

**California
Prison Health Care
Receivership Corporation
(CPR, Inc.)**

Prison Medical Care System Reform

Plan of Action
PART II

November 2007

5,000 PRISON MEDICAL BED CONSTRUCTION INITIATIVE (POA OBJECTIVE F.3)

BACKGROUND AND INTRODUCTION

The second of the Receiver's construction Initiatives involves the building of 5,000 medical beds, a project that is anticipated to be implemented in coordination with the need for approximately 5,000 mental health beds for the *Coleman* class action. The Receiver first referenced this project in Second Bi-Monthly Report filed September 19, 2006, following his meeting with State officials concerning the need for additional and appropriate medical beds for prisoner patients. Earlier, in response to the Governor's decision to call a Special Session of the California Legislature to address the problem of prison overcrowding, the Receiver pointed out the following:

As you are aware, Judge Henderson took the drastic action of placing the medical care system under a Federal Receivership after years of well-documented State neglect of the medical needs of its inmate population. The medical crisis, however, is, in part, a byproduct of the overcrowding problem in California's prisons. It cannot be fully resolved until appropriate corrective action is applied to both of these problems in a thoughtful, coordinated manner. In short, the overcrowding and medical crises are integrally related.

The extreme overcrowding of the system, however, makes the challenge of providing constitutionally adequate medical care dramatically more difficult.

While I do not believe that the State can realistically "build its way" out of the chronic overcrowding crisis, new major construction must be a component of mitigating the current acute crisis. Maximizing taxpayer benefit from such projects, however, demands "smart" programming for any new construction. Conventional programming wherein conventional prisons are built (with traditional medical and mental health "components" allocated within each) has failed in the past and will fail again, if pursued.

Initial data indicates that the "smart" use of \$1 billion (\$2 billion including finance costs) would be to construct two multi-purpose medical/mental health facilities rather than two conventional prisons. By so doing, inmate/patients may be appropriately placed by disease category (e.g., acute care, long-term care/skilled nursing care, chronic care, care for seriously mentally ill, crisis care for the mentally ill, hospice and palliative care, "home" care and assisted living care) and custody/security levels to create a system of care which is sadly missing today. The current waste of taxpayer money resulting from duplicative service locations in so many prisons across the State is enormous and is a significant barrier to providing cost effective, constitutional care.

Thus, by engaging in “smart programming,” the State can simultaneously accomplish its dual goals of reducing overcrowding and improving the delivery of medical, mental health and dental care – and make a tremendous stride forward toward the ultimate return of the medical care system to the State.

Whatever construction is to be accomplished, the location is critical. Any new facility should be situated in, or immediately adjacent to, major urban areas.

The Third Bi-Monthly Report at 27, beginning at line 22, provided an update of the 5,000 medical bed project:

As a result of the legislative inaction emanating from the Special Session convened by the Governor, the Receiver commenced planning for 5,000 multi-purpose beds, anticipated to be operational within the next three to five years. The project will begin with a survey of prisoners/patient medical bed needs to be conducted by a private consulting firm in early 2007. In addition, coordination with the Special Master in *Coleman* has begun to determine whether the project should be expanded to provide for an additional 5,000 beds needed for CDCR mental health patients.

Exhibit 8 is the CDCR's response to the Receiver's request for CDCR to develop and submit a plan to site, design and construct 10,000 health care beds (5,000 medical beds and 5,000 mental health beds) to be located at up to seven sites.

On May 7, 2007, the Governor signed into law, Assembly Bill-900 (AB 900) titled, the “Public Safety and Offender Rehabilitation Services Act of 2007.” The Act authorizes in part, in Phase I construction of new buildings at existing CDCR facilities “to provide medical, dental, and mental health treatment or housing for 6,000 inmates.” In Phase II, the Act authorizes the CDCR to construct new buildings at existing CDCR facilities “to provide medical, dental, and mental health treatment or housing for 2,000 inmates.” Phase II of the Act can not begin until the a “three-member panel, composed of the State Auditor, the Inspector General and an appointee of the Judicial Council of California, has certified that 13 specific requirements have been met. The total beds anticipated to be built under the Act within CDCR facilities is 24,000 beds. Additionally, 16,000 Re-Entry beds are authorized within the Act. The total estimated cost of the Act is \$7.8 billion to be financed via revenue bonds, negotiable bonds, or negotiable bond anticipation notes issued by the State.

A number of concerns relative to AB 900 have been brought to the attention of the Receiver that requires discussion. First, AB 900 does not adequately address the medical bed needs of CDCR as determined by the Receiver's Abt Associates Final Report titled *Chronic and Long Term Care in California Prisons: Needs Assessment*, issued August 31, 2007 and the mental health bed needs as reported in the *Navigant Report*. These two definitive source documents indicate that more than 8,000 medical/mental health beds are required to ensure capacity through 2012. Second, the fund source(s) for AB 900 have been brought into question by the California Office of

the Attorney General who have opined that bonds cannot be issued to fund the new prisoner/patient housing. This opinion was collectively stated by the Deputy Attorney Generals assigned as lead counsel for the State on the various health care related class action law suits. This legal opinion is of serious concern for the Governor's Office as well and they are attempting to identify a funding source for these critically needed beds within CDCR. Third, the State and CDCR has already authorized/used funds appropriated in AB 900 for construction projects that were planned, approved and began to be constructed months or even years prior to the passage of AB 900.

The impact of these three concerns is that the needed medical and mental health beds may never be built as a result of no identified funding source and even if a funding source is identified, the funds may be prematurely expended on projects not identified within AB 900. Additionally, if beds are built only to the level authorized within AB 900, they will not be sufficient by the year 2012 based on the definitive beds needs reports and studies provided to the Receiver and the *Coleman* Court.

The Fourth Bi-Monthly Report at 19 - 20 provided yet another update, as did the Sixth Quarterly Report at 77 -79.

NOVEMBER 15, 2007 STATUS OF THE 5,000 PRISON MEDICAL BED CONSTRUCTION INITIATIVE

A. Introduction

Plan of Action, Goal F.3, states as follows: Plan, design, and build 5,000 new medical beds and 5,000 new mental health beds (estimates) in various regions to provide additional bed capacity and appropriate levels of care.

Before planning for medical beds, the Receiver needed to determine the exact nature of those beds. To effectuate an accurate, timely, and professional study, the Receivership contracted with Abt Associates and Lumetra. Abt Associates and Lumetra completed their Final Report in September 2007. This document provides the Receiver with the necessary data concerning chronic diseases, aging, and physical and cognitive functioning of the current CDCR prisoner/patient population to appropriately plan for needed medical beds. It will serve as the planning document for building the necessary medical beds to accommodate CDCR through 2017. Refer to 5,000 Medical Bed Project Initiative Appendix 1 – September 2007 ABT Associates Final Report.

In addition, the mental health bed needs are identified in the Navigant Report, which has been accepted by the *Coleman* Court as the basis by which to plan and build additional mental health capacity within CDCR. Refer to 5,000 Medical Bed Project Initiative Appendix 2 – August 2007 Navigant Report.

B. Overview of 5,000 Medical and 5,000 Mental Health Beds Project

1. Selection of URS-Bovis For Program Management Services

In early 2007 the Office of the Receiver requested qualifications for program management services to provide capital facilities development expertise for the design, construction and commissioning of new facilities in the most expeditious and cost effective manner. After extensive review, evaluation, and personal interviews, URS-Bovis was selected to provide these Program Management services on March 15, 2007. Since that time, URS and Bovis Lend Lease executed a Joint Venture agreement and executed subcontracts with Brookwood Program Management, Lee, Burkhardt, Liu, Inc. Architecture, Planning, and Interiors, and Robert Glass & Associates, Inc.

2. Construction Coordination

Because of the complexities of the project, other construction projects being planned by other entities within DCHCS and CDCR, the need for class action coordination, and AB 900 implications, regular construction coordination meetings have been established between the Receiver's Team, DCHCS and CDCR officials, and the Governor's AB 900 Team. These meetings have been vital to ensuring a coordinated effort for all construction work being planned and completed relating to medical, mental health, dental, in-fill bed project, and Prison Industry Authority expansion projects. Bi-weekly meetings were held through the months of June, July, August, September, and October 2007 and will continue into the foreseeable future.

The Receiver has also taken a number of steps to ensure construction coordination with the other health care class action cases, *Coleman*, *Perez*, and *Armstrong* in order to avoid inefficiencies and duplication of effort. To that end, on November 13, 2007, the *Plata*, *Coleman*, *Perez* and *Armstrong* Courts issued an Order to Show Cause regarding the Office of the Receiver assuming leadership responsibilities for the 5,000/10,000 health care bed construction project. As the construction lead, the Office of the Receiver will collaborate and coordinate with representatives of the other health care class action cases in order to ensure that what is built is constitutionally adequate for all plaintiff class members. Refer to 5,000 Medical Bed Project Initiative Appendix 3 – November 13, 2007 Order to Show Cause.

C. The 5,000 Medical and 5,000 Mental Health Beds Project Planning Process

In consideration of the urgent need for 5,000 medical and 5,000 mental health beds, URS-Bovis developed a Program Management Plan with seven major concurrent activities. The seven activities are:

1. **Site Assessment**, multiple candidate sites
2. **CEQA**, Initial environmental analysis of sites
3. **Infrastructure**, Site improvements
4. **Facility Planning**, medical and mental health services for the total of 10,000 new beds
5. **Project Delivery**, Design/construct delivery planning
6. **Funding Plan**, Funding and budget planning, and

7. **Program Management Plan**, program policies, plans, responsibility matrix.

Each activity is interrelated, and to a large degree must be addressed simultaneously in order to meet the Receiver's objective of opening and operating the new facilities within three to five years. Summaries of these activities are set forth below.

Site Assessment

The Office of the Receiver identified a total of ten sites for consideration for health care facilities. The ten sites are as follows:

1. Folsom State Prison/California State Prison Sacramento, Represa CA.
2. California Medical Facility/California State Prison-Solano, Vacaville, CA
3. San Quentin State Prison, San Quentin, CA
4. Deuel Vocational Institution, Tracy, CA
5. California Men's Colony, San Luis Obispo, CA
6. California Institution for Men, Chino, CA
7. California State Prison-Los Angeles County, Lancaster, CA
8. RJ Donovan Correctional Facility at Rock Mountain, San Diego, CA
9. Fred C. Nellis-California Youth Facility, Whittier, CA
10. Ventura Youth Correctional Facility, Camarillo, CA

Site visits have been conducted at each of the ten locations and reports have been provided to the Office of the Receiver with preliminary recommendations. Additional targeted site analysis is required prior to a final report and recommendations are made to the Office of the Receiver.

CEQA

A recommendation to prepare concurrent technical site assessments and preliminary environmental analysis reports for up to ten sites is being prepared. URS-Bovis is preparing an Environmental Impact Report (EIR/CEQA) process and recommendation for resources and consultants needed for implementation. The EIR/CEQA process routinely requires 12-16 months for public projects, and is vulnerable to open-ended delay, particularly for controversial projects. A strategy for mitigating the time requirements is being prepared, including recommendations for expert legal counsel to assist in strategic planning, as well as for required site assessment and CEQA consultants.

Infrastructure

Existing site documentation is being collected from the CDCR and is under review. However, based on documentation submitted to date, the CDCR data will be incomplete and will require searching for alternate sources as well as conducting site surveys, geotechnical investigations and engineering analysis. This critical information is

needed to qualify site assessments, determine costs for construction and determine whether sites are viable candidates for the new medical and/or mental health facilities.

A solicitation has been issued and responses received for Civil Engineering consulting services to assist with the analysis of infrastructure of the potential sites.

Facility Planning

a. Phase I Planning

In September 2007, URS-Bovis initiated planning sessions to define the scope of the program and discuss lessons learned from similar projects. These planning sessions include CDCR, DCHCS (mental health and dental program managers) and CPR staff as well as representatives from the *Coleman* Special Master's staff and a consultant with extensive experience concerning ADA issues. In October 2007, however, the Receiver and his staff determined that greater expertise was needed regarding National and International trends and solutions relative to correctional health care. Based on this determination, the services of Stephen A. Carter, Carter Goble Lee, Inc. were retained. In addition to Mr. Carter, the services of Bert Rosefield, and Barbara Cotton were acquired in order to bring to the team a broader vision of correctional health care as provided by other systems within the United States and Abroad.

A research component has also been added to the planning effort via the services of Mark Goldman and Associates, Inc. and Dita Peatross. The last component added to the Planning effort is Dick Engler, Staff Consultant to the Receiver. Mr. Engler has more than 35 years of experience in correctional planning, programming, and design and construction efforts.

b. Phase II Planning

Beginning in September 2007, a series of comprehensive planning and programming workshops and briefing commenced. The Receiver has identified the following subject matter experts to attend these meetings:

Terry Hill, M.D., Chief Medical Officer, Office of the Receiver
Nadim Khoury, M.D., Chief Deputy Director, Clinical Services, CDCR
Kathy Page, Nurse Consultant, Office of the Receiver
Cindy Ricker, Supervising Nurse, CDCR
Steve Cambra, Custody Expert, Office of the Receiver
Tim Rougeux, Correctional Administrator, CDCR/Office of the Receiver

The planning and programming sessions are also attended by various CDCR and DCHCS staff, as well as *Coleman* Special Master's staff in order to ensure coordination and cooperation with mental health and dental services. Again, a consultant with ADA knowledge attends as necessary to ensure compliance with *Armstrong* concerns. Staff from DCHCS and the *Coleman* Special Master includes the following:

Jeffery Metzner, M.D., Psychiatrist, *Coleman* Mental Health Expert
Margaret McAloon, Ph.D., Psychologist, DCHCS
Haunani Henry, *Coleman* Special Master staff
Kim Garcia, DCHCS
John O'Shaughnessy, DCHCS
Vic Brewer, California Department of Mental Health

The sessions are also attended, as necessary, by CDCR facilities management and program staff to ensure potentially impacted entities are present during discussions and to build consensus regarding the total 10,000 health care beds.

With the addition of National and International experts on correctional health care being added to the team in October 2007, a tour of other State's correctional health care facilities has been planned and will take place the week of November 26, 2007. Site visits are scheduled for the following locations:

Butner Federal Medical Facility in North Carolina
Iowa Medical & Classification Center
Iowa State Penitentiary, and
Falkenberg Detention Center in Tampa Florida

Project Delivery

URS-Bovis continues its analysis into the optimal project delivery system. The method to be recommended will take each site into consideration separately, and the same method may not be recommended for all sites. Potential methods include traditional design/bid/build, design/build, lean construction, and bridging, among others. Additional investigation and analysis is required before a final recommendation and decision is made.

Funding Plan

URS-Bovis is conducting preliminary order-of-magnitude assessments of the overall program costs. Early assessment methodology is based on parametric estimating methods, using assumed bed counts, square foot per bed estimates, dollars per square foot, assumed ratios of net bed space to gross facility space, and factors for site infrastructure cost and price escalation.

Program Management Plan

The Program Management Plan (PMP) provides the strategic plans for managing and planning the Office of the Receiver's Capital Program, (e.g., 5,000 medical and 5,000 mental health beds). The PMP includes the planning, design, construction, and turnover of the new health care facilities to serve the needs of the CDCR and DCHCS. The program management and planning will be performed by URS-Bovis. A DRAFT

PMP has been submitted to the Office of the Receiver, but has not been approved for release as of this date. Once approved, the PMP will be issued for public review and comment.

5,000 PRISON MEDICAL BED CONSTRUCTION INITIATIVE: NOVEMBER 2007 TO NOVEMBER 2010

Six month Objectives:

Based on the current, very aggressive planning process, 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.

Given, however, the number of variables which may arise (for example, site selection, funding problems, coordination issues, etc.) in the next six months, it is premature at this time to project the details of this project past the next six months. It remains, however, the intention of the Receiver to construct 5,000 medical beds, and if approved by the Coleman Court an additional 5,000 mental health beds in three to five years commencing April/May 2008.

BARRIERS TO THE SUCCESS OF THE 5,000 PRISON MEDICAL BED CONSTRUCTION SIX MONTH OBJECTIVES

Numerous, very serious barriers may arise concerning this element of the Receiver's construction Initiatives, including:

1. Problems with funding.
2. Coordination problems with other class action needs, AB 900 construction, etc.
3. Site section problems, including but not limited to serious infrastructure shortfalls that require remedial action.
4. CEQA challenges and resulting delays in construction.
5. Funding, hiring and training the necessary clinical and correctional personnel to appropriately staff the new facilities.

6. Effectuating the necessary large scale transfer to medical and mental health prisoner/patients from their current prison to a new medical/mental health bed in a timely, safe, and cost effective manner.
7. Unanticipated construction related problems, including but not limited to a small pool of firms able to proceed with a project of this magnitude.

FACILITY IMPROVEMENT CONSTRUCTION INITIATIVE (POA OBJECTIVE F.1)

BACKGROUND AND INTRODUCTION

In the Findings of Fact and Conclusions of Law Re Appointment of Receiver (“Findings”) filed October 3, 2005 the Court held that “physical conditions in many CDCR clinics are completely inadequate for the provision of medical care . . . Many clinics do not meet basic sanitation standards . . . Exam tables and counter tops, where prisoners with infections such as Methicillin-Resistant Staph Aureus (MRSA) and other communicable diseases are treated, are not routinely disinfected or sanitized . . . Many medical facilities require fundamental repairs, installation of adequate lighting and such basic sanitary facilities as sinks for hand-washing. In fact, lack of adequate hygiene has forced the closure of some operating rooms. . . In addition, many of the facilities lack the necessary medical equipment to conduct routine examinations and to respond to emergencies . . . Clinics lack examination tables and physicians often have to examine patients who must sit in chairs or stand in cages. The Court observed first-hand at San Quentin that even the most simple and basic elements of a minimally adequate medical system were obviously lacking. For example, the main medical examining room lacked any means of sanitation – there was no sink and no alcohol gel – where roughly one hundred men per day undergo medical screening, and the Court observed that the dentist neither washed his hands nor changed his gloves after treating patients into whose mouths he had placed his hands.” *See Findings at 21:90 to 22:17.*

The Receiver has inspected all but two of the thirty-two *Plata* prisons, and observed first-hand the unacceptable conditions in many prison clinical environments. At the request of the Court, in May 2007 he also prepared an extensive report concerning the impact of overcrowding on the delivery of CDCR medical care, noting the following:

In the beginning of the prison construction boom in the early 1980s, the CDCR developed a Prototypical Prison Policy Design Criteria (Exhibit 17). This policy has been revised over the years and continues to reflect CDCR and the States’ policy on what will be built at each new prison. In 1988 the policy was revised to clearly reflect the reality of overcrowding in the prison system even at that time. The policy states that at Level II, III, IV and reception centers, certain functional areas of the new prison will be built to accommodate 130 percent overcrowding. Those functional areas included *only* personnel, accounting, inmate records, procurement, receiving and release and family visiting. The policy goes on to mandate that the infrastructure at new prisons, (which includes *only* water, wastewater, electrical, mechanical) will be designed to accommodate 190 percent overcrowding in celled prisons and 140 percent overcrowding in dormitory prisons. Thus, at a policy level, by default, the CDCR short-changed by at least 50% all health care related space needs.

