across all disciplines has been good.

3. Organizational Culture

The belief that each prison is solely responsible for clinical support operations is deeply embedded in CDCR institutional culture. Attempting to centralize management of functions such as transcription or lab services may meet passive or active resistance.

4. Lack of Appropriate Management Personnel Classifications

One reason that CDCR has never been able to centrally manage clinical support operations, such as lab services or health information management, has been the inability to hire healthcare professionals with expertise to provide leadership in these areas. Current personnel classifications, policies, and salaries make it impossible to attract highly qualified applicants who must often be found outside state service.

SAN QUENTIN CONSTRUCTION INITIATIVE
(POA OBJECTIVE F.2)

BACKGROUND AND INTRODUCTION

A. The San Quentin Pilot Project

The Receiver's first prison construction Initiative involves San Quentin State Prison. On July 5, 2006 the Office of the Receiver commenced a prison specific corrective action project to improve the medical services provided at San Quentin State Prison. The Project originally addressed the following elements of prison medical care delivery:

1. Reception Standards and Compliance
2. Outpatient Housing Unit (OHU)
3. Equipment (this element is now titled "Supplies and Equipment")
4. Medical Records (this element is now titled "Health Records")
5. Specialty Services
6. Laboratory (this element is now titled "Laboratory Services")
7. Diagnostic Imaging
8. Patient Complaints/Grievance Process (this element is now titled "Patient Advocacy Process")
9. Clinical Space
10. Facility Maintenance
11. IT, Communications and Power (this element was added to the Project, as explained below)
12. Sanitation/Janitorial
13. Custody & Clinical Relations
14. Organizational Structure
15. Staffing
16. Salaries
17. Internal and External Communications (this element was added to the Project, as explained below)
18. Evaluate *Plata* Remedial Plan Requirements

The purpose of the San Quentin Project was to prepare the Office of the Receiver for the daunting task of restructuring the massive California prison medical delivery system into a constitutionally adequate system. The preparation involves two distinct challenges. First, the Project has begun to deliver timely, necessary relief in the clinical trenches by improving the day-to-day conditions encountered by prisoner/patients and clinical personnel. Second, the Office of the Receiver utilized the Project to gain insight and experience concerning the most effective manner to address systemic problems (including, for example, conducting evaluations of how the State's business practices, laws, regulations, and policies serve to inhibit the remedial action that is necessary to bring the San Quentin medical delivery system up to constitutional standards). For more details of the status of this effort, *see* the San Quentin Pilot Initiative.

B. The San Quentin Construction Project

The San Quentin Pilot Project illustrated in stark detail the desperate need for adequate clinic space in California's prison. The lack of space in which to work, not only clinical space but also desperately needed space for services such as telemedicine, for specialty providers, for offices, for meetings, for information technology, for office equipment and for supplies has been identified as a major factor driving the inability to provide constitutionally adequate medical care at San Quentin.[1] After ten weeks of intensive study and corrective action, the Project Team and Receiver were forced to conclude that only a limited number of patients could be provided constitutionally adequate medical care given the limited space, the limited correctional officer staffing, and the old, decrepit conditions of confinement at San Quentin State Prison.

Therefore, the San Quentin Team initiated a number of steps whereby San Quentin prisoner/patients will be provided with constitutional levels of medical care. This entailed establishing a special project element which has three construction packages involving temporary structures and permanent facilities. These projects are the result of a collaborative effort between San Quentin clinical personnel, custody personnel staff from the Office of the Receiver, representatives of the other class action courts who worked together in a detailed, time consuming manner to develop the overall plan and the details for each specific project, as set forth below. Representatives from the State Department of Finance were involved and were instrumental in securing appropriate funding for the project.

1. Construction Package One

Package one consists of construction that is necessary to "create space" for longer term projects, modifications to enhance the unacceptable level of services in the aged Neumiller Infirmary Building, and a temporary structure which will provide San Quentin personnel access to the basic support space necessary for an adequate medical delivery system such as office space, parking, and supplies. Package One will provide the following:

a. Personnel Offices: In order to support the recruitment and hiring of healthcare staff for the institution, the Receiver will construct a building that will allow the recruiting, interviewing, examination, and hiring of potential staff under one roof, with the objective of providing expedited hiring during a single visit by an applicant to the prison. The existing CDCR clinical hiring system is entirely inadequate, forcing a very limited pool of clinical candidates to undergo several unnecessary bureaucratic procedures which in actual practice leads to weeks of delay in the hiring process, with resultant loss of candidates. The building will include office space for nine staff, two enclosed interview rooms, a central exam area, computer workstations with internet access, an area for livescan screening, a filing room area, restrooms and ancillary support space. It will be located east of the In-Service Training ("IST") building, to the west of the existing personnel office.

[1] Photographs are available which depict the space limitations and the extensive facility problems limiting prisoner/patient access to medical care at http://www.cprinc.org/projects.htm.

b. Replacement Parking Spaces: San Quentin did not have adequate parking for its staff, nor is there adequate parking for escort vehicles, etc. To address this problem, parking additions and renovations were necessary.

c. Relocation of the "Walk Alone" Exercise Yards from Upper Yard to 'C' Yard: This relocation is necessary to allow for the construction of temporary clinical offices and examination areas in the Upper Yard in 2007 (see Construction Package Two, below)

d. Medical Supply Warehouse: At present, medical supplies are located in various spaces throughout the institution's grounds, including the use of four "Con-X" boxes. A single warehouse will provide for effective inventory control and dispersal of supplies. The warehouse will be designed to allow for multi-tier storage of supplies with forklift access and a truck level loading dock. The warehouse will additionally provide a secure storage area with temperature/humidity control and workspace for warehouse staff.

e. Trauma Treatment Area (TTA) Renovations: The San Quentin TTA provides emergency care to the entire inmate population and staff, including emergency procedures, treatments, and necessary patient stabilization prior to emergency transport to an outside facility. Minor out-patient procedures are additionally performed in the TTA. The project has relocated the TTA from its prior location at the northern entrance to the Neumiller building to within the Neumiller building's core on the first floor. Renovation of the TTA has provided the following: four trauma areas for the emergency treatment of patients, including minor out-patient procedures; secure storage room to provide redundant security of the night locker pharmaceuticals and items such as sharps, syringes, etc.; office technician work area for scheduling and TTA support; a nursing work area for charting, form access and TTA nursing operations functions; a primary care provider work area for charting, phone consults, etc; space for the storage of medical supplies, materials and equipment; a pharmacy call window to allow request and transfer of pharmaceuticals directly to the TTA; inmate holding areas to allow secondary staging from the primary Neumiller holding areas down the hall for immediate access of TTA inmates into the trauma rooms.

f. Expansion of the West and East Block Rotundas to Establish Clinical "Sick Call" Areas: At present, many critical clinic services (e.g. sick call, screening, and assessments) at San Quentin are provided from converted cells and make-shift office space within the prisoner/patient's cell block, resulting in entirely inadequate space and equipment to provide minimal services. The project will utilize the space in the rotundas of East and West Blocks for expanded and better equipped clinical areas.

g. Miscellaneous, Limited Upgrades to the North, AC and Gym Clinics.

h. Addition of a "triple wide" relocatable trailer to provide needed office space for medical care delivery personnel.

2. Construction Package Two

Package Two consists of three projects, which began in early 2007:

a. The Primary Care/Specialty Medical Services Modular, to be placed in the Upper Yard: This modular is needed as soon as possible because there is insufficient space within the Neumiller Infirmary Building to support the necessary medical and mental health services needed to adequately care for the San Quentin inmate population. Due to this space limitation, primary care and specialty medical services have been identified to be relocated to this temporary modular building in the upper yard. This modular will accommodate the out-patient and specialty clinic functions as well as medical staff support functions for the Institution temporarily until the new Central Health Services Building (see Package Three, below) is completed.

b. Limited and minor remodel of the existing medical records unit; and

c. Limited and minor remodeling of the existing Receiving and Release modular.