Therefore, while the overcrowded populations of the modern facilities approach or exceed two hundred percent, and regardless of how the CDCR attempts to *characterize* the level of crowding, the available clinic space is one half of what is necessary for daily operations.

This CDCR policy and practice, for more than twenty years, to limit health care space, including staff offices, examination/treatment rooms and medical beds, to only the base staffing level of the institution, ignoring pre-existing plans to double-cell the prison up to 200 percent of capacity, adversely impacts the daily medical, mental health, and dental operations at the following prisons:

1. Avenal State Prison
2. California State Prison-Calipatria
3. California State Prison-Centinel
4. California State Prison-Corcoran
5. California State Prison-Solano
6. Chuckawalla Valley State Prison
7. California State Prison-Sacramento
8. High Desert State Prison
9. Mule Creek State Prison
10. Ironwood State Prison
11. Kern Valley State Prison
12. California State Prison-Los Angeles County
13. North Kern State Prison
14. Pelican Bay State Prison
15. Pleasant Valley State Prison
16. R.J. Donovan Correctional Facility
17. California Substance Abuse Treatment Facility and State Prison at Corcoran
18. Salinas Valley State Prison
19. Wasco State Prison – Reception Center

Receiver's Report re Overcrowding at 21.

Therefore, a third element of the Receiver's medical construction program, the Health Care Facility Improvement Program, was developed and implemented to effectuate necessary improvements in clinical space at specific prisons in a carefully planned, coordinated manner. The primary objective of the Health Care Facility Improvement Program is to plan, design, and build clinical space, within the prisons, to provide a safe and clinically appropriate environment for staff to deliver prisoner/patient care. The following steps are utilized for each prison under review:

1. Conduct evaluations of clinical space needs to ensure prisoner/patient access and holding areas are adequate.
2. Review and evaluate, redesign and supplement primary care [sick call, chronic care, TTA] and infirmary space needs at each prison.

3. Identify areas, where clinical space is inadequate and areas to place new space, e.g., modular buildings, trailers or new structures within the prison perimeter. The assessment also will consider existing spaces that can be used more effectively and efficiently.
4. Establish adequate custody work stations within institution clinics or medical housing areas.
5. Implement space additions at the prison sites to achieve our program goals and objectives.

NOVEMBER 15, 2007 STATUS OF THE FACILITY IMPROVEMENT CONSTRUCTION INITIATIVE

A. Overview of the Facility Improvement Process

A planning and implementation strategy has been adopted which in effect pairs one of the Receiver's custody subject matter experts with representatives of the Vanir Corporation, the construction management firm which has been selected by the Receiver to design and manage the construction of the additional clinical space needed.

1. Initial Evaluation Process

To commence the evaluation process at each specific institution, the custody subject matter expert will complete the following tasks and activities:

- Contact the institution to notify of intent to initiate assessment and project planning and implementation.
 - Schedule date for team kick-off meeting, and assessment and planning meetings.
 - Schedule pre-meeting for Warden and HCM, and Receiver's Custody and Clinical experts.
- Prepare task schedule for assessment and planning activities.
- Notify Court Representative and CDCR Mental Health Director of intent to begin assessment and planning of clinical upgrades at institution. Invite these individuals to participate.
- Notify Court Representative and CDCR Dental Director of intent to begin assessment and planning of clinical upgrades. Invite these individuals to participate.
- Notify CDCR, Facilities Planning Branch, and advise of the start of assessment and planning and request notification of any developments related to CDCR work and AB 900 developments for affected prison.
- Notify CDCR Chief Deputy Secretary, Health Care Services.
- Notify CDCR *Armstrong* and *Clark* court litigation team.

2. Planning and Implementation Team

The Receiver's custody subject matter expert thereafter establishes a Planning and Site Implementation Team, who meet weekly during an approximately eight week project planning process at the institution. The team consists of the following participants:

- Vanir Construction Management Project Manager
- Vanir Construction Management Architects and Facility Planner
- CPR Custody Expert
- Prison security personnel
- Health care managers
- Facilities management personnel

The team assesses the clinical needs of the institution, and, over the course of the planning phase, develops a concept plan. The tasks and activities accomplished for the planning phase include the following:

- Assign and schedule planning and assessment meetings conducted at the institution with Vanir Construction Management, Inc. (VCM) and the local institution.
- Reserve meeting room(s) and distribute calendar notifications to team members. (CPR).

3. Facility Assessment Process

The Site Facility Assessment is accomplished by conducting weekly meetings of the planning and site implementation team at the institution. The team meets each week to assess all existing resources and space available within the institution and determine the best solutions to improving clinical space. The team tasks and activities include the following:

- Review AB 900 plans and other improvements being planning by CDCR and the Institution to avoid conflict of project space.
- Hold a kick-off meeting to orient the planning and site implementation teams to the objectives and work plan to perform the assessment, planning and project implementation.

Attendees (required):

Warden/AW	Regional Administrator, Health Care
HCM	Court Rep. (M.H.)
CMO	Court Rep. (Dental)
DON	Chief of Plant

- Hold a planning meeting to review programming and planning checklist/questionnaire with site planning team to define existing conditions and parameters of the institution.
- Discuss and project plans and ideas that the institution has to address identified clinical deficiencies. Consider and validate suggestions.
- Assemble as-built plans of institution for use in assessment.
- Walk the facilities to assess existing conditions and deficiencies as outlined by questionnaire discussions of team.
- Compare information and data collected with model space program/guidelines.
- Highlight clinical deficiencies required to be addressed.
- Identify site locations and options for facility improvements.
- Coordinate and share with CDCR Mental Health and Dental to advise of planned projects and integrate mental health and dental needs as applicable.
- Review proposed projects and options with Planning Team and refine consensus for project definition.
- Confirm if CDCR Mental Health and Dental contacts for respective departments will be participating in clinical health services space revisions concurrent with CPR's schedule and plans. Coordinate agreement with them for their participation or inability to participate.
- Finalize project definition scope, and conceptual planning, including budget and schedule.
- Have the principals of the Planning Team and the local executive managers (Warden, Health Care Manager, etc) sign off on the proposed plan.
- Prepare and present to Receiver for final project approvals.
- Define possible implementation strategies for consideration and execution by the Construction Implementation Team.

4. Construction Implementation Team

Upon the Receiver's approval of the proposed project plan, the Planning Team will hand off the project to the Construction Implementation Team. The Construction Implementation Team consists of the following individuals:

- Vanir Construction Management Construction Manager
- CPR Custody Expert
- Prison security personnel
- Prison facilities management personnel

The Construction Implementation Team establishes the strategy for each project identified in the approved plan and defines an implementation schedule with activities to complete each project. The Construction Implementation Team will review the project schedules to ensure all site-specific issues have been coordinated with the institution to assure access is not hampered and all the security requirements of the institution are not compromised during construction. The Team will execute and complete the project, coordinating occupancy with institution staff.

B. Status of Construction - The Avenal Facility Master Plan

1. Background

The Avenal State Prison (ASP) Facility Master Planning effort was initiated on July 9, 2007. ASP was selected as the first site for the program to begin remediation of the deficient clinic/treatment and support space needs. All planning efforts have been coordinated with other health care-related class action cases affecting prisoner/patients, as well as CDCR AB 900 construction efforts.

ASP was opened in 1987. The prison was designed to house approximately 2,500 inmates in dormitory housing units. The prison has experienced severe overcrowding, including double bunking, triple bunking, gym conversions to dormitory housing units and construction of additional dormitory housing units within the facilities. At present, ASP houses 7,700 prisoners. Original construction provided a 100 bed administration segregation (Ad Seg) celled housing unit for inmates displaying problem behavior, without the clinic/treatment space necessary to minimize the need to escort prisoner/patients out of the unit for medical care. The unit, however, has been overcrowded to 190% of design capacity, further aggravating treatment access problems.

ASP has also experienced CDCR mission change decisions that have increased prisoner/patient clinical acuity levels at the prison. For example, ASP now houses mobility impaired inmates, mentally ill inmates, and a significant number of elderly inmates. These changes were made with very little or no construction of additional medical, mental health or dental facilities to serve the prisoner/-patient needs. For example, although ASP was provided additional staffing resources as overcrowding increased, CDCR did not construct appropriate space to accommodate the additional staffing resources. Much of the space originally designed for inmate program and/or treatment areas has been converted to provide accommodations for the increased staff arriving at the prison.

2. The ASP Projects and Construction Phases

The ASP plan consists of several projects that are summarized below. All of the construction projects will be divided into two basic phases, a model that will be emulated in most other Facility Improvement projects. Phase I involves projects that can be completed quickly, within 60-90 days to provide urgently needed temporary clinic space. Phase II consists of projects requiring longer planning and construction time; however, provide longer term solutions than those attained in Phase I.

- 60-90 day projects:

Purchase eight “5th wheel” custom designed clinic trailers, each providing two exam rooms. This adds a total of 16 clinic exam rooms and is a temporary

immediate solution. These mobile clinic exam rooms may be relocated to other prison sites as construction is completed.

Lease two construction type modular trailers to locate near the Central Medical Building for temporary administrative office space. The relocation of medical staff out of the Central Medical Building will provide four additional exam rooms at that site. This temporary solution will be discontinued following construction of the administrative health services modular.

Relocate sergeant office and convert space to one exam room and temporary conversion of two isolation rooms to exam rooms. The isolation rooms will be reestablished following construction of the administrative health services modular as well.

- Projects longer than 90 days:

Construct three complex clinic modulars. Each complex clinic will provide needed medical and mental health clinic treatment space for the prisoner/patients housed in the two adjacent facilities (for example, one clinic complex will serve A and B yards, one will serve C and D yards, etc. Three clinic complexes will serve six yards).

Construct exam rooms within the Ad Seg building to provide appropriate medical/mental health clinic treatment space, and minimize escorts outside the building.

Construct a modular health services administration building allowing for the conversion of central medical building space to specialty clinic/treatment space. Remodel and expand the medication distribution areas in the existing facility clinics to accommodate the prisoner/patient population presently housed there.

Construct a permanent medical supply warehouse. Medical supplies are presently maintained in conex containers and rented space in the city of Avenal.

All of the projects in the ASP construction plan are scheduled to be completed within 15 months once the implementation phase begins. Some of the projects will proceed simultaneously while others must be carried out sequentially.

3. The ASP Complex Clinic Plan

The Receiver's ASP Health Care Facility Improvement Program has been designed to improve the quality and delivery of medical care and mental health treatment to the prisoner/patients at ASP, allowing health care staff to see more patients in a timely manner within quality facilities. The plan was developed and coordinated with CDCR representatives the court experts representing other health care-related class actions affecting prisoner/patients. Every effort was made to

minimize costs through the use of temporary mobile clinics and construction trailers, modular construction and remodeling of existing buildings. The Program minimizes operating expenses by utilizing the “complex clinics” concept (one clinic building serving two facilities) as opposed to the CDCR’s “facility clinic” model (one clinic building in each facility). The complex clinic model results in (1) a reduction of the number of clinics that need to be constructed (from six facility clinics to three complex clinics) thereby reducing construction expenses. More importantly, however, considering the long term operational need of ASP, the complex model maximizes the use of correctional officer and clinical staffing resources by allowing one clinic to serve two facilities. It should also be noted that mental health treatment space will be provided in the complex clinics, addressing *Coleman* concerns. This space was provided by simply adding additional space to the complex clinic designs, a very efficient, cost effective solution to a critical treatment problem at ASP both in terms of construction expenses and in terms of long term future staffing expenses. Refer to Facility Improvement Construction Initiative Appendix 1 – Avenal State Prison Program Document.

4. ASP Project Cost

The ASP Facility Master Plan construction cost (hard cost of construction) for all the projects totals \$17,423,000 with a total project cost (soft costs associated with planning, design and construction) of \$23,860,000. In a program of this nature with multiple projects, contingency planning is necessary. With the appropriate contingencies added, the Facility Master Plan for ASP would result in a Program Budget of \$27,500,000. Costs for each prison’s Facility Master Plan will be established upon completion of the site planning phase.

C. Status of Construction - The Correctional Training Facility (CTF) Facility Master Plan

1. Background

The CTF Facility Master Planning effort began on September 5, 2007. CTF was selected as the second site to develop a Master Plan because of the age, size, the deteriorated condition of the health care facilities, and the magnitude of the need for adequate clinical space. As with the ASP planning project, all planning efforts have been coordinated with the other litigation cases affecting inmate-patients, as well as CDCR AB 900 construction planning efforts.

CTF is a large institution comprised of three physically separate facilities, each with its own security perimeter. CTF-South Facility was opened in 1946, CTF-Central Facility was opened in 1951 and CTF-North facility was opened in 1958. The prison complex was designed to house approximately 3,300 inmates. The prison has experienced severe overcrowding including double celling and double bunking, the conversion of inmate program and recreation space to dormitory housing and the

construction of additional dormitory housing units. The CDCR presently lists the inmate capacity as over 7,000 inmates.

The clinic treatment space provided in the 1940's and 1950's is totally inadequate for the current number and type of prisoner/patients presently housed within the prison. There was minimal medical and dental space and no mental health space provided in the original design of CTF. As the inmate population has increased, additional health care staff has been added, however, clinical and clinical support space has not been added to accommodate these inmates or the clinical staff. This has further reduced the space available for prisoner/patient care.

2. Summary of the CTF Projects

- CTF-Central Facility Infirmary renovation will establish additional specialty clinics on the first floor and return the second floor prisoner/patient rooms to that purpose (currently the second floor patient rooms are occupied as clinician offices).
- Construct two modular buildings in CTF-Central Facility to provide medical clinic space and mental health treatment space for prisoner/patients housed in two administrative segregation housing units.
- Convert S-Wing space in CTF-Central Facility to a new Triage and Treatment Area (TTA).
- Convert five former inmate housing unit dayrooms in CTF-Central to medical/mental health treatment space.
- Renovate space within the CTF-Central Facility inmate housing units into cell block medication distribution rooms.
- Demolish the CTF-North Facility medical, mental health and dental treatment areas and construct a new building with adequate space to provide services for the CTF-North inmate population.
- Convert two vacant buildings to provide space for health care administrative functions
- Construct a modular clinic at CTF-South Facility to provide medical clinic treatment space for prisoner/patients.

3. CTF Project Costs

The CTF Facility Master Plan construction cost (hard cost of construction) for all the projects totals \$24,750,000 with a project cost (soft costs associated with planning, design and construction) of \$36,030,000. With the appropriate contingencies added, the CTF Facility Master Plan will result in a Program Budget of \$41,100,000. Refer to Facility Improvement Construction Initiative Appendix 2 – Correctional Training Facility Program Document.

FACILITY IMPROVEMENT CONSTRUCTION INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

The order of prisons selected for the Health Care Facility Improvement Program is based upon site visits, the lack of adequate clinic/treatment space for prisoner/patients and the magnitude of the health care delivery problems faced by the prisons health care team. The conceptual schedule developed in conjunction with Vanir Construction Management, Inc., includes the following:

Prison sites that planning is currently under way or completed:

1. Avenal State Prison:

The planning process began at ASP on July 9, 2007 and concluded on August 28, 2007. The current status of the implementation of the approved construction plan is as follows: The two emerging (60-90 day) projects as described above involving mobile clinic trailers and construction type modular trailers are proceeding as scheduled. These projects will provide approximately sixteen additional clinical/treatment areas, throughout the prison, for prisoner/patient care. The other ASP projects are pending the Receiver's request for waivers from Judge Henderson to allow for completion of those projects. The proposed completion date for all projects at ASP was established at March 1, 2009. This date will be impacted based on the waiver process. Funding for this project was included in CPR's current year program 97 budget.

2. Correctional Training Facility:

The planning process began at CTF on September 5, 2007 and concluded on October 29, 2007. Implementation will begin following the Receiver's request for waivers from Judge Henderson. Funding for this project has been requested as part of the FY 07/08 state budget BCP process.

3. California Rehabilitation Center:

CRC started the site planning phase on November 5, 2007. Planning is scheduled to continue until completion in January 2008. The appropriate funding request has not been submitted to the state.

Projected schedule for all the other prisons:

Twelve Month Objectives:

The following prisons are scheduled (in the order listed) to begin project planning through the end of June 2008:

- Mule Creek State Prison
- California Institution for Men
- California Institution for Women
- Folsom State Prison
- California State Prison, Sacramento
- California Conservation Center
- High Desert State Prison

The following prisons are scheduled to begin project planning through the end of December 2008:

- Deuel Vocational Institution
- Sierra Conservation Center
- California Correctional Institution
- California State Prison, Los Angeles County
- Wasco State Prison – Reception Center
- California Men’s Colony
- Salinas Valley State Prison
- Pleasant Valley State Prison

Twenty-four Month Objectives:

By the end of 2009 the project planning for all prisons will be complete.

- Chuckawalla Valley State Prison
- Ironwood State Prison
- California State Prison, Solano
- Calipatria State Prison
- Centinela State Prison
- Richard J Donovan Correctional Facility
- California Substance Abuse Treatment Facility and State Prison at Corcoran
- California State Prison, Corcoran
- Valley State Prison for Women
- Central California Women’s Facility
- North Kern State Prison
- Kern Valley State Prison
- California Medical Facility

As project plans are completed at each prison the implementation phase will begin. This means that by the end of calendar year 2008 there will be as many as 12 construction projects under way in as many prisons. By the end of 2009 that number will have more than doubled.

FACILITY IMPROVEMENT CONSTRUCTION INITIATIVE METRICS

In conjunction with staff at ASP the Receiver's custody expert assigned to the Health Care Improvement Program is in the process of developing a method of measuring the progress of the facility space improvements. The establishment of meaningful metrics for clinic operations at ASP is premature at this time for two reasons:

1. There are not accurate baseline metrics currently being maintained at ASP.
2. The improvements which should be achieved by construction cannot yet be measured because the construction has not begun.

Nevertheless, relevant clinical information will begin to be gathered, including such things as the number of completed facility clinic appointments, the number of specialty clinic appointments completed on site at the prison, and the number of patients seen at sick call lines. Information such as clinic backlogs, clinic waiting periods and number of patients seen will then be able to be compared to the data received from the prison during the project planning phase. The evaluation of this information will illustrate the impact the new space provided by the Facility Master Plan is having on the delivery of health care services.

It is anticipated that the beginning phase of these program metrics will be in place at ASP by December 1, 2007. This will enable measurement as the temporary mobile clinics come on line adding examination rooms. The ASP program metrics will be refined as necessary over the months ahead and utilized as a standard at other prisons as the implementation phase is initiated at these sites.

It must be emphasized that because access to information technology is so limited, obtaining relevant data will begin via a manual gathering process. As automated systems become available in the future, more timely and accurate information will be utilized to evaluate the impact of the new clinical facilities. The Receiver will provide the Court with additional, more specific information re construction related metrics in his Quarterly Reports.

BARRIERS TO THE SUCCESS OF FACILITY IMPROVEMENT CONSTRUCTION'S SIX TO THIRTY-SIX MONTH OBJECTIVES

As a preface, it is important to note that the planning for new and improved clinical and clinical support space is intended to provide adequate space for the existing prisoner/patient population and to accommodate that population for at least the next ten years.

1. Funding

Funding required to construct the needed clinical space in the existing prisons will approximate \$900,000,000 over the next four years. The State's normal, routine process for establishing capital outlay dollars for construction purposes will not meet the Receiver's immediate need to improve the delivery of health care with the building of new clinical space. The Receiver has met with State officials concerning this issue, and will endeavor to work with the State concerning the most effective and cost efficient manner to move this critical funding effort forward in a timely manner. Ultimately, it may be necessary for the court to intervene in order to provide funding for these projects.

2. Continued Overcrowding

The CDCR plans, through AB 900 funding, to construct thousands of additional prison beds in existing institutions in an effort to move inmates out of non-traditional ("ugly") beds in gymnasiums, dayrooms, etc. This effort, however, will not reduce the current population numbers in the prisons. Therefore, even if the prison population doesn't grow in the coming years the overcrowding of the inmate program space and the numbers of inmates to be served will not be reduced. Attempting to improve the delivery of health care by constructing new clinical spaces within existing overcrowded prisons presents serious challenges. While it is anticipated, as explained above, that the plans for ASP and CTF, for example, will provide relief for a decade, these projections will not hold if the CDCR decides to overcrowd its institutions to an even higher degree than exists as of November 2007.

3. Aggressive Construction Planning, Design and Implementation Schedule

Because of desperate conditions and the continuation of unnecessary morbidity and mortality at many prisons, and, therefore, the need to immediately improve the ability to deliver adequate health care, an aggressive construction schedule has been established, as set forth above. For example, by July 2009 there will be as many as 21 prisons with health care facilities being constructed/renovated and under construction throughout the State. Nothing of this magnitude has ever been attempted by the State. This process will require precise coordination and very close supervision by the Receiver and his staff, and will require significant resources from the Office of the Receiver as well as good cooperation from the CDCR to properly manage clinic upgrades in a timely and fiscally responsible manner.

CUSTODY ACCESS INITIATIVE (POA GOAL E)

BACKGROUND AND INTRODUCTION

In the Findings of Fact and Conclusions of Law Re Appointment of Receiver (“Findings”) filed October 3, 2005 the Court held that “[a] major problem stemming from a lack of leadership and a prison culture that devalues the lives of its wards is that custody staff present a determined and persistent impediment to the delivery of even the most basic aspects of medical care. Too frequently medical care decisions are preempted by custody staff who have been given improper managerial responsibility over medical decision making . . . Correctional officers are often not available to take prisoners to medical appointments or to enable the physicians to do examinations...In medical units that lack call buttons for prisoners to contact doctors, custody staff routinely fail to make rounds and check on patients...All in all there is a common lack of respect by custody staff for medical staff, and custody staff far too often actively interfere with provisions for medical care, often for reasons that appear to have little or nothing to do with legitimate custody concerns...This exacerbates the problem with physician retention, and the evidence reflects that a number of competent physicians have left CDCR specifically due to conflicts with custodial staff.” *See* Findings at 22:19 to 23:9.

To address this problem the Receiver has established a Custody Support Division. At present, the Division consists of a Director, 4 Custody Support Specialists, 2 Correctional Administrators, 2 Analysts and an Office Technician. The Director and Custody Support Specialists collectively have over 150 years experience in the California prison system at all levels from correctional officer through executive management. There are two major components to the Receiver’s Custody Support Division: (a) operational assessments/remedial plans; and (b) facility assessments/remedial plans. Refer to the Facility Improvement Construction Initiative. The Division’s mission includes addressing the following problems:

1. A custody-driven correctional culture which interferes unnecessarily with the delivery of medical services.
2. The lack of clinically-oriented correctional teams to provide support for medical services.
3. Inadequate and, many times, inappropriate correctional staffing necessary to deliver medical services in a timely and professional manner.
4. The CDCR’s failure to implement the appropriate correctional organizational and operational schedules dedicated to the delivery of health services.

A. San Quentin Pilot Project: Corrections/Medical Delivery Assessment.

In order to gauge the scope and severity of the Findings, and to commence a process to determine the most appropriate strategy for remedial action, the Receiver began his assessment of custody-related problems with the delivery of medical services

on a pilot basis at San Quentin State Prison beginning in mid-2006. He found that along with a severe shortage of custody personnel to escort and transport prisoner/patients to their appointments, the institution lacked an organized operational schedule of daily activities that integrated institution security operations with access to care requirements. The lack of dedicated resources or any integrated plan, as well as a dire shortage of clinically appropriate treatment space, offered significant barriers to prisoner/patient care.

For example, newly arrived inmates were routinely held in outdoor holding cages until 3:00 a.m. waiting to be admitted and processed into the institution. Custody escort officers were assigned to each housing unit. If, however, the escorts within a particular housing unit were completed, the officers sat idle while prisoner/patients in other housing units missed their appointments because the escort officers in the other buildings were unable to complete their assigned escorts. Instead of relying on an organized, institutional appointment scheduling system, each health care discipline (medical, mental health and dental) submitted to custody staff some form of a prisoner/patient list. There was no ability to coordinate, or even be aware of, competing appointments “scheduled” for the same prisoner/patient on the same time and/or date. There was no system in place to follow-up if a general population prisoner/patient failed to report to a medical appointment. This resulted in numerous missed appointments and excessive backlogs. Prisoner/patients were often not escorted to the lab for blood draws. Follow-up, due to the lack of escort officers and an ineffective appointment scheduling system, was not possible. Institution managers faced an ongoing backlog of incomplete physical exams which were ordered, by the Court as well as by clinicians, to be completed on all new admissions. Because the physical exams could not be completed, the prisoner/patients could not be processed in a timely fashion which delayed transfers out of the San Quentin Reception Center. This only served to further exacerbate the overcrowded conditions, the inability to provide timely medical care, and the general level of chaos and dysfunction within the institution.

In addition, appointments with outside specialty clinic providers were cancelled or postponed on a regular basis at San Quentin. Transportation vehicles were completely inadequate; indeed, much of the prison’s vehicle fleet was so worn that they were not roadworthy. The institution did not have a formal medical emergency response team, and cross training for correctional officers and medical personnel was not provided. Operationally, San Quentin was suffering from years of dysfunction without the necessary resources to meet increasing demands. Neither the institution nor the CDCR had been able to galvanize and organize the resources or the will required to provide adequate and sufficient health care.

B. The Custody Support Division’s Statewide Correctional/Medical Delivery Assessment Program.

During the course of the Receiver’s prison visits, it became apparent, consistent with the Findings, that the custody-related problems with the delivery of medical services at San Quentin are endemic throughout the prisons in the CDCR. To evaluate these problems, and to begin to effectuate needed remedial action concerning it, the Custody

Support Division was established and commenced a three-pronged evaluation/remedial process as set forth below:

1. Individually assess the adequacy of institution custody operations and their nexus to health care operations at each institution with a goal to improve prisoner/patient access to care by enhancing institution staffing (both custody and health care) and transforming each institution's operations (starting with preliminary operational reviews).
2. Re-assess each institution's custody and health care operations following the completion of a Health Care Facilities Improvement Plan prison assessment to ensure the institutions continue to be resourced appropriately once new clinical spaces have been constructed.
3. Create individual custody access units at each institution, following the model created through the San Quentin pilot project.

Two points require emphasis:

- a. This process focuses upon the inter-relation between custody operations and the delivery of health care services. It is not an overall assessment of a prison's correctional operation.
- b. The three prongs are not linear in terms of implementation. Instead, the process requires simultaneous work completed on several fronts in order to effect the Receiver's remedial plan.

As explained below in the timeline, that as the process unfolds, the remedial plan will become more ambitious, involving detailed staffing analyses and clinical space improvements at multiple institutions simultaneously.

NOVEMBER 15, 2007 STATUS OF CUSTODY ACCESS

To commence the statewide correctional/medical delivery review, onsite reviews were completed at five institutions (Avenal State Prison, Ironwood State Prison, Sierra Conservation Center, Wasco State Prison – Reception Center, and the Correctional Training Facility) in order to determine the scope and magnitude of the problems that may be anticipated prior to determining a plan of action to address staffing and operations for access to health care. For each inspection, the Custody Support Division established a "review team" of Custody Support Specialists to conduct the evaluation. Review teams included the Receiver's medical and custody experts, regional and local CDCR officials, and, when indicated, representatives from the *Perez*, *Coleman* and *Armstrong* class actions. In addition, these review teams conducted a review of the hemodialysis programs at Kern Valley State Prison and at the California Substance Abuse Treatment Facility.

Based on the findings at the above reviews, it became evident that preliminary operational reviews needed to be conducted at all prisons. Thus far, preliminary operational reviews, in addition to the aforementioned, have been completed at High Desert State Prison, California Correctional Center, California State Prison - Solano, RJ Donovan Correctional Facility, Folsom State Prison, California Institution for Men, California Rehabilitation Center, California Institution for Women, Deuel Vocational Institution and California State Prison - Los Angeles County.

The purpose of the on-site preliminary operational review is to 1) identify the site-specific as well as systemic issues impeding custody from facilitating prisoner/patient access to health care, and 2) where possible, to offer and provide resources and solutions. The process has focused on how custody and the health care operations intersect at those times and locations where prisoner/patients access health care services within the institution. While on-site, the review team takes the opportunity to emphasize the importance of inter-disciplinary communication, recommends systems to resolve operational problems and suggests the establishment of important linkages between custody and health care staff at various operational levels.

The process generally requires the review team to spend three to four days at each institution on all three watches. Interviews are conducted with the Chief Medical Officer/Health Care Manager, Chief Psychiatrist, Correctional Health Services Administrator, Supervising Registered Nurse III, Health Records Technician II, Custody Captain, Medical Appeals Coordinator, specialty clinic nurses, correctional officers assigned to health care access points within the institution, outside transportation officers, custody supervisors, and other personnel as needed based on site-specific issues. The review team also takes into account institution-specific factors such as the physical plant, institution security level(s), inmate housing configuration(s), and anything significantly impacting operations. Information is reviewed on current population and the extent to which the institution is overcrowded, operational issues such as any special missions, inadequate/inappropriate clinical space, prisoner/patient appointment scheduling, and vacancies among custody and health care staff that are obvious management concerns. In the course of its review, the review team collects numerous documents and reports¹ to aid in its analysis, including:

- Institution mission statement
- Vacancy reports for custody
- Vacancy reports for health care staff
- Post assignment schedule
- Master assignment roster
- Post orders
- Sample movement sheets
- Sample ducat lists

¹ The quality and veracity of the information is questionable due to the lack of any viable data systems or quality control mechanisms. Existing data was utilized, however, as no other data is available.

- Operational procedures
- Off-site specialty clinic aging report
- On-site specialty clinic aging report
- Medical Appeals reports
- Previous staffing requests
- Previous space requests
- Daily activity report
- Overtime and budget information
- List of institution vehicles/mileage
- Transportation data (standard CDCR monthly report)
- Other reports as provided by the institution.
- Key indicator report(s)

The review team also reconciles the post assignment schedule against the master roster for all health care custody positions, and interviews as many of the correctional officers and supervisors as possible to ascertain if their duties are consistent with written post orders. In addition, the review team obtains information through observation of prisoner/patients as they access medication lines, facility clinics, specialty clinics, sick call and all other services delivered by health care clinicians and providers. Information obtained in these reviews continues to underscore the fact that institutions do not have adequate resources (quantitative or qualitative), and existing resources are not organized in a manner that provides appropriate access to care. For example:

1. On-site specialty clinic appointments were cancelled due to one or more of the following reasons: a lack of custody officers, a lack of transportation vehicles, other competing priorities, or inappropriate cancellation of appointments by both health care and non-health care personnel.
2. One institution established a practice of taking blood pressure checks by having the prisoner/patient place his arm through the food tray port in the cell door. Upon being advised the procedure was inappropriate, the institution modified the practice by having custody staff escort the prisoner/patient to a holding cell, where he was still instructed to place his arm through the food tray port in the holding cell. (The review team worked with the institution to establish a clinically appropriate procedure.)
3. Prisoner/patients do not present themselves to the clinic to refuse medical service. Instead, clinic officers accepted refusals over the telephone and signed the refusal form on behalf of the prisoner/patients. In one instance, the prisoner/patient's work supervisor called to cancel the prisoner/patient's appointment because he was needed in the shop to assist in meeting a production schedule.
4. In at least two institutions, inmates were performing clerical functions in the medical clinics.

5. The alarming number of correctional officer vacancies at some locations presents serious problems relative to health care access as well as safety and security for all personnel including the inmate population. During a review conducted in July 2007, numerous correctional officers and supervisors commented on the unprecedented number of vacant custody posts that must be covered by involuntary overtime on a daily basis. Several stated they had already been ordered over three to four times during the first twelve days of July.
6. Patients were transported to outside hospitals in medical transportation vehicles which exceeded the State and CDCR mileage limitations and were in such poor condition that continued use poses significant risk to both staff and prisoner/patients. Appointments were often cancelled due to the lack of available transportation vehicles.
7. At one institution, one week prior to the preliminary review, a Code 3 ambulance was required to wait for over one hour before transporting the patient to the outside community hospital due to no other vehicles being available to provide security coverage in a chase vehicle.
8. There is limited or non-existent communication between custody and medical staff in coordinating health care access, delivery, and movement of prisoner/patients within the institution.
9. At some locations, staff have been provided no training in the Inmate Medical Scheduling and Tracking System (“IMSATS”) data collection system (a notoriously inaccurate data source to begin with), resulting in prisoner/patients missing critical appointments with specialty clinic providers. Other prisoner/patients have been required to repeat previously administered clinical procedures because essential follow-up was not provided following the prisoner/patient’s return from treatment by an outside community provider.

At the conclusion of each review, appropriate staffing resources specifically tailored to address the shortcomings are recommended. As these resources are approved, instructions are transmitted to the respective Wardens and Chief Medical Officers, Health Care Managers to implement the recommendations and hire the additional personnel resources authorized in this process. Where new custody positions are recommended, the review team outlines the specific responsibilities of the new positions. Recommendations are also made to make more efficient use of existing resources by modifying duties, and clarifying roles, responsibilities and supervision. The Warden, Chief Medical Officer, and Health Care Manager sign an agreement with the Receiver that establishes how the recommended positions shall and shall not be utilized, and that the post orders/duty statements for the positions must be approved by the Director of the Receiver’s Custody Support Division before the positions may be established. Refer to Custody Access Initiative Appendix 1 – Sample Operational Review Report for CIM and Agreement Letter and Custody Access Initiative Appendix Appendix 2 – Summary of New Positions Approved by the Receiver.

CUSTODY ACCESS INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

A. Preliminary Operational Reviews POA

A schedule has been developed that will enable all institutions to be evaluated over the next six months, with the final preliminary assessment completed by May 2008. Preliminary Operational Reviews for the remaining institutions will commence as follows:

- KVSP November 5, 2007
- NKSP November 12, 2007
- SATF December 3, 2007
- MCSP December 17, 2007
- CMC January 7, 2008
- SVSP January 21, 2007
- CVSP February 4, 2008
- CEN/CAL February 25, 2008
- CCWF/VSPW March 10, 2008
- CCI March 24, 2008
- COR April 7, 2008
- PVSP April 21, 2008
- CSP/SAC May 7, 2008

B. Follow-Up Prison Assessments

The Receiver's Facilities Improvement Construction Initiative calls for an assessment at each prison during the course of the next thirty-six months, culminating in a Facility Master Plan Report for each prison that will outline plans to renovate and construct clinical and selected clinical support space. As this process is implemented at each institution, a follow-up reassessment of operations will be completed. The purpose is to determine whether retrofitted or new clinical space, as outlined in each prison's Facility Master Plan Report, will require additional custody staffing, a realignment of existing staffing, or operational changes to ensure continued access to health care services in the renovated physical plant. As of this date, staffing and operational reassessments have been completed for Avenal State Prison and for the Correctional Training Facility following the completion of the Facility Master Plan Reports.

The schedule for Follow-Up Assessments is set forth below.

Six Month Objective:

Complete Facility Master Plans and Follow-Up Assessments for staffing at 6 prisons.

Twelve Month Objective:

Complete Facility Master Plans and Follow-Up Assessments for staffing at 7 additional prisons.

Twenty-Four Month Objective:

Complete Facility Master Plans and Follow-Up Assessments for staffing at the remaining 17 prisons.

C. Creation of Custody Health Care Access Units

The creation of prison-specific Health Care Access Units represents the final phase of the Receiver's three-prong process to address the corrections-related problems with inmate access to medical care. Health Care Access Teams are the organization of a specific custody team of officers, custody supervisors and managers within each institution that are specifically dedicated to prisoner/patient access to health care. The personnel are to be accountable for escorting, transporting and guarding prisoner/patients to and from medical appointments within the institution and to specialty care providers within the local community. This Unit will also be responsible for providing the requisite security coverage for all points of access to care within the institution. The Unit is made up of new and existing custody resources managed by an Associate Warden working in concert with medical personnel to constitute a system which effectively utilizes custody and health care resources and establishes prisoner/patient access to care in conformance with established policy and standards.

The Health Care Access Unit pilot project was implemented in December 2006 at San Quentin State Prison. Development of the Access Unit was divided into several stages and required meticulous planning and attention to detail. Custody requirements for the day-to-day security and medical operations were analyzed to ensure safe access to health care for all prisoner/patients. Of equal importance, the need for custody personnel and equipment were evaluated to facilitate the off-grounds medical transportation workload and custody supervision of prisoner/patients in community hospitals.