3. Construction Package Three

Construction Package Three involves the construction of a permanent Central Health Services Facility at San Quentin. Included in the Facility will be 50 bed correctional treatment center ("CTC") and a state of the art correctional reception center, including appropriate and adequate clinical and support space for Mental Health, Medical and Dental programs, to accommodate the mission of San Quentin as a CDCR reception center. This construction includes appropriate and adequate clinical and support space for Mental Health, and Dental programs thus addressing the shortfalls of services and space for clinical personnel in the *Coleman* (mental health) and *Perez* (dental) class actions. All space is ADA compliant.

NOVEMBER 15, 2007 STATUS OF SAN QUENTIN CONSTRUCTION PROJECT

The November 15, 2007 status of the San Quentin construction projects are described above:

1. Construction Package One:

a. Personnel offices: Construction documents are close to finalization, incorporating changes by adding additional staff work area, to reflect evolving needs. Project will proceed to bid in early December. Construction is expected to be complete by August 2008.

b. Replacement parking spaces: This project is complete.

c. Relocation of the 'walk alone' exercise yards from upper yard to 'C' yard: This project is currently under construction. Construction is expected to be complete by February, 2008.

d. Medical Supply Warehouse: Contract documents are nearing completion to procure this project using the 'design-build' procurement methodology. It is expected that the project will proceed to bid in December and construction will start in February 2008. Occupancy is anticipated towards the end of 2008.

e. Trauma Treatment Area Renovation: This project is complete, occupied and fully functional.

f. Expansion of the West and East block rotundas to establish clinical "sick call" units: This project is currently going through the bid solicitation process. Construction is expected to start in January 2008.

g. Miscellaneous, Limited Upgrades to the North, AC and Gym Clinics: Minor improvement have already been made. Additional improvements are under review.

h. Addition of a triple wide relocatable trailer to provide needed office space for medical care delivery personnel: This project is complete.

2. Construction Package 2:

   a. The Primary Care/Specialty Medical Services Modular, to be placed in the Upper yard: Contractor has been selected and is beginning work. Occupancy is anticipated in August 2008.

   b. A limited and minor remodel of the existing medical records unit: This project is complete.

   c. A limited and minor remodeling of the existing Receiving and Release: This project is complete.

3. Construction Package 3:

   a. Central Health Services Facility: Design-Build team is on board. Abatement of hazardous material is complete in building 22, to prepare it for demolition. CEQA process has been complete without any litigation. Design Development is progressing, with the full involvement of the clinical staffs of all health care programs. Demolition is expected to start in late November. New construction is expected to start in February to March 2008 time frame. The occupancy for this building is scheduled for the spring of 2010.

SAN QUENTIN CONSTRUCTION INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

6 Month Objective:

Personnel Offices will be in construction. Relocation of the exercise yards will be complete. Medical Warehouse will have a design-builder on board, with design and some construction started. The West and East block rotunda sick call units will be under construction. The primary care/specialty modular in the upper yard will be in the middle of construction. Central Health Services Building construction will have started.

12 Month Objective:

Personnel offices, West & East block rotunda project & the primary care/ specialty modular projects will be complete. Structural steel erection will be well underway for the Central Health Services Building. Medical warehouse will be nearing completion.

24 Month Objective:

All projects will be complete with the exception of the Central Health Services Building. This project will be nearing completion.

36 Month Objective:

All projects, including the Central Health Facility, will be complete, occupied and fully functional by this time.

BARRIERS TO THE SUCCESS OF THE SAN QUENTIN CONSTRUCTION PROJECT SIX TO THIRTY-SIX MONTH OBJECTIVES

Funding has been secured and construction is underway. The remaining barrier involves standard construction risks related to unknown site conditions, strikes and future impacts based on lack of labor & availability of materials.