In collaboration with San Quentin staff, operational procedures and post orders were developed, as well as a Health Care Access Unit organizational structure. Existing custody resources within the prison were realigned to reflect the new organizational structure. In order for the new Health Care Access Unit to function as intended, additional custody resources were necessary. Unfortunately, due to the inability of the CDCR to recruit, screen, hire, and train sufficient correctional officers, it was necessary to implement the Access Unit at San Quentin with only a fraction of the total custody personnel required. As of this date, the Unit is required to utilize officers hired on an overtime basis in an attempt to meet operational needs.

Nonetheless, as of June 11, 2007 all existing custody personnel involved in health care access at San Quentin have been assigned to the new Health Care Access Unit. The

Receivership continues to closely monitor the progress of this pilot program, as well as the status of the CDCR efforts to fill the correctional officer vacancies. An additional 50+ correctional officer posts at San Quentin will soon be activated in order to achieve the access to care requirements which have been determined essential in providing constitutionally adequate health care.

The Custody Support Specialists of the Receivership have developed a plan to establish Custody Access Units at each institution, following the model created through the San Quentin Project. Early in the San Quentin pilot, it became evident that simply replicating the San Quentin pilot project at each institution would be much more complex than previously projected. The process would require a well-planned and thoughtful approach tailored to the specific characteristics of each prison based on its inmate population, mission, geography (internal and external), provider network, etc.

At the current time, the Receivership's Custody Support Specialists continue to monitor the implementation phase at San Quentin. As part of implementation, processes are being developed for collecting information to evaluate the progress of the Access Unit at San Quentin (See discussion of metrics below).

On June 18, 2007, site work began at the California Medical Facility to replicate the San Quentin Project Health Care Access Unit. In-depth interviews were conducted with a lengthy list of both health care and custody personnel. The post assignment schedule and the master roster were reconciled. Numerous documents were collected. A gap analysis was completed of custody posts on each shift throughout the institution to determine if current duties are consistent with the post assignment schedule and post orders. Analysis is nearing completion. A proposed organization structure has been crafted, and all parties are working to finalize the design so the implementation, training and activation of the California Medical Facility Health Care Access Unit may begin in November 2007.

Six Month Objective:

Avenal State Prison has been identified as the third location for replicating the San Quentin Health Care Access Unit pilot project. Initiation of the site work is projected for a start date in January 2008 with implementation to follow in May 2008.

Twelve Month Objective:

It is anticipated that by June 30, 2008, Health Care Access Units will be established and in operation at San Quentin, California Medical Facility and Avenal State Prison.

Twenty-Four Month Objective:

By June 30, 2009, complete Health Care Access Units are scheduled to be established at four additional institutions. Tentatively, those institutions have been identified as California Institution for Men, California Rehabilitation Center, California Institution for Women and Mule Creek State Prison.

Thirty-Six Month and Longer Objectives:

By June 30, 2010, complete Health Care Access Units are scheduled at six additional institutions. Tentatively, those institutions have been identified as Folsom State Prison, California State Prison - Sacramento, California Conservation Center, High Desert State Prison, Deuel Vocational Institution, and Sierra Conservation Center.

By June 30, 2011, complete Health Care Access Units are scheduled at eight additional institutions. Tentatively, those institutions have been identified as the California Correctional Institution, California State Prison - Los Angeles County, Wasco State Prison – Reception Center, the California Men’s Colony, Salinas Valley State Prison, Pleasant Valley State Prison, Chuckawalla Valley State Prison, and Ironwood State Prison.

By June 30, 2012, complete Health Care Access Units are scheduled at eight additional institutions. Tentatively, those institutions have been identified as the California State Prison - Solano, Calapatria State Prison, Centinella State Prison, Richard J. Donovan State Prison at Rock Mountain, the California Substance Abuse Treatment Facility and State Prison at Corcoran, Valley State Prison for Women, and Central California Women’s Facility.

The remaining two prisons will be scheduled for complete Health Care Access Unit implementation by January 2013.

D. Transportation Vehicles

The Preliminary Operational Reviews also provide an assessment of the medical transportation needs of the institutions. For most institutions reviewed to date, the lack of transportation resources is directly associated with canceling or postponing prisoner/patient appointments. Custody supervisors routinely do not have enough vehicles to meet the scheduling needs for off-grounds specialty clinic appointments.

To date the Receivership has purchased thirty para-transit vans for the institutions to transport mobility impaired prisoner/patients. Security modifications are complete on all but six vans. Twenty-four para-transit vans have been delivered to the institutions. Another eighty-six passenger vans have been purchased, delivered to various vendors for security modifications, and are currently being released to the institutions as completed.

It is projected that by January, 2008, all after-market security modifications and distribution to all thirty-three adult institutions will be complete.

Preliminary Operational Reviews enable the Receiver to address the most significant deficiencies at each institution as expediently as possible. Consequently, when the complete Access Unit review is conducted, the basic elements of operation should be in place. A written procedure has been developed for the procurement of medical transportation vehicles including the aftermarket security hardening and equipment necessary for prisoner/patients transportation. Refer to Custody Access Initiative Appendix 3 – Procurement of Medical Transportation Vehicles Procedure. In addition, a tracking process has been initiated that enables the tracking and status of every medical transportation vehicle from the day it is ordered through delivery, outfitting with security equipment and delivery to the institutions. Refer to Custody Access Initiative Appendix 4 – Medical Transportation Vehicle Tracking Process.

Specifications are being developed to demonstrate the standards for security equipping the medical transportation vehicles. These specifications will be utilized to ensure vendors clearly understand the requirements for bidding and that all medical transportation vehicles will be security equipped in an appropriate and standardized manner.

It should be noted as well that these new vehicles are medical vehicles designated by the Receiver and stenciled as such. They are not just added to the Warden’s general vehicle fleet. Wardens have been advised that they may, upon request and if granted permission, borrow the vehicles for urgent, non-medical, one-time purposes.

CUSTODY ACCESS METRICS

Currently, the Receiver’s Custody Support Division is developing performance metrics to establish ongoing accountability and measure the success of the Health Care Access Units. The following statistical information will be developed into a monthly “report card” to measure the overall effectiveness of each Access Unit:

1. Total number of appointments scheduled for medical treatment inside and outside the institution:
 - a. Facility/yard clinic appointments total: _____
 - b. Specialty clinics on-site total: _____
 - c. Specialty clinics off-site total: _____

2. Total number of prisoner/patients who failed to answer medical appointment ducats scheduled at each facility/yard clinic within the institution: _____
 - a. Of the number of prisoner/patients who failed to answer medical appointment ducats scheduled at each facility/yard clinic within the institution, what is the number of failures to appear caused by:

- i. Prisoner/patient refusals: _____
 - ii. Lack of custody escort: _____
 - iii. Access Unit error: _____
 - iv. Clinician cancellation: _____
 - v. Other (specify): _____

- 3. Total number of prisoner/patients who failed to answer for medical ducats scheduled for on-site specialty clinic appointments: _____
 - a. Of the number of prisoner/patients who failed to answer medical ducats scheduled for on-site specialty clinic appointments, what is the number of failures to appear caused by:
 - i. Prisoner/patient refusals: _____
 - ii. Lack of custody escort: _____
 - iii. Access Unit error: _____
 - iv. Clinician cancellation: _____
 - v. Other (specify): _____
 - vi. Lack of transportation vehicles: _____

- 4. Total number of prisoner/patients who failed to answer medical appointments scheduled for off-site specialty clinic appointments: _____
 - a. Of the number of prisoner/patients who failed to answer medical appointments scheduled for off-site specialty clinics, what is the number of appointments canceled for each of the following reasons:
 - i. Prisoner/patient refusals: _____
 - ii. Lack of transportation officers: _____
 - iii. Lack of transportation vehicles : _____
 - iv. Clinician/provider cancellation: _____
 - v. Other (specify): _____

- 5. Total number of prisoner/patient medical appeals received each month:
 - a. Of the total number received, how many were categorized as “Access to Care”: _____

- 6. Total number of prisoner/patients transported during reporting period to:
 - a. scheduled appointments at community providers: _____
 - b. community hospitals: _____

- 7. Total number of medical Emergency Code transports to outside hospitals:

- a. First Watch: Code III _____ Code II _____
- b. Second Watch: Code III _____ Code II _____
- c. Third Watch: Code III _____ Code II _____

8. Custody Assignments and Vacancies:

- a. Total number of authorized budgeted correctional officer positions: _____
- b. Total number of correctional officer positions assigned to Access Unit: _____
- c. _____ Total number of vacant correctional officer positions in the institution:
- d. _____ Total number of vacant correctional officer positions in the Access Unit:

9. Total overtime hours expended for Medical Transportation: _____

10. Total overtime hours expended for Medical Guarding: _____

11. Total hours covering health care functions (clinics, medical transportation, custody escort coverage for ambulances, medical guarding, etc.) through the use of redirecting custody personnel from other (non-program 50) areas: _____

12. Number of program modification reports caused specifically by insufficient custody staffing for health care functions (clinics, medical transportation, custody escort coverage for ambulances, medical guarding, etc): _____

While the Receiver recognizes there is currently no electronic data collection system available for this purpose, it is nonetheless important to begin piloting a management tool to capture Access Unit performance. A monthly report will be developed and used on a pilot basis beginning on January 1, 2008 at San Quentin. The performance metrics will be collected and evaluated for six to eight months at San Quentin to ensure the data being collected provides an accurate measure of the Access Unit performance. Within twelve months, the monthly report will be instituted at institutions as each Access Unit is established. As information technology systems are developed and implemented the collection of data for purposes of evaluating Health Care Access Unit performance will be standardized at all the prisons.

BARRIERS TO THE SUCCESS OF THE CUSTODY ACCESS SIX TO THIRTY-SIX MONTH OBJECTIVES

1. Correctional Officer Vacancies

One potential risk to the Receiver’s remedial plan is the continued inability of the CDCR to fill all of its vacant correctional officer positions. Even worse, the department has long ignored the totality of vacant positions generated by non-budgeted workload such as medical guarding, medical transportation and other critical custody functions the

department has historically failed to acknowledge. The department's continued failure to address the full extent of its correctional officer shortfall is a serious threat to the Receiver's remedial efforts as well as the security and safety of the institutional environment and surrounding community. The annual funding for a correctional officer is \$86,648 (\$60,816 for salaries and wages, \$24,673 for benefits and \$1,159 for OE&E). The annual cost to fill a position on overtime is \$89,268 (\$7,439 per month) at time and a half. This is based on a mid-range salary of \$4,959 per month.

In a response to a request for information regarding correctional officer vacancies, the CDCR estimated there are currently 1,486 unbudgeted correctional officer positions being posted statewide. Refer to Custody Access Initiative Appendix 5 – California Department of Corrections and Rehabilitation's Response to the Receiver's Request for Information. These posts, although unbudgeted, are presently being covered on an overtime basis at the time and a half rate of pay. Using the formula above it costs \$2,620 per year more to fill a correctional officer post on an overtime basis than it does to fill the post with a full-time employee. If there are 1,486 unbudgeted correctional officer positions being posted at a cost of \$2,620 per year each, it is costing an additional \$3,893,320 per year to not fill the positions.

While it is only somewhat more costly to run a position on overtime instead of filling the position (\$3,893,320 annually), there are other variables that need to be considered as well. For example, if the institutions are operating with excessive overtime, it leads to lower productivity and higher workers' compensation claims because the employees are overworked. The excessive and continued *involuntary* overtime for correctional officers driven by the effort to fill only those positions the department has officially budgeted, has created conditions at many institutions where the custody staff are forced to call in sick in order to get a day off.

2. Formalizing and Monitoring Change

Another potential barrier the Receiver has foreseen is that with any significant change, it is always much easier to change the written policies and procedures than it is to change the institutional and organizational culture. This must occur to make the remedial plans successful. A lengthy period of structured observation and continued monitoring by the Receiver's Custody Support Specialists will be required for years to come as the CDCR transitions to the new model of access to care.

Ideally, it is envisioned that a formalized Health Care Access compliance review will be conducted annually at each institution. Under this structure, review teams would initiate on-site evaluations at each institution. In addition to evaluating records, files and documents, the review would include direct observations of all points within the institution where prisoner/patients access health care. Conceivably, the reviews will be designed to measure compliance with departmental standards, as well as mandates implemented by the Receiver.

Development of a formalized audit instrument and schedule will not occur until after the Access Units have been implemented at several institutions.

3. Funding

All remedial efforts being envisioned and implemented by the Receiver are dependent upon adequate funding, not as defined by the State (including the Legislature and administration), but rather as defined by the Receiver and the Court.

CONTRACT AND INVOICE PROCESSING INITIATIVE (POA OBJECTIVE A.4 AND A.6)

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 “[d]efendants have failed to provide patients with necessary specialty services. Patients with very serious medical problems often wait extended periods of time before they are able to see a specialist due to unnecessary and preventable delay...In one instance a patient with a colonoscopy referral had to wait ten months before his appointment, by the time he was seen the mass in his colon was so large that the colonoscope could not pass through...Even when patients do see a specialty consult, medical staff often do not follow-up on the specialist’s recommendations.” *See Findings at 24: 19-28.*

The Court (and the State) recognized that problems with the delivery of medical services in California’s prisons involved an inadequate infrastructure. In other words, the underlying administrative organizations necessary to deliver adequate health care services in California’s prisons simply does not exist. For example:

“Defendants concede that this rapid growth of the correctional system was not accompanied by organizational restructuring to meet increasing system demand and that it requires fundamental reform in a variety of areas, including management structure, information technology and health care services in order to function effectively and in compliance with basic constitutional standards.” *See Findings at 4:22-26.*

“Furthermore, central office staff do not have the tools they need to handle the vast quantity of information necessary to manage a billion dollar, 164,000 inmate system. . . Data management, which is essential to managing a large health care system safely and efficiently, is practically non-existent.” *See Findings at 6:16-25.*

A critical component of the CDCR’s program for providing specialty care to prisoner/patients is a more than \$400,000,000.00 per year health care contract system. The State’s inability to procure, manage, and pay for specialty providers, registry personnel, and hospital services provides a classic example of how an inadequate infrastructure lead to the failure to deliver constitutionally adequate medical care. Indeed, problems with State health care contracts reached crisis proportions during the months prior to the creation of the Receivership. Two interrelated factors contributed to the crisis:

1. CDCR utilized, prior to the Receivership, a confusing, duplicative, and overall inadequate three-tier contract procurement and payment system whereby the State personnel responsible for determining appropriate medical providers and negotiating rates were physically located at 501 J Street; the State personnel responsible for verifying insurance, licenses and documents, processing of contracts and ensuring compliance with all State contracting laws and regulations were located at 1515 S Street; and the State personnel

responsible for reviewing provider invoices and paying those invoices were located in thirty-three separate prisons and a number of regional CDCR regional accounting offices.

2. Management Memo 05/04, issued by the Department of General Services (“DGS”) on January 26, 2005 ruled that State departments could no longer issue medical contracts for hospitals, medical groups and physicians without formally bidding for these services. The issuance of this Management Memo was due to the Bureau of State Audits April 2004 Report No. 2003-117 “California Department of Corrections: It Needs to Ensure That All Medical Service Contracts It Enters Are in the State’s Best Interest and All Medical Claims It Pays Are Valid.” This report concluded that CDCR did not adequately ensure that the medical service contracts executed were in the State’s best interest, as they were negotiated based on a 30-year-old state policy exemption, an exemption that could not be substantiated due to lack of sufficient documentation required to uphold this policy. In essence, Management Memo 05-04 stopped the approval process of all medical contracts that were not bid (approximately 66% of health care contracts). Unconcerned with or unaware of the impact on inmate-patients’ health and lives, no grace-period for emergency cases or on-going services was contemplated by the State officials who implemented the Memo.

As found by the Court in its March 30, 2006 Order re State Contracts and Contract Payments Relating to Service Providers for CDCR Inmate/Patients (“Order re Contracts”), this form of State mismanagement presented:

[A]nother chilling example of the inability of the CDCR to competently perform the basic functions necessary to deliver constitutionally adequate medical health care. In this instance, the abdication not only threatens the health and lives of inmates but also has significant fiscal implications for the State.

See Order re Contracts at 1:25-28.

Instead of approaching these new requirements proactively, the CDCR and the State’s control agencies - the Department of Finance, the Department of Personnel, and the DGS - stuck their collective heads in the sand. The administrative processes required by the new DGS requirements are quite time-consuming and complex. Yet the CDCR and the State’s control agencies failed to provide the staffing and training necessary to handle the newly heightened obligations and implement effective fiscal controls over the contracting process.

See Order re Contracts at 2:27 to 3:6.

Therefore, on the second day of the Receivership, April 19, 2006, the Receiver assumed responsibility for overseeing the State’s compliance with the provisions of the Order re Contracts, including the Court’s mandate (1) that “all current outstanding, valid, and CDCR-approved medical invoices” be paid within 60 days of March 30, 2006; and (2) that under the direction of the Receiver, the CDCR and State entities responsible for contracts develop and implement health care-oriented policies and standards to govern the CDCR medical contract management system, considering both the need for timely on-going care and the fiscal concerns of the State.

NOVEMBER 15, 2007 STATUS OF CONTRACT AND INVOICE PROCESSING INITIATIVE

Under direction of the Receiver, the CDCR's health care contract units have undergone significant changes. For the most part, these changes have focused on five critical problems: (1) resolving the invoice payment crisis; (2) recreating a viable contract processing unit and thereby establishing an infrastructure for future contract processing reform; (3) implementing badly needed information technology; (4) establishing initial programs to better coordinate the contracting process with the clinical and administrative needs of the *Armstrong*, *Coleman*, and *Perez* class actions; and (5) beginning the initial steps to better manage contract costs.

Examples of the more significant contract processing changes which have been implemented during the first eighteen months of the Receivership include the following:

1. Under the direction of the Receiver and his staff, the CDCR paid all outstanding invoices within 60 days in compliance with the Order re Contracts. This effort called for diligence, organization, and constant monitoring, improved coordination between the prisons and CDCR's Central Office, and improved cooperation between health care personnel and accounting/contracts personnel. Once the backlog was eliminated the CDCR has, by and large, remained current with its invoice processing, continuing to rely upon the provision of the Court's March 30, 2006 Order.
2. The previously separate work units which process CDCR health care contracts have been entirely reorganized into the new *Plata* Contract and Invoice Branch ("PCIB"). Refer to Contracts and Invoice Processing Appendix 1 – Plata Contract and Invoice Branch Organizational Chart. More significant changes include the following:
 - A. Combining of contract personnel from 1515 S Street with the contracting staff from 501 J Street to establish one streamlined and centralized location, under the direction of the Receivership, for all phases of health care contract processing (completed January 2007).
 - B. Commencing a pilot program to merge prison Health Care Cost Utilization Program ("HCCUP") staff into one central office location rather than thirty three separate prisons (completed August 2007).
 - C. Commencing a pilot program to merge CDCR regional accounting staff responsible for health care invoice payment from multiple regional accounting offices into one central office location (completed October 2007).
 - D. Commencing a pilot program at the California Correctional Institution and California State Prison - Los Angeles County to reach out to additional specialty providers in a effort to improve the scope of covered services available and to improve relations with the specialty providers for these prisons. *See also* Specialty Services Pilot Initiative.
 - E. Restructuring the work units which process CDCR health care contracts to provide improved management coverage and operational oversight. Restructuring of a critical State function to this degree has generated a number of very serious management challenges. For example, as of October 2007 PCIB was experiencing a 40% vacancy

rate for the critical Staff Services Manager position, and a 36% vacancy rate in the analytical classifications. Furthermore, almost 70% of the current contract analysts have less than one year of CDCR experience.

3. Procuring, customizing, and implementing, on a pilot basis, a contract specific information technology program called the Health Care Document Management System (HCDMS) and thereafter implementing HCDMS, on a pilot basis, at four institutions: California Medical Facility; Central California Women's Facility; Pelican Bay State Prison; and San Quentin State Prison. As a result, significant improvements in quality control, contract management, and invoice processing time have been achieved at these institutions.
4. Establishing new practices which provide for clinical and administrative involvement by medical, mental health, and dental staff in State procedures for procuring statewide registry contracts. In the past, the rates paid to registry staff were determined by the CDCR's central office without regard of the needs on the part of CDCR medical and mental health officials who were attempting to secure a full time permanent State clinical workforce in the prisons. New practices have been implemented to coordinate registry contract rate negotiations with the appropriate CDCR disciplines, including representatives from the Special Master's Office in *Coleman*.
5. Commencing a process to convert rate negotiations from the prior standard of "Relative Value for Physicians" to a more standardized and manageable "Medicare-based" reimbursement system. In addition, initial work has been completed concerning the development of rate negotiation and analytical tools to be used for negotiating with individual specialty providers and medical groups.

CONTRACT AND INVOICE PROCESSING INITIATIVE: NOVEMBER 2007 TO NOVEMBER 2010

The primary objective of the PCIB is to process efficient and cost effective direct medical service contracts which provide appropriate and timely care for prisoner/patients. When doing so the PCIB must also provide adequate contract oversight, consistent and timely processing/payment of medical invoices, and it must develop systems which capture relevant cost and utilization data. Two fundamental changes in PCIB operations are needed to reach these objectives:

1. The PCIB itself (in other words, the underlying contract organization) must continue to be structurally reorganized and adequately and appropriately staffed. This future reorganization will consist of two primary elements: (a) the merging of contract and invoicing functions at 501 J Street; and (b) the roll-out of the contracts information technology system (HCDMS) and streamlined processing systems (for both procurement and invoice processing) at all thirty three CDCR institutions through a four stage process.
2. While these contract infrastructure enhancements are being implemented, the Receiver will establish programs to create an adequate statewide specialty provider and hospital

network for more than 170,000 male and female prisoners. The network will serve inmates who are confined to thirty-three prisons and a host of community correctional facilities scattered throughout the State, often in some of the most desolate, remote locations in California.

Two critical considerations will guide the Receiver's contract project over the next thirty-six months:

1. The PCIB restructuring program and the Receiver's plan to establish a statewide network of specialty providers and hospitals must complement each other. Neither can be entirely successful without the other. To complicate matters, both projects represent challenges for which there is no State precedent. Because there is no effective State model to emulate, the POA concerning these changes requires pilots, the services of outside consultants, and thoughtful, time-phased implementation.
2. At this point in time the Receiver remains committed to the goal of establishing an effective health care contract process within State service. For this reason, the Receivership has invested considerable time and resources in securing new information technology, additional contract staffing, and improved working conditions. There are those who urge the Receiver to "privatize" this critical State function, responsible for more than \$400,000,000 in annual disbursements. To date, however, the Receiver has chosen to work within the State structure, to the degree possible, and he continues to seek a long-term contract solution which utilizes CDCR employees. This form of solution may take somewhat longer and will certainly present additional challenges; it is, however, consistent with the mission of the Receivership: to correct systemic unconstitutional problems with the delivery of medical care in California's prison and thereafter return the system to the State of California.

The Receiver's first steps in a 36-month program to establish a statewide provider network of specialty providers for California prisoner/patients will consist of two elements. First, the Receiver has concluded that the State lacks the expertise and experience necessary to conduct competent negotiations with hospitals and provider groups to render specialty care to inmate-patients. CDCR staff are untrained, they have been forced to function at unreasonable, low salary levels, they were not provided with minimally adequate information technology (until the Receiver was appointed), and as a result all too often decisions were made concerning hospital contracts on an ad hoc, short term, or politically motivated basis. To summarize, there is no current system which provides a patient-oriented, cost-effective network of specialty care for prisoner/patients. Therefore, the Receivership engaged, effective September 5, 2007, the services of the Chancellor Consulting Group to provide a number of hospital-related contracting services to PCIB, including the following:

1. Prioritizing select hospitals and related physician contract negotiations.
2. Developing standard hospital contract templates.

3. Develop a hospital managed care strategy, including profiles of key hospitals and physician groups that serve inmate populations.
4. Develop analytical tools for hospital, ancillary and physician rate and strategy development.
5. Develop analytical tools for hospital contract performance evaluation.
6. Develop educational workshops for CDCR contract staff.

Second, the Receiver, after extensive consultation with CPR and CDCR staff, has concluded that health care contracting, given the size and scope of the CDCR's operation, requires an independent evaluation by experts in the field of medical contracting and provider networking. To accomplish this, the Receiver, after 19 months of appointment, determined that the State's contracting and payment impediments are more problematic than originally anticipated. External intervention will be necessary if the State is to succeed in improving the contract and payment processes. These are critical components in providing constitutionally acceptable level of medical care to adult inmates.

Some of the issues plaguing the state's ability to improve the contract and payment process are rigid policies/procedures set forth by oversight agencies, assumedly in an effort to "protect" the tax payers. Although conceptually sound, the State's focus often does not mesh well with the delivery of constitutionally adequate medical care or cost effectiveness.

Although CDCR has made attempts to rectify the deficiencies, the Receiver and his staff have concluded that this issue requires outside intervention. Thus a Request for Proposal ("RFP") was released in September 2007 requesting proposals from experienced contractors to assess CDCR's contracting units and develop a plan to provide the steps and resources necessary to improve the overall management and operations. The initial RFP generated NO responses though contacts were made to various firms with known expertise. Bidders were contacted to determine their reluctance in submitting a proposal and their responses ranged from not wanting to deal with the state's bureaucratic processes to their firm is too busy to take on a project of this magnitude.

A revised RFP was released on October 14, 2007 with a submittal date of November 13, 2007. To improve the candidate pool, additional canvassing/marketing was undertaken to attract contractors/firms. These efforts seemed to be successful as several firms have requested clarification of issues/parameters of their role/responsibility and general CDCR operational issues. It is anticipated that some number of firms will respond; however, to be successful, the RFP applicants should have familiarity with the state's bureaucratic process in order to determine which areas can be removed, altered, or improved versus those that require waiver of State law in order to effectuate change.

It is premature, given the work which needs to be completed by these consultants, to establish a detailed program which will address, in necessary detail and on a statewide basis, changes in current practices that will be effectuated during the next thirty-six months to establish

an adequate network of specialty providers and hospitals. Furthermore, the nature, scope, and location of the network may need to change as the construction of medical beds proceeds. Nevertheless, the following can be said: the Receiver intends to have in place a statewide network of specialty providers and hospitals that will serve all of California's inmate-patients within the next thirty-six months and most likely sooner. This system will provide prisoners with access to the needed specialty services within the appropriate time standards, including those mandated in the *Plata* stipulated injunctions, and it will be operated with significantly improved cost controls compared to the existing system established by the State.

To the degree possible, the time-phased objectives of this aspect of the Receiver's contract reform program is set forth below. The Receiver anticipates providing the Court with more detailed and developed information after the consultant reports are received and evaluated, most likely in the form of a progress report on this Plan of Action. In the interim, efforts will continue and in some cases they will be intensified to provide timely specialty care to all prisoner/patients. While a long term sustainable fix is not possible now, prison by prison improvements will continue to be sought; including pilot project. (See e.g. the Specialty Services Pilot at CCI/LAC Institutions.

Six Month Objectives:

Phase 1: Complete and stabilize implementation at the four initial pilot institutions: Four institutions were selected to participate in the pilot of the computerized HCDMS contract and invoice systems. The four pilot institutions were: Central California Women's Facility; California Medical Facility; Pelican Bay State Prison and California State Prison, San Quentin. Staff at these institutions received the equipment and training needed to allow them to process and approve healthcare invoices electronically, and to negotiate, process and approve contracts within their delegated authority. As the pilot project progressed, it became clear that systemic change needed to take place before the pilot could be rolled out statewide. The invoice receipt, scanning, and indexing functions, originally the responsibility of the various CDCR Regional Accounting Offices, were taken over by the PCIB and performed centrally in Sacramento. The invoice review and adjudication functions, originally performed locally at each institution, were also taken over by the PCIB and performed centrally in Sacramento. Both of these changes involved the establishment of an organization, the development of policies and procedures, the hiring and training of staff, and the resolution of labor relations issues.

Phase 2: Roll out to six additional institutions: Phase 2 is identical to Phase 1 and is anticipated to include: California Correctional Institution; Folsom State Prison; California State Prison, Los Angeles County; California State Prison, Sacramento; California State Prison, Solano and Valley State Prison for Women. Based on our assessment of the readiness of specific institutions to convert to the new system, it is possible that one or more of the above institutions will be move to a later phase, to be replaced with one of the below.

12 Month Objectives:

Phase 3: Roll out to eleven additional institutions: Phase 3 is identical to Phase 2 and is anticipated to include the following eleven institutions: California Correctional Center; California Institution for Women; California State Prison, Corcoran; California Substance Abuse Treatment Facility and State Prison at Corcoran; High Desert State Prison; Ironwood State Prison; Kern Valley State Prison; Mule Creek State Prison; North Kern State Prison; Pleasant Valley State Prison and Wasco State Prison.

Phase 4: Roll out to the final 12 institutions: Phase 4 is identical to Phases 2-3 and is anticipated to include the remaining 12 institutions: Avenal State Prison; Calipatria State Prison; Centinela State Prison; California Institution for Men; California Men's Colony; California Rehabilitation Center; Correctional Training Facility; Chuckawalla Valley State Prison; Deuel Vocational Institution; Richard J. Donovan Correctional Facility at Rock Mountain; Sierra Conservation Center and Salinas Valley State Prison.

Establish an administrative support unit to develop and implement policies, procedures and training materials to support the roll out schedule and on-going operation of the health care invoice and contract processing functions: A Support Services Unit will be established to develop and maintain training material and to provide training to staff at institutions and headquarters on both the existing contract processes, and the new HCDMS contract and invoice processes. This unit will also be responsible for the development and maintenance of policies and procedures required in order to provide staff the necessary tools to perform their job functions. Implementation of a web-based solution for providers to access standardized exhibits, documents and other pertinent information will be developed and maintained by this unit.

Establish an internal post review unit to support management oversight of contract and invoice processing: A post review unit will be established to provide management the necessary information to properly oversee the processing of the thousands of contracts and invoices. The unit will be responsible for the random and targeted review of processed contracts to ensure they are executed within the parameters of established policies and procedures, desk manuals, and all applicable state laws and regulations. Random and targeted review of processed invoices will also be performed to ensure that the appropriate verification of services provided was performed, and that the billing was in accordance with the terms of the contract or letter of intent

Given the pending consultant evaluation, it is premature to project the specifics of the contracts POA past twelve months at this point in time. The Receiver anticipates, however, having the information necessary to establish 24 and 36 month projections within the next six months. The Court will be informed of additional contract related projects, as well as specific timelines for those projects in the Receiver's Quarterly Reports and the next iteration of the POA.

CONTRACT AND INVOICE PROCESSING METRICS

Metrics will be utilized to measure the overall processing timeframes for bid and exempt contracts processed in the HCDMS system and to evaluate overall performance measures. For

example, 90% of bid contracts will be processed through contract execution within 60 days. The metrics to measure processing timeframes for negotiated contracts will be implemented within 90 days. The metric package will include performance measures for both medical specialty services and hospital contracts.

Invoice metrics will be measured by the time it takes to process invoices from receipt through the *Plata* Support Division. 98% of invoices will be processed within 30 days. Future metrics will be implemented to measure the timeframes between specific steps in invoice processing, ranging from receipt through payment.

Because consultants have not yet been retained by the Receiver and no formal reviews have commenced, it is premature to provide more detailed 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 contracts and invoice processing in his Quarterly Reports and future iterations of the POA.

BARRIERS TO THE SUCCESS OF CONTRACT AND INVOICE PROCESSING SIX TO THIRTY-SIX MONTH OBJECTIVES

1. Staffing

As described above, the successful restructuring of PCIB will depend upon the recruitment, hiring, training, and development of a new central office workforce. A host of human resources challenges, including the development of supervisors and managers, the development of a competent analyst workforce, overcoming inexperience, and establishing appropriate work standards must be achieved, and all within a relatively short timeframe. The contract RFP, as explained, will provide a real life answer to the question of whether the State, its rules and its employees, are up to the task of instituting the service-oriented and fiscal contracting reforms necessary to provide constitutionally adequate specialty care to California's prisoners.

2. Information Technology

As described above, HCDMS was successfully implemented on a pilot basis at four prisons. The basis of this system, Prodagio Contracts and Prodagio Accounts Payable provide numerous benefits including improved accountability, visibility of records, transparency of processing, and access to user information. Without question, the pilot conversion represents a significant step forward; indeed, without HCDMS implementation statewide effective contract management is simply not possible.

One the other hand, two significant problems remain. First, HCDMS is not as user friendly as it could be, therefore requiring extensive training for the new users. Enhancements will need to be considered during the later phases of the roll-out process.

Second, for many years the CDCR relied upon a handful of outdated computer programs to provide cost and utilization data concerning inmate-patient specialty care. These

programs, which include the Contract Medical Database (tracks invoice payment history by diagnosis code); Utilization Management (captures patient care by diagnosis code and referrals to outside providers); Census and Discharge Information System (captures patient census data for outpatient hospital services) and the Offender Based Information System (tracks prisoner movement within and between institutions) are not connected in any manner, therefore the information about initial in-prison evaluations, referrals, specialty care rendered, post specialty care follow-up etc. is simply not accessible for either clinical review or systemic tracking. In other words, there is no adequate method to track the continuum of care necessary for appropriate correctional specialty services. It is premature, at this iteration of the POA, to propose a timeline for the long term solution necessary to address this issue. It will, however, be considered for attention after the consultant evaluation described above and during the next thirty-six months.

3. Space and Equipment

In order to effectively roll-out the PCIB restructuring describe above adequate space and equipment must be available at 501 J Street or an alternative central office location.

4. Change and Stabilization

The PCIB central office changes combined with the four-phased prison roll-out described above present the challenge of effectuating change while, at the same time, achieving a degree of stability for staff and managers whereby day-to-day operations continue to provide essential inmate-patient services. Too many changes too soon will serve only to delay the final result. The deadlines set forth above appear to be reasonable and achievable. However, each step of the contract reform process will need to be carefully monitored to ensure that the appropriate structures, controls, and organizational culture are established which enables lasting change.

5. Consultant Evaluations

As mentioned above, the challenges facing the Receiver in order to provide cost effective, efficient, and timely contract processing given the morass of State regulations and other barriers to adequate hospital and specialty services are so significant that, thus far, RFPs for help have not met with a response. It may be necessary to seek a Court waiver of these processes to accomplish these objectives.

**FISCAL SERVICES INITIATIVE
(POA OBJECTIVE A.2.4 AND A.2.5)**

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 “central office staff do not have the tools they need to handle the vast quantity of information necessary to manage a billion dollar, 164,000 inmate system. Data management, which is essential to managing a large health care system safely and efficiently, is practically non-existent.” *See* Findings at 6:16-25.

Accurate budget information, including the timely tracking of critical patient related expenditures, is essential to the operation of a responsible health care delivery system. This information is also required for the Receiver to comply with the Court’s February 14, 2006 Order Appointing the Receiver (“Order”), which sets forth the Receiver’s duties and powers, including orders relating to sound fiscal management, specifically:

Executive Management (*See* Order at 2:9-17): “The Receiver shall provide leadership and executive management of the California prison medical health care delivery system with the goals of restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable. To this end, the Receiver shall have the duty to control, oversee, supervise, and direct all administrative, personnel, financial, accounting, contractual, legal, and other operational functions of the medical delivery component of the CDCR.”

Budgeting and Accounting (*See* Order at 3:8-13): “The Receiver shall determine the annual CDCR medical health care budgets consistent with his duties and implement an accounting system that meets professional standards. The Receiver shall develop a system for periodically reporting on the status of the CDCR’s medical health care budget and shall establish relations with the California Office of Inspector General to ensure the transparency and accountability of budget operations.”

The Receiver has approached the Court’s instructions that he implement an accounting system which meets professional standards very seriously, as well as the Court’s instruction that he manage the Receivership in as transparent manner as possible. Therefore, in preparation for his initial May 2007 iteration of the POA the Receiver instructed his Chief Financial Officer to meet and confer with Plata Support Division and CDCR budget and accounting staff to obtain a better understanding of CDCR’s financial analysis, reporting and budgeting systems. During these initial meetings, the Office of the Receiver was informed that although CDCR had planned to develop a Business Information System (“BIS”) Project, that project had been cancelled. As a result, the Receiver determined that a need existed to have an outside professional service firm

develop an interim financial reporting and decision support tool. A Request for Proposal (RFP) was sent to three firms for bids on a statement of work that included reviewing CDCR's existing budgeting and accounting processes, documenting how the existing processes work; identify "bottlenecks" in current processes; and providing a plan of "work arounds" to produce more timely and reliable financial information pending the development of a viable accounting and financial system for health care within the CDCR. The deliverables of this engagement are to support Goal A of the May 2007 POA, to: "establish meaningful and effective financial and administrative infrastructure and processes that are precursors to clinical transformation."

Since filing the May 2007 POA, however, the Receiver was informed that CDCR will in fact be proceeding with the BIS Project. During June and July 2007, the Receiver's Chief Financial Officer and the Receiver's Chief Information Officer met with BIS vendors and CDCR's BIS Project Manager and were provided with a system overview and demonstrations of systems applications. Based on these meetings and assurances from CDCR officials of the high priority of a successful installation of the system, the Receiver significantly modified the scope of the interim financial reporting and decision tool RFP. Refer to Fiscal Services Initiative Appendix 1 – Letter to CPR CFO Rich Wood from CDCR Undersecretary Steven Kessler.

SHORTFALLS OF CDCR'S FINACIAL INFORMATION SYSTEMS

No one seriously argues that CDCR's fiscal information systems are adequate. To the contrary, BIS was initiated by the CDCR itself to address the weaknesses in the existing financial analysis, reporting, budgeting, and human resources "systems" currently in place. Based on the Bureau of State Audit (BSA) Report dated January 2000 and CDCR's own internal review, the current system simply does not provide the information necessary to project, track or control the significant resources allotted to CDCR to maintain the State's corrections and rehabilitation system. Refer to Refer to Fiscal Services Initiative Appendix 2 – January 2000 Bureau of State Audits Report.

The Feasibility Study Report (FSR) developed by the State to support BIS provides detailed information on the weaknesses that existed within CDCR in 2004 when the proposal was submitted and that still exist as of the date of this report. Refer to Fiscal Services Initiative Appendix 3 – July 6, 2004 CDCR Feasibility Study Report. A summary of the more significant system shortfalls are noted below. These and other system deficiencies will hinder the Receiver and his staff from effectively carrying out the instructions for sound fiscal management included in the Court Order. To comply with the Order of February 14, 2006, these deficiencies must be corrected.

1. Examples of problems aligning spending authority with spending plans:
 - Headquarters Budget Analysts spend over 7,000 hours of unfunded overtime annually preparing initial allotments and adjusting the allotments for changes in spending plans related to May Revision, Executive Orders, and Budget Revisions. Spending and funding plan data is manually entered multiple times

into stand-alone spreadsheets resulting in repetitive data entry and increases the possibility of data entry errors.

- Headquarters Budget Analysts spend 2,000 hours of unfunded overtime annually, manually tracking funds requested through the budget change process, not yet received, or received and not yet reflected in an existing accounting system known as the California State Accounting and Reporting System (CalSTARS). This is a manual process, which provides no continuity of data for all requests made. Funding is allotted to the various divisions and institutions that are not reflected in the automated CalSTARS because it has not yet been allocated through cost distribution. The Department needs to track funds to ensure they are received and to determine the impact of outstanding funds by program and line-item available at the local and statewide levels.

2. Examples of Untimely and Inaccurate Data:

- CDCR does not have the timely and accurate data required to make sound fiscal decisions. Data is often retrieved on a manual basis making it cumbersome and allowing for errors that negatively affect the budget process.
- Personnel Offices in the institutions spent an excessive amount of staff hours manually retrieving and preparing position, vacancy, and salary information required for budgetary reports.
- The untimeliness of fiscal data adds to CDCR's inability to mitigate fiscal exposure. Personnel expenditure data, which drives approximately 80 percent of the Department's budget, is up to 90 days in arrears. Management must estimate labor expenses until overtime and temporary help costs are posted in CalSTARS. For example, overtime and temporary help worked in February is paid in March and posted in CalSTARS in April.
- CDCR is unable to respond to requests made by outside entities, such as those noted in the BSA Report, requesting detailed fiscal reports or quarterly reports that delineate detailed personnel services funding appropriations and expenditures by custody and non-custody staff. CDCR staff is unable to provide this information because the process to collect and summarize this report is cumbersome and would have to be completed manually.

3. Examples Concerning the Inability to Manage Positions:

- Tracking positions to their origins is difficult, if not impossible, when mission changes or programmatic changes occur. The manual, cumbersome research to determine origin may take several days or more, if accomplished at all. These strategic and operational changes impact the Institution's budget, which

have an overall adverse effect on the Department's and the State's fiscal status.

- CDCR lacks a system that tracks position vacancies. Vacancy tracking must be done manually which results in errors and is so untimely and inaccurate as to make it meaningless for management purposes.

4. Examples of Problems with Program Funding:

- CDCR lacks an integrated process and system to capture program costs, "per bed" costs, and services related to a program. Labor intensive, manual research requires an excessive amount of time to recover sufficient data to "estimate" costs. In the absence of timely fiscal data, institution staff is not able to accurately project their annual expenditures, nor is the Department able to capture the underlying reasons for the expenditures to the level required to respond to BSA audit findings or to provide information needed to more accurately project program costs.

NOVEMBER 15, 2007 STATUS OF FISCAL SERVICES SECTION

At the time the BIS FSR was developed in 2004, CDCR's Division of Correctional Health Care Services (DCHCS) had only six positions (one supervisor and five analysts) assigned to the Fiscal Unit which provided fiscal liaison services between the health care staff at 33 institutions statewide and CDCR's Budget Management Branch (BMB). The primary responsibility for all financial services for CDCR, including budgeting and accounting, belonged to CDCR's Financial Management Branch. This level of staffing was grossly inadequate. Therefore, to create an adequate fiscal services infrastructure, and as one part of the Receiver's Fiscal Year 2007-2008 May Revise Process, the Plata Support Division requested and received position authority to establish a Fiscal Management Section ("FMS"). In addition, Health Care Budget Analysts were provided for each institution which did not already have one. Since May 2007, the Plata Support Division has focused on establishing organizational structures, developing job descriptions, and actively recruiting to fill the newly authorized positions in the field and at headquarters.

The Plata Support Division's FMS consists of several operating units. Refer to Fiscal Services Initiative 4 – Health Care Administrative Operations Branch Fiscal Management Section Organizational Chart. The first is the Office of Fiscal Field Support Services, which provides a direct link between the field and headquarters. This Unit is responsible for such areas as monitoring expenditures and projections via the Monthly Budget Plan (MBP); providing direction and guidance to the institution's Health Care Budget Analyst and Health Care Manager regarding discrepancies with projection methodologies and required modifications; generating MBP Executive Summaries for management and executive level staff in the field and at headquarters; and monitoring position authority for the field via a Position Reconciliation Report that will be reconciled quarterly with the institution's Health Care Budget Analyst.

A second unit within FMS, the Office of Policy and Training Services, is responsible for services such as: developing policies and procedures for financial and budget management protocols for the field and headquarters; acting as Subject Matter Experts to develop lesson plans; conducting training for headquarters and institution staff (including, but not limited to Health Care Budget Analyst, Health Care Managers, Regional Management, etc.); and developing standardized reports that will be used by management and executive staff to make sound fiscal decisions.

The third and final unit within FMS, the Office of Technical Support, is responsible for all technical aspects of the budgetary process, which is currently being performed by CDCR's BMB staff. Because of the current focus on filling positions in the Office of Fiscal Field Support Services, the Office of Policy and Training Services and assisting the institutions with filling vacancies. It is not anticipated that this unit will be fully staffed until March 2008.

Because the Receiver needs reliable and timely financial information in order to monitor the considerable State resources expended on health care services provided for the inmate population both now and in future periods, an Interim Financial Reporting and Decision Tool had been proposed and included in the 2007-2008 CPR budget. This tool was intended to only be an interim solution, providing access to financial information in the near term, with an understanding that installation of an enterprise wide financial system (BIS) will provide the long term solution to CDCR's financial recording, reporting, and budgeting needs.

Since receiving additional information regarding BIS, the scope of the interim project was modified, a Request for Proposal has been sent, and the Receiver is in process of selecting one of the respondents. It is estimated that the cost will be approximately \$700,000. The deliverables will support financial reporting for current and budget year and support budget development for fiscal year 2008-09. Additionally, it will serve as a back up to BIS until it is fully implemented and operational (projected by CDCR to be July, 2008).

The "Interim Financial Reporting and Decision Tool" will identify the available and critical report elements (e.g. productive hours); develop an automated "download" of identified data elements into up to date and flexible data base software; identify and develop useful high level reports and institution /HQ specific analyses; and program such reports so that they are produced on a regular basis automatically through either data base or other off the shelf software for management and analyst decision making. It will also provide support for the budgeting process including the data elements described above along with historical utilization by institution, institution specific trends and intra and inter- institution comparison of expenditures and resource utilization

BIS is an ambitious and comprehensive information technology solution to address most of the current shortfalls identified above. As shown in Fiscal Services Initiative Appendix 1 – Letter to CPR CFO Rich Wood from CDCR Undersecretary

Steven Kessler, the project has the support of CDCR's executive management with specific and secure funding. When implemented it should provide the framework for an up to date financial and human resource system that can produce reliable and timely information. The BIS project will use software applications that incorporate the latest technology to produce industry best business practices and manage all of CDCR's business operations. The goal is to support one time entry of information at the point where it is created, and to make it available to all approved system users within the organization. Staff will be able to complete tasks more efficiently and management can utilize more timely and accurate information when making operational decisions. The Receiver's Chief Financial Officer and various PSD staff will participate in the BIS Project as subject matter experts to ensure the Receiver's information and reporting needs are known and considered as part of the final BIS solution for CDCR.

To summarize, as set forth in CDCR's BIS Connection, which was released in July 2007 (Refer to Fiscal Services Initiative Appendix 5 – July 2007 BIC Connection Newsletter) BIS will be designed to:

“automate, integrate, and standardized CDCR's business processes related to Financial, Budget, Accounting, Procurement, Contracting, and Human Resources Management practices. The scope of this project includes the implementation of an integrated system that will serve CDCR constituents throughout the State. This is the first endeavor of its size and scope in the State of California's Public Sector.”

FISCAL SERVICES INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

Six Month Objectives:

Define CDCR's current accounting structure and processes.

- Engage an independent consulting firm with recognized public sector financial expertise to review CDCR's current recording and reporting of financial information and produce deliverables.
- Evaluate existing reporting capabilities of CALSTARS and MIRS.
- Identify or design a database to maintain the data elements in useable and “report friendly” formats. Assistance with the design and development of a limited number of critical reports.
- Assist with developing support for the Fiscal Year 2008-2009 CDCR Division of Health Care Services (DCHCS) budget, with an emphasis on staff hours development and support. Other data and reporting issues related to decision making and financial projections (within the scope of work noted above).
- Prepare critical, high level financial and management reports that are timely, accurate and compliant with Generally Accepted Accounting Principles (GAAP) as appropriate on a regular and periodic basis. (no less than quarterly)

Develop a Fiscal Management Section to establish a financial infrastructure for headquarters and institutions statewide. By ensuring adequate staffing levels at both

the headquarters and field levels, implementing the budget structure as indicated in the plan of action goals can be obtained.

- Define headquarters Fiscal Management Section organizational structure and hire staffing. By ensuring adequate staffing levels at the headquarters and field levels, implementing the budget structure as indicated in the plan of action goals can be obtained.
- Establish all field medical budget analyst positions and hire staff. By ensuring that the healthcare program has a dedicated budget analyst, it will provide for a more accurate budget projection and quality review of expenditures at the institution.

Define and implement a structure for required budgeting processes for CDCR.

- Identify funding issues related to the Fiscal Year 2007-2008 budget developed by CDCR Budget Management Branch (BMB) prior to the implementation of the Fiscal Management Section. In order to transfer the responsibility of the medical budget program from the CDCR Budget Management Branch to the Fiscal Management Section, it will be necessary to review all budget processes for accuracy. It is the responsibility of the Fiscal Management Section to ensure that the medical budget and position authority are accurate and defensible prior to transferring responsibility for completion of future budget functions.
- Identify position reconciliation issues related to Fiscal Year 2007-2008 budget developed by CDCR BMB prior to implementation of the FMS to ensure an accurate accounting of the total budget authority.
- Develop a budget timetable for the Plata Support Division to use as a shadow budget with CDCR for Fiscal Year 2008-2009 formal budget processes and for transferring fiscal responsibility for various Fiscal Year 2009-2010 processes.

Address high priority issues that must be completed that are not part of existing budget processes.

- Establish a Position Roster Report for the Receiver and executive staff.
- Develop a process for requesting additional positions and funding for the field and headquarters.

Twelve Month Objectives:

Define internal budget processes that BMB will transfer responsibility to the FMS.

- Develop a process for reviewing Monthly Budget Plans and conducting Fiscal Reviews.

Develop a training program for all headquarters' FMS staff and for institution's Medical Budget Analysts statewide.

Define and implement accounting structure and processes for CDCR.

- The Interim Financial Reporting and Decision Tool will work along with the implementation of BIS to monitor expenditures and develop the budget for medical care provided to the CDCR inmate population.

Define internal budget processes that BMB will transfer responsibility to the FMS.

- Develop a process for ensuring allotments are accurate and within budget authority.
- Develop a process for reconciling institution medical position authority on quarterly basis.

Define high priority issues that must be completed that are not part of existing budget processes.

- Reconcile budgeted Post Assignment Schedules (PAS) for all posted positions, including RNs, LVN's, etc. tie to budgeted positions authority.
- Establish and implement a program to utilize BIS, including staff training, revised policy and procedures, follow-up evaluation, etc.

Twenty-Four Month Objectives:

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 starting in 2009.

Thirty-Six Month Objectives:

Given the above and the development of BIS, it is premature to project priorities and timelines past twenty-four months at this point in time.

FISCAL SERVICES METRICS

- All budget staff, both at headquarters and in the field, will be provided training on developing analytical skills, completing accurate projections, monitoring expenditures, understanding allotments, reconciling position authority, and understanding personnel and financial reports. Training will be provided on a quarterly basis by the Fiscal Management Section staff as well as outside consulting firms.
- A well-trained staff coupled with real time financial data will result in more accurate projections. Inaccurate projections lead to the inability to address deficiencies in a timely manner or to make critical purchasing decisions. Detailed financial and statistical reports prepared from the information above will allow budget analyst staff at individual institutions, and headquarters to review, compare and report on inter and intra institution performance against budget projections and each other.

- The real-time data will be provided with the implementation of the Interim Financial Reporting and Decision Tool and permanently through BIS.
- High level “dashboard” reports prepared from information above will enable the Receiver to monitor financial resource utilization and performance of the budget compared to actual expenditures. The high level “dashboard” reports that will be developed include the establishing and filling of positions, expenditures and projections by specific functions, and registry usage compared to position vacancy data.
- Access to real-time position authority and vacancy information, instead of the current reports that are two to three months behind, will result in the ability to accurately project recruitment needs and enable appropriate management of personal services resources (overtime and temp help), as well as registry usage.

BARRIERS TO THE SUCCESS OF FISCAL SERVICES’ SIX TO THIRTY-SIX MONTH OBJECTIVES

1. BIS

If BIS is not implemented, the data necessary for accurate budgeting will continue to remain in several different databases and must be compiled manually to develop the necessary reports. This process is very labor intensive, is more prone to errors and does not provide timely information. In addition, information regarding such issues as vacancy reports will continue to be inaccurate because the current data represents only the information that has been processed by the State Controller’s Office and does not consider positions that are in process and pending establishment. Consequently, the only way to obtain the current vacancy data is to contact each location for an update.

The Receiver believes, at this point in time, that it is not fiscally prudent to proceed with the development of an independent CDCR based budget program given the time and money invested by the State in BIS. On the other hand, the State’s track record concerning successful computer projects is poor, and the effective full use of BIS will require a degree of connectivity between prisons that may not be achievable in the time frames projected by the State. The Receiver and his staff will continue to monitor BIS very carefully.

2. Coordination and Cooperation of the CDCR’s Budget Management Branch

The ability to achieve a significant number of goals identified as part of the POA is predicated on having cooperation from and coordination with the CDCR Budget Management Branch. While there is currently a good working relationship with the Budget Management Branch, there are concerns that their future workload demands or the continual turnover of experienced staff may cause delays in providing requested documents or providing explanations of the development of budget processes. This

cooperation and knowledge will be necessary for the development of new processes within and to transfer fiscal responsibility for formal budget processes to PSD.

**PERSONNEL SERVICES INITIATIVE
(POA OBJECTIVES A.7, A.8, AND A.8.5.3)**

BACKGROUND AND INTRODUCTION

In the Findings of Fact and Conclusions of Law re Appointment of Receiver (“Findings”) filed October 3, 2005, the Court found:

“Certain obstacles external to the CDCR have hindered the Department’s ability to effectively take action regarding medical care... These obstacles are presented by the State of California’s civil service system and the related operations of the State Personnel Board (“SPB”), the Department of Personnel Administration (“DPA”), the State budget process, and the collective bargaining obligations of the CDCR with respect to its union-represented employee groups.” The Court further found that “...these obstacles do not in any manner excuse defendants, including the Governor, from taking effective action to cure constitutional violations.”
See Findings at 25: 18-26.

“Certain State civil service rules, grounded in the California Constitution and other laws and regulations, place the authority over creating new job classifications, hiring, setting compensation levels, and creating recruitment and retention bonuses within the authority of the State Personnel Board, the Department of Personnel Administration and other agencies, thus preventing CDCR from acting unilaterally in these areas... These requirements have directly affected the CDCR’s ability to hire and recruit, because when the CDCR attempts to create new job classifications, or change the salary for an existing position, it generally must endure a lengthy process involving the DPA, SPB and the applicable bargaining unit representatives.”
See Findings at 26: 2-11.

Within California State government, there are a number of agencies that are responsible for ensuring individual State departments operate consistent with the State Constitution in all matters, including hiring. These entities, commonly referred to as “control agencies” do just that: control much of the Human Resource (HR) operation of all State departments. In addition to ensuring State law is followed, these agencies are also responsible for *interpreting* California law, and establishing HR policies that each State department is directed to follow. Unfortunately, many of the States’ current policies were established many years ago, when the State as an employer had many benefits to offer that most private and many other public employers did not. In effect, the State established policies and practices designed in large part to keep the applicant pool for new State jobs small enough to be managed by the staff within the “control” agencies. Over the years, the State workforce grew, including the workforce for the CDCR. As noted by the Court:

“Over the past 25 years, the California correctional system has undergone a vast expansion in size and complexity. . . Since 1980, the inmate population has grown well over 500 percent and the number of institutions has nearly tripled from 12

to 33 . . . Currently, the CDCR has approximately 164,000 inmates, 114,000 parolees, and 45,200 employees.”
See Findings at 4:16-21.

However, the rules and policies established many years before have been continued by the State, despite that fact that they are long outdated and cannot meet the evolving hiring needs of the CDCR. Not surprisingly, as a result, the CDCR has for years suffered a number of serious problems including, as set forth in the Findings, a “lack of leadership,” and a “prison culture that devalues the lives of its wards” (*see Findings at 22:19-20*); a “prevailing lack of accountability” (*see Findings at 4:27-28*); as well as the lack of qualified medical staff including medical administrators (*see Findings at 7-8*), physicians (*see Findings at 8*), nurses (*see Findings at 14*), and medical supervisors (*see Findings at 14*).

The CDCR HR operation was, prior to the appointment of the Receiver, chaotic, ineffective, and a barrier to hiring qualified health care personnel. Filling critical positions within CDCR via the convoluted State hiring process, coupled with the remote prison locations and inadequate salaries, presented challenges that the State simply has not been able to meet, despite years of opportunity. For example, the interview and selection processes conducted at the local institutions were highly variable and dependent upon the support of the institution and quality of the management. Many local managers lack the skill to recognize and reliably evaluate the quality of their candidates. Consequently, qualified applicants have been rejected and incompetent applicants hired. Salaries for critical clinical staff, such as physicians and nurses, lagged behind those in the private sector. This coupled with substandard working conditions found in many of the State’s prisons resulted in futile recruitment efforts and expanded the clinician vacancy rate to dangerous levels. Distorted job classifications created for inmate care resulted in unsafe practice patterns. For example, the role of Licensed Vocational Nurse (LVN) had been assumed by a Medical Technical Assistant (MTA). MTAs performed dual duties as nurse *and* correctional officer causing confusion in the workplace, divided loyalties and making recruitment of qualified nursing staff even more problematic.

The Receiver and his staff have concluded that without establishing an adequate HR infrastructure, it will be impossible to hire and retain the competent clinical staff necessary to bring California’s prison healthcare up to constitutional minimal standards. Furthermore, without adequate salaries to attract and retain qualified State clinicians, the CDCR will continue its prior practices of effectively “privatizing the CDCR physician and nursing program by relying on contract registry staff.” As noted by the Court, “[t]he CDCR’s spending on health care is so poorly managed, that it is tantamount to throwing good (taxpayer) money after bad.” *See Findings at 5:8-10*. The Receiver will not duplicate the CDCR’s waste; however, to provide appropriate levels of staffing in the prisons, an adequate HR program must first be established.

NOVEMBER 15, 2007 STATUS OF PERSONNEL SERVICES

Hiring competent health care staff is the Receiver’s number one priority. In little over a year, the Receivership has made significant headway in reversing many of the pre-existing conditions that prevented CDCR from hiring qualified clinical staff and in addressing many of the problematic HR matters. Highlights include:

- Quality medical personnel are being attracted by a new salary structure for CDCR medical professionals. As a result, for example, the vacancy rate for Registered Nurses is currently approximately 6 percent.
- 1,050 LVN positions were established with over 600 positions filled. The LVNs replaced MTAs in all institutions, eliminating problems posed by the presence of the dual-role MTA classification.
- A process to enable hiring to occur in one day has been developed, and implemented on a pilot basis. at six institutions
- The process of delineating all CDCR functions for which the Receiver is responsible and establishing a meaningful reporting structure under his direction has commenced with development of an entirely new HR program that is responsible solely for HR activities related to medical professionals and their support staff.
- A separate personnel office and a separate workforce development office have been created and are now partially staffed with specialized units that have taken control of the HR functions previously under the control of CDCR.
- Three Regional Personnel Administrator positions have been established and two of the three have been filled. The existence of HR managers with regional responsibility will provide the oversight and leadership necessary to ensure appropriate hiring activity is being carried out at all institutions and that HR staff are adequately trained to perform their duties proficiently. An assessment has been completed of all 33 institutions and a training plan is in development.
- Workforce Management offices were established in northern and southern California to assist individual institutions with recruitment and filing of clinical vacancies.
- HR positions were established in all 33 institutions to ensure the HR needs of the medical department are met. Once filled, the new staff will be provided thorough training specific to the hiring process and will become the foundation for separating the HR function of the institution medical department from the rest of the institution.
- Workforce Management offices were established in northern and southern California to assist individual institutions to recruit and fill clinician vacancies.
- A thorough and comprehensive position-by-position analysis of the organizational make up of DCHCS headquarters was conducted in preparation for the administrative separation of responsibilities
- Responsibility for pre-employment credentialing of all medical/mental health/dental providers has been consolidated under the Receiver, and is in the process of being fully automated; thereby greatly improving the process to ensure only quality health care professionals are hired. The consolidation of the function came about as a result of discussion and agreement with the Court Experts in the *Coleman* and *Perez* class actions.
- Certain of the State's most time-consuming and cumbersome hiring practices have been changed to streamline the process and provide hiring authorities with more options for hiring the most qualified applicants. For example, the State's examination process was revamped for all licensed clinical State classifications so that all who are successful in the civil service examination are eligible for hire. Previously, only those with the highest scores could be hired; leaving the others to languish on the list, wondering why they were never afforded a hiring interview, not because they were not the best candidates but rather simply because they were lower on the State's employment lists than others. This change has provided hiring authorities a much broader candidate pool from which to

choose to fill vacancies and has allowed applicants to feel they are not wasting their time in applying for a job with CDCR.

- The antiquated process of sending letters to those on lists to ascertain their interest in a specific job has been revamped. Rather than waiting for the return of the letter and suspending the applicant's eligibility for hire should they fail to return the letter, phone calls are now made to applicants which allows for a conversation to take place about such important subjects as; what it's like to work in a prison, what promotional opportunities exist after hire, what the total compensation package includes, the vision of the Receiver for the future of inmate-patient care, etc.
- An expedited pre-employment clearance process has been implemented that removes the responsibility from the applicant for having to secure their own medical and background clearances. Now, those services are available on-site at every institution and can be completed upon making a job offer to an applicant.
- Regional Directors of Nursing and Nurse Consultants assisted the Health Care Managers and Supervising Nurses in the interview and selection of senior level supervising nurses in more than half of the prisons.
- Nurse Consultants reviewed staff assignments at all institutions based on the scope of practice license requirements associated with each assignment and reallocation of nursing positions in each institution was based on license appropriate care.
- A new civil service classification of Receiver's Nurse Executive has been established to put into place a critical civil service nursing management structure.

PERSONNEL SERVICE'S INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

As explained above and described in detail in prior Quarterly Reports, HR programs have been a Receivership priority. They will remain so during the next 36 months, as described below.

Six Month Objectives:

By March 2008, fully implement a system to track credentialing and continuing education requirements for all clinicians to ensure credentialing is completed expeditiously and that 100% of clinicians are appropriately credentialed before providing prisoner/patient care.

Implement a web based solution that provides access to a centralized repository of information relative to the credentials of applicants and staff, including registry and contractual staff as well as civil service employees. The system will provide for automatic notification of all activity relative to the licensure status of CDCR clinicians who are providing inmate-patient care. Tasks to accomplish this objective include:

- Finalize contract with vendor and implement web-based solution
- Develop policies and procedures
- Determine roles and responsibilities of institution credentialing coordinators verses headquarters Credentialing Unit staff
- Develop and issue written policies and procedures
- Train staff on use of the system and the new/revised policies and procedures

- Establish credential “hotline” for questions and/or concerns for existing staff or potential providers.

By May, 2008 implement an Executive Medical Management team including Nurse Executives and Physician Executives at pilot institutions in order to populate local, regional, and statewide leadership positions with qualified, responsive leaders. This objectives requires the establishment of new classifications and an innovative salary administration program that will ultimately allow for flexible appointment and assignment of individuals in all executive management positions based on levels of responsibility (institution, region, and statewide). The salary administration program for these new classifications will provide flexibility in the salary offered to a given applicant based on tangible criteria such as the specific skills, experience, education, etc. that they bring to the job. The steps in the process include:

- Establish the new classifications through the State Personnel Board and the Department of Personnel Administration (the first classification to be established was Nurse Executive which was officially established effective October 22, 2007. The Physician Executive classification is in the final phase of establishment)
- Develop automated Civil Service Examinations
- Determine methodology for salary setting
- Secure appropriate authority for salary ranges
- Determine which positions (institutions/regions, etc.) will be included in pilot
- Develop and implement a broad net recruitment strategy
- Conduct hiring interviews once employment lists are established
- Make hires into key medical management positions
- Evaluate success of program for pilot institutions
- Make any needed changes to classifications/salary structure/recruitment strategies/examination tool/hiring process
- Roll out department wide

By May 2008, have a fully functional disciplinary unit that will be responsible for working directly with managers and supervisors within both CDCR headquarters and institutions to provide “hands on” assistance, mentoring and training in the area of employee discipline and supervising employees on probation. The new Plata Support Division HR staff trained as disciplinary specialists will need to address a huge backlog of discipline cases. Once the backlog has been eliminated, they will focus on preventing the need for formal discipline when possible by ensuring employees understand work expectations and that supervisors and managers understand the process for corrective action. Meanwhile, a training module and supervisor’s guide to employee discipline is in development.

Twenty-Four Month Objectives:

By December 2008, reduce the vacancy rate for primary care providers to no more than 10%.

- Update all existing advertisements and recruitment material with new physician salary rates.
- Implement new salaries for physicians.
- Working closely with a consulting firm, develop and implement focused recruitment and hiring plans for primary care classifications
 - Visit and present media program regarding CDCR medical career opportunities at medical schools
 - Send letters of opportunity to all appropriately licensed/certified physicians and mid level practitioners
 - Attend all recruitment events
 - Finalize plan to utilize marketing firm to address image of a career in correctional medicine
 - Assess success of pilot centralized hiring model for physicians and correct any deficiencies prior to permanent implementation and expansion to mid level practitioners and physician supervisors
 - Work with academic institutions to tap major Internal Medicine and Family Practice residency programs in California. This will be a joint effort between CDCR clinicians and academic faculty to educate physicians about and recruit them to correctional medicine. This partnership recruitment effort will include presentations at medical Grand Rounds.
- Conduct job and salary analysis for primary care providers and make appropriate adjustments to both how they are used within correctional medicine and at what rate they are to be compensated.
- Develop and implement a loan repayment program (LRP) to pilot at select institutions as an incentive to recruit and retain qualified physicians. Tasks to obtain this objective include:
 - Determine at which institutions the LRP will be offered
 - Develop policy and procedures for administering the LRP
 - Market availability of program
 - Assess success of program
- Fill the one vacant (of three) Regional Personnel Administrator position to oversee the hiring activities of all institutions and to work hand in hand with the Regional and Statewide Medical Directors to ensure their hiring needs are addressed timely and appropriately. Develop clearly delineated roles, responsibilities and accountabilities among headquarters, regions, and local institutions.
- Redesign and fully implement a hiring model utilizing a central list canvassing process for recruitment and regionally based hiring of physicians and mid-level practitioners. Streamline and coordinate hiring so that multiple vacancies and candidates, interested in more than a single facility can be “matched.” The primary components of this system will include the following:

- Regional vacancies identified by input from the field, regional staff, and HR department
- Centralized and regional canvassing of the employment list
- Regional screening of applications and CVs for desirable candidates
- Regional coordination of credentialing with the HR staff for screened applicants
- Assembly of regional hiring panel to include Chief Medical Officers and the Regional Medical Director to interview applicants to determine competency
- Site visit of the facility, where the applicant has expressed interest in working, including an introduction to the CMO or Chief Physician and Surgeon who can discuss the specifics of their facility.
- Completing the “Offer and Acceptance” of employment the day of the site visit
- Offering selected candidates the option to obtain the required pre-employment TB clearance on-site rather than from their personal physician.
- Justification required of the local CMO for candidate rejections

By December, 2008 reduce the number of vacancies in all nursing classifications to no more than 10%. To accomplish this objective, the following activities are required:

- Conduct gap analysis of one-day expedited hiring process at six pilot institutions and develop plan to correct deficiencies.
- Expand the one-day expedited hiring model to include all institutions, including providing training to all HR and medical staff who are involved in the process.
- Attend all appropriate recruitment events
- Visit nursing schools to discuss nursing careers within CDCR
- Centralize the hiring process of all nurses at the regional level with the participation of the Institution and Regional Director of Nursing.
 - Develop standardized nursing hiring practices and procedures, including a resource manual for all Directors of Nursing, Health Care Managers and HR staff
 - Provide overview of hiring process to Directors of Nursing and Health Care Managers.
 - Nursing vacancies identified by region with input from regional staff, and HR department
 - Regionalized canvassing of the employment list
 - Regional screening of applications for desirable candidates
 - Regional coordination of license verification with the HR staff for screened applicants
 - Assembly of regional hiring panel to include Institution Director of Nursing and Regional Director of Nursing to interview applicants to determine competency
 - Site visit of the facility, where the applicant has expressed interest in working
 - Completing the “Offer and Acceptance” of employment the day of the site visit
 - Offering selected candidates the option to obtain the required pre-employment TB clearance on-site rather than from their personal physician.
- Standardize orientation program for all new hires.
- Establish Regional Personnel Office on pilot basis to carry out all HR processing activities for 3-5 institutions, including benefits and payroll administration
 - Identify location and secure space
 - Establish and fill positions

By August 2009, Establish a new Executive Health Care Manager classification who will be the Chief Executive Officer for the entire health care administrative operation for an institution/region and at the Statewide level in order to effectively coordinate all administrative activities of the health care delivery system.

Delineate the administrative functions of a number of pilot institutions whereby the entire business services operation of the medical department (personnel, fiscal, contracts, etc.) are separate from the institution at large and managed within the medical department itself. Currently, this model is in place at San Quentin and will be monitored and assessed on a continuous basis to determine how to best implement in additional institutions and eventually on a statewide basis.

- Determine the success of the Regional Personnel Office operation and decide the future plan of action to expand at additional institutions and eventually statewide, assuming the operation proves successful.
- Recruit and fill positions to perform administrative duties
- Train staff to perform duties of positions

Thirty-Six Month Objective:

Conduct job analysis and salary surveys for all clinical classifications in a manner whereby critical classifications that continue to experience staffing shortages will be evaluated to ensure the salary remains competitive, and that the classification and salary assigned to the position truly reflects the duties being performed. Modify job specifications/duty statements to accurately reflect duties and realign salaries to a fair, competitive level.

PERSONNEL SERVICES METRICS

- Percentage of credential verifications completed within one day of request, percentage of clinicians fully credentialed prior to providing care, number of clinicians who are appropriately re-credentialed, and percentage of staff compliance with continued education requirements.
- Number of Executive Management applicants, percentage of applicants with requisite skills/experience and the percentage who attain permanent status following the probationary period.
- Percentage of managers and supervisors trained in employee discipline and supervising employees on probation, the number of formal discipline actions taken, the percentage of formal discipline cases that are sustained by the State Personnel Board, and the number of new employees who successfully complete probation.
- Number of primary care physicians hired by location each month, the number of applicants; the percentage of applicants who are successful in the credentialing process and the overall vacancy rate in all primary care positions.
- Number of applicants to the LRP by locations, the number accepted into the program by locations, the number of years that the accepted applicants remain in the LRP by location, the

number who leave the LRP by location and their reason for de-enrollment, the number of participants that remain employed by the CDCR following completion of the LRP, the comparison of vacancy rates at LRP institutions versus non-LRP institutions, and the statewide physician vacancy rate.

- Percentage of nurse applicants that are offered jobs within one day of the interview compared to the goal of 90%; the number of nurses hired and separated each month and the number of nursing vacancies by location.
- Number of Executive Health Care Manager positions established/filled and the success of a system-wide approach to health care administration.
- Number of pilot institutions whose administrative activities are completely under the control of the medical department rather than custody and the success of the model.

BARRIERS TO THE SUCCESS OF PERSONNEL SERVICES' SIX TO THIRTY-SIX MONTH OBJECTIVES

A number of barriers may impact the timeframes of meeting these objectives:

1. The State's convoluted processes including components of the hiring process that continue to be a hindrance to expeditiously hiring qualified staff in all civil service classifications
2. Non-competitive salaries in numerous classifications, including non clinical positions that support the medical care delivery system. Many of these classifications are "service wide classifications", meaning they are used by most State agencies and any changes to their compensation rate must be negotiated with the respective unions. There may be a reluctance to increase the salaries of these classifications and others that impact other agencies ability to recruit and retain staff should any revised salaries only apply at CDCR and their budget expenditures if applied across the board at all agencies. Concerning some salary issues, the Receiver may need to seek a waiver of State law.
3. The potential lack of cooperation by the "Control Agencies" in areas such as establishing an autonomous administrative operation in each institution and operating as a separate State agency in such areas as conducting critical civil service examinations to fill vacant positions.
4. The CRCR culture continues to be a barrier to change as almost every attempt to remove responsibilities from CDCR to the Receiver, often creating "power struggles" in the central office and certain prisons.
5. Space limitations will make it difficult to secure adequate space at each institution to separate out administrative functions
6. The lack of trained staff to carry out administrative functions
7. Job burnout – change takes much effort and is difficult and frustrating for some staff and can cause morale problems if not managed carefully
8. The convoluted State space allocation process may hinder the ability to establish a Regional HR function.

**HEALTH CARE APPEALS, CORRESPONDENCE CONTROL, AND
HABEAS CORPUS PETITIONS INITIATIVE
(POA OBJECTIVE C.3)**

BACKGROUND AND INTRODUCTION

The CDCR's Title 15 Appeal Response System

Prisoner/patients concerned about their access to or the quality of medical care may file an appeal pursuant to Title 15 of the California Code of Regulations, which affords California prisoners the right to appeal “any departmental decision, action, condition, or policy which they can demonstrate as having an adverse effect upon their welfare.” According to CDCR policy, appeals must be researched, documented, and responded to in writing. CDCR policy also provides for four levels of appeal review, each level having a specific time limit for a response:

1. Informal Level - written response is required within ten working days.
2. First level - written response is required within thirty working days.
3. Second level – written response is required within twenty working days.
4. Third level – written response is required within sixty working days.

Informal, first and second level responses are completed at the institution and the third level response is completed by the CDCR, Institution Appeals Branch (IAB). The third level responses constitute a director's level decision, are not appealable, and “conclude the inmate's or parolee's departmental administrative remedies.” Once a prisoner/patient has exhausted his/her administrative remedies, he/she may file a federal civil rights action or a Petition for Writ of Habeas Corpus in State Court for relief.

According to policy, all appeals are to be tracked, processed and responded to by the Institution Appeals Office (IAO) at each institution. Due to the increasing number of health care appeals, the Inmate Medical Appeals Tracking Program (IMATP) was implemented in June 2000. The IMATP was developed as a statewide structured program to reduce the number of overdue health care appeals, to ensure appeal responses would withstand legal scrutiny, to collect data for risk management purposes, and to provide a liaison with the Quality Management Assistance Team (QMAT). Each institution was allocated one analyst position to track appeals, interview prisoner/patients, review appeal responses, participate in quality improvement team meetings, and provide monthly reports to management staff.

Given the unconstitutional level of medical care provided within California's prisons, it should be no surprise that the CDCR prisoner/patient appeal system suffers from severe problems. While there exist many dedicated appeal analysts, and many clinical staff endeavor to respond to appeals in a timely and adequate manner, the CDCR appeal system is not functioning in an adequate manner due to the following: corrections-oriented culture of the CDCR, systemic failures involving medical records, tracking lab

results, the inability to obtain timely specialty care, and clinical staffing shortages. A few examples of typical problems (which vary prison by prison) include the following:

1. All prisoner appeals, as mentioned above, are referred to an institutional appeal office, which is staffed with correctional positions. At some prisons, because of either staffing shortages or management neglect, appeals are not referred to clinical staff until far outside the time period for response. In addition, at some institutions, the correctional appeal administrator inappropriately “screens out” legitimate prisoner/patient medical appeals.
2. In some institutions, because of severe shortages of clinicians, appeals are not adequately investigated and are not answered in a timely manner.
3. In some institutions the prisoner’s real complaint is not corrected in a timely manner because of problems with medical records, specialty services, staffing shortages, etc.
4. In some institutions the number of prisoner/patient appeals exceeds the capacity of the health care staff assigned to manage appeals, resulting in unreasonably long delays when responding.
5. The final level of review, pursuant to CDCR policy, involves a correctional official evaluating a medical appeal, a practice that is entirely inappropriate given the state of medical services within California’s prisons as well as the lack of medical knowledge attributable to non-clinical personnel.

NOVEMBER 15, 2007 STATUS OF APPEALS RESPONSE SYSTEM

Because of long standing problems with the CDCR’s appeal program, and because of concern by family members, attorneys, and public officials about the medical care delivered to prisoners, the Receiver, the Receiver’s staff, and the CDCR staff who work under the Receiver’s direction now respond to a variety of forms of inquiries regarding prisoner/patient health care issues, including controlled correspondence, Inmate Health Inquiry Hotline calls, correspondence sent to the Office of the Receiver, Prison Law Office (PLO) inquiries, health care appeals, and Petitions for Writ of Habeas Corpus actions.

Correspondence Control and Inmate Health Care Inquiry Hotline

The Controlled Correspondence Unit (CCU) received 1,905 pieces of correspondence and 393 hotline calls in Fiscal Year (FY) 06/07. Refer to Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative Appendix 1 – Controlled Correspondence Unit Workload Statistics FY 2006-2007. Correspondence and hotline calls are received from prisoner/patients, family members, the California Department of Corrections and Rehabilitation (CDCR), members of the legislature, the PLO, law advocacy groups and the Governor’s Office. Each letter is reviewed, researched and responded to within thirty business days, and each hotline call is reviewed, researched and responded to within seven business days.

Correspondence Addressed to the Office of the Receiver

The Office of the Receiver received 2,215 pieces of correspondence in Fiscal Year 2006/2007, and 450 of those were repeat writers. Refer to Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative Appendix 2 – California Prisoner Health Care Receivership Correspondence Workload Statistics FY 2006-2007. The CPR Inmate Patient Relations Manager reviews each piece of correspondence and enters identifying information into the CPR database for tracking purposes. All correspondence is then forwarded to the CPR medical consultant for clinical review. An acknowledgement letter is sent to each author in response to the correspondence.

PLO Inquiries

The Stipulated Agreement dated June 13, 2002 provides counsel for the plaintiff class the opportunity to bring a prisoner/patient's "medical concern to the attention of the defense counsel" if the medical concern is urgent or if the prisoner/patient has exhausted their administrative remedies. In Fiscal Year 2006/2007, the CCU received 687 written PLO inquiries. In addition, 1,093 issues were discussed (by CDCR clinical staff and PLO lawyers) in various regional teleconferences. Refer to Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative Appendix 3 – Plata Paragraph 7 Correspondence Workload Statistics FY 2006-2007.

Health Care Appeals

As stated above, the number of appeals has increased over the last six years. Accordingly, the number of overdue appeals has also increased. In Fiscal Year 2005/2006, the total number of overdue appeals was 15,952. In Fiscal Year 2006/2007 the number of health care appeals increased by 23.7%. In Fiscal Year 2006/2007, the number of overdue appeals increased 43.3%. Without additional support and staffing, health care appeals will only continue to grow worse. Refer to Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative Appendix 4 – Overdue Appeals Comparison Summary and Statistics.

Petitions for Writ of Habeas Corpus

Beginning in early 2007, the California Attorney General began to take the position, when responding to State Court petitions for writs of habeas corpus concerning medical care complaints, that the state court had no jurisdiction over such claims because of the existence of the Receivership. A number of California trial courts and courts of appeals have adopted this position. Therefore, one possible venue utilized by prisoner/patients to obtain relief concerning medical problems may now be foreclosure.

In response to this development, the Receiver has concluded that the concerns raised by the petitioner should be investigated and corrected by CDCR staff working under his direction. A pilot policy has been developed and implemented to ensure that timely and appropriate responses are provided to the court when requested or ordered. Refer to Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative Appendix 5 – Pilot Writ of Habeas Corpus Response Policy. Monthly reports concerning the status of this new project will be provided to Receiver, Plata Support

Division Management, and counsel. The pilot will be reevaluated every 90 days and revised as necessary until a permanent policy is adopted

HEALTH CARE APPEALS, CORRESPONDENCE CONTROL AND HABEAS CORPUS PETITIONS INITIATIVE: NOVEMBER 2007 TO NOVEMBER 2010

An increasing number of appeals, letters of concern, writs of habeas corpus and other inquiries about prisoner/patient care is not, in itself, a problem. More complaints represent serious systemic problems including shortages of clinical staff, inadequate medical records, poor health care management, etc. As well, complaints are now being received which indicate that due to the intervention of the Federal Court and the appointment of the Receiver, appeals and complaints are viewed as a meaningful, as opposed to a fruitless, mechanism for relief. Therefore, during the first months of operation the Receiver chose to: (1) hire the expert staff necessary to effectuate lasting change; (2) focus on priorities such as hiring clinical personnel (through improved salaries and recruitment programs), correcting the specialty contract crisis, developing a program to hire needed State clinical managers and executives (through the Receiver's Career Executive Assignment program), establishing a structure to ensure the delivery of medication through the Maxor contract; and (3) assuming direct day to day control over medical care delivery with the creation of the Plata Support Division. Now, however, with the Receivership's infrastructure in place, with significant results concerning nursing recruitment, and with the successful development of the Plata Support Division, the Receiver has determined that the improved management of appeals and all other prisoner-related inquiries should become a Receivership priority.

Six Month Objectives:

Specifically, over the next six months, the Receiver will launch a four element medical appeal program as follows:

1. Consolidate all inmate health care inquiries functions including controlled correspondence, correspondence addressed to CPR, PLO inquiries, Inmate Health Inquiry Hotline calls, Health Care Appeals and Petitions for Writs of Habeas Corpus responses, into one unit and develop a program designed to alleviate duplicate efforts, improve management of inquires, and establish the conditions for more consistent, comprehensive and timely inquiry responses. This program has been initiated and will be completed within six months.

As part of this process, additional positions have been established, including positions for Registered Nurses to triage incoming correspondence, assist in providing clinical evaluations, and ensure adequate follow-up on responses to prisoner/patients. It should be emphasized that this is a developing process, subject to change. It will continually be evaluated in conjunction with the program described directly below.

2. A task force of stakeholders (including clinical staff, counsel, and correctional staff) has been convened to conduct a system-wide analysis of the current statewide appeals process. An analysis will be completed to both identify problems with the current system and determine best practices. Once this analysis is completed, the framework for a new streamlined prisoner/patient health care inquiry system will be developed and submitted to the Receiver for approval for implementation on a pilot basis. This program has also commenced, and it is anticipated that the final recommendations of the task force will be provided to the Receiver within six months. The program includes representatives from the other health care class actions (*Armstrong, Coleman and Perez*) in order that the system proposed addresses all of CDCR health care, and not just medical (which, however, represents the great majority of health care related appeals).
3. Discussion will begin with CDCR correctional officials to effectuate, as soon as possible, two changes to the current CDCR inmate appeal program:
 - a. All prisoner medical appeals will be provided directly to medical appeal personnel, by-passing the institution appeal office.
 - b. All third level appeals will be answered by the medical staff who report to the Receiver, and not by CDCR correctional employees.

These discussions, which call for the transfer of budget positions from corrections to the Receiver, will begin in December 2007. The necessary changes will be effectuated within six months.

4. The habeas corpus pilot program described above will continue to be monitored and modified as necessary with the objective of making the program permanent as one element of the newly designed consolidated appeal process described in numbers 1 and 2 above.

Given the current status of this project and the need for stakeholder participation concerning the development of an adequate, streamlined appeal system, it is premature to provide specific timelines for implementation further out than six months. Likewise, it is not realistic to project future metrics except to state that the Receiver expects the team evaluating the appeal system, which includes parties' counsel, to provide recommendations that call for 1) timely, accurate, and clinically based responses to medical delivery inquires; 2) measurable, documentable results, not bureaucratic rules and regulations; and 3) a system which functions primarily on an institution basis, where prisoner/patient medical care is actually delivered by the providers and support staff who need to be an integral, accountable part of the system.

**BARRIERS RE THE SUCCESS OF THE HEALTH CARE APPEALS,
CORRESPONDENCE CONTROL AND HABEAS CORPUS PETITIONS SIX TO
THIRTY-SIX MONTH OBJECTIVES**

The long-term barriers to an adequate medical appeal system involve systemic issues such as clinical competency, adequacy of staffing, and access to information technology-based tracking systems. It is too soon, however, to address those potential barriers because a new system has not been proposed to the Receiver. Concerning the six months ahead, two barriers exist.

1. If the task force is to be successful, a divergent group of clinicians from several disciplines, correctional officials, administrators, and attorneys must work together with a common understanding of: the need for cooperation and accommodation, the existing limitations of the CDCR's medical delivery system, the importance of coordinating the health care class actions and the mission of the Receivership, which is to establish a constitutional standard of medical care in California's prisons.
2. The timely change-over of appeal delivery in the prisons and the handling of Third Level Appeals will require cooperation and timely, effective administrative changes by CDCR officials.

INFORMATION TECHNOLOGY INITIATIVE (POA GOAL D)

BACKGROUND AND INTRODUCTION

A. There Is No Functioning CDCR Health Care IT System

In the Findings of Fact and Conclusions of Law re Appointment of Receiver (“Findings”) filed October 3, 2005 the Court found that “central office staff do not have the tools they need to handle the vast quantity of information necessary to manage a billion dollar, 164,000 inmate system. Data management, which is essential to managing a large health care system safely and efficiently, is practically non-existent.” See Findings at 6:16-25.

Data management drives every element of health care organizational performance. What data is collected, by whom, for whom, how it travels, how it informs clinical and business decisions -- all of these very basic questions are the starting point for many of the Receiver’s remedial efforts. The Receiver’s efforts will not succeed without sufficient investment in information technology -- people, processes, and equipment. In a typical IT turnaround, the project might be to upgrade, modernize, revamp, reprioritize projects and initiatives, retrain staff or redesign existing IT structures and programs. That is not the case here. There is virtually nothing worth saving in what attempts to pass for health care information technology at CDCR. Furthermore, a credible remedial program must account for more than 170,000 patients scattered into 33 institutions (not based on their status as patients, but on their classification as prisoners). In addition, an effective remedial program must also consider the needs of three other major Federal Court class action cases: *Armstrong* (Americans with Disabilities Act); *Coleman* (mental health), and *Perez* (dental).

In practical terms, that means virtually everything in CDCR’s medical system today is done manually on paper, or on antiquated, computer applications,¹ or not done at all. Medical records, appointment scheduling, prescriptions, lab and test results, outside consult notes, communication among medical staff and with custody counterparts – all of these functions take place with a low degree of certainty and accuracy in the current system. Whether data is recorded on paper or on CDCR computers, there is no consistency from one prison to the next in terms of which information is recorded or how it is kept. This makes it impossible to create trustworthy management reports² or even to track an inmate’s medical information properly as he or she moves from one prison to another. As the court stated, “The medical records in most CDCR prisons are either in a shambles or non-existent. This makes even mediocre medical care impossible.” See

¹ Such as 3,700 non-connected, non-verified Microsoft Access databases. Another example can be found in the pharmacy system, which runs on a DOS 3.0 system that Microsoft has not supported for 10 years.

² Such as reports to the court measuring progress on remedial efforts.

Findings at 20:18. This is a crucial defect in CDCR in particular, where the volume and velocity of inmate movement within the system would challenge even the most organized record keeping.

Before the Receivership, this situation showed no signs of improving. For instance, CDCR's entire IT Department, a cadre of over 125 persons, assigns only *four* field technicians to health care, including all disciplines at all sites.

The information deficit translates into poor medical care, up to and including needless patient deaths. An analysis commissioned by the Receiver of CDCR inmate deaths in 2006 found that 66 of them – or 15 percent – were preventable or possibly preventable. Many of those deaths stemmed from a broken infrastructure which did not provide clinicians with the information they needed to make decisions. This included incomplete or missing medical records, lack of timely lab and test results, specialty consult notes and hospital discharge orders. Pharmacy errors and botched transfers of patient information also contributed to the deaths.

B. The Scope and Depth of IT Inadequacies Within CDCR

As with many of the remedial challenges facing the Receiver, without studying the entire information technology problem, an adequate, coordinated and cost effective remedial program will not be implemented in a timely, cost effective manner. Therefore, the Receiver's experts spent much of the past year examining in detail all of the elements of necessary reform. The Receiver has concluded that systemic shortfalls can be addressed through reforms to CDCR's health care information technology. However, improving the information apparatus does not affect the quality of the information, per se. Reform to information technology is an effort essential to, and supportive of, changes to clinical and operational systems and behavior laid out elsewhere in the Plan of Action. The IT approach encompasses technological infrastructure and architecture, data standardization, and reform of operations and workflow processes. The steps to get there are spelled out below. This is much more complicated than merely automating all the inadequate and dangerous clinical and business processes that today characterize healthcare in CDCR.

To begin, it is crucial to illustrate the lack of information handling and technology currently in use at CDCR's prisons. In site visits to individual prisons the Receiver's staff have observed clinical areas without phones or fax machines, let alone computers. In areas where computers are present, they are unconnected to any other computer networks or to the Internet.

California State Prison - Los Angeles County lost its ability to deliver telemedicine services when the Southern Regional Accounting Office did not pay the phone bill, preventing prisoner/patients from receiving essential specialty medical care.³

³ CDCR's outdated telemedicine network relies on ISDN phone lines, with the voice and video systems separate. To participate in a clinic visit, CDCR calls outside providers.

For all of the aforementioned reasons it took more than seven weeks to correct this problem. At San Quentin, in the entire institution, there was one phone that could receive inbound calls available to clinicians and *no* phones that could make outbound calls. Medical staff were not allowed to bring cell phones into the institution, and had to borrow phones from correctional officers. The first corrective action – to install phone lines – was turned back by the discovery that the entire prison’s phone system was antiquated and not running properly. Laying new phone cable was not possible due to the high levels of lead and asbestos in the walls. Instead, the Receiver’s IT team purchased and installed a \$1.5 million digital phone system for San Quentin, which benefits the entire institution, not just the medical program. These are but two examples of the terrain the Receiver’s IT team has inherited.

Statewide, physicians in the prisons do not have access to disease protocols, medical literature or best practices that routinely are available to physicians in the free world through desktop or laptop Internet access or handheld computers. Prior to the Receivership, CDCR attempted to distribute personal digital assistants (PDAs) to all its physicians, an effort that completely failed because of lack of appropriate IT support, inability to synchronize the devices over the Internet, and lack of coordination with custody staff who often confiscated the devices.

Medical staff members cannot share appropriate patient care information within a prison without physically transporting that information from one place to another. There is no prison-to-prison connectivity, so when inmates transfer (as 170,000 did in the first quarter of 2007 alone), pertinent medical information is routinely lost, delayed or incomplete. The transfer of medical information to and from the counties – upon intake and parole – is equally broken. For example, it was recently discovered that the CDCR parole offices and storage areas had a combined total of approximately 8.5 million loose, un-filed health record documents.

The most widely deployed health care computer application in CDCR is the Inmate Medical Scheduling and Tracking System (IMSATS). This application, however, was designed by a CDCR physician’s son at home using Microsoft Access. It has no central database; information on various computers using IMSATS must be synchronized daily by hand using a portable USB hard drive (also known as a flash drive or stick). As a result, data in IMSATS is almost uniformly corrupted, incomplete, and non-standardized. IMSATS users get virtually no training and have no help desk to turn to if the “system” fails. Meanwhile, there is no understanding throughout the organization of how inmate medical scheduling and tracking should be performed efficiently and effectively because staff haven’t been trained, there is no qualified leadership and scheduling and tracking have never been addressed as a discrete project.⁴ Beyond

⁴ “The CDCR’s system for managing appointments and tracking follow up does not work.” See Findings at 6:16.

IMSATS, there are several other examples of dysfunctional CDCR IT projects that the Receiver's IT team has discovered during its first year of exploration.⁵

Thus, the effort to bring IT up to a position where it can support delivery of constitutionally adequate medical care is starting from a point *well below* zero. The goal of the Receiver's IT plan over the next 36 months, therefore, is to start from the beginning and create an environment in which all 33 prisons are ready and able to receive IT support and an organizational culture within which these IT systems can succeed. The Receiver must construct the pathways and processes for the information superhighway before any material can travel on it.

NOVEMBER 15, 2007 STATUS OF CDCR HEALTH CARE IT PROGRAMS

A. Indications of IT Progress Under the Receivership

As grim a picture as this paints for the way medical care has been inappropriately delivered to date, it also provides a unique opportunity to achieve a state-of-the-art system without first having to adjust the existing system upwards. The blank slate has its advantages, and the Receiver's team has the expertise to recognize and act upon that. Indeed, this proficiency already has been demonstrated in a series of activities that the Receiver's IT leaders have undertaken prior to and parallel with the Plan of Action. A sample of early accomplishments is listed below.

- Establish Healthcare Information Technology Executive Committee (HITEC) (described below)
- Receiver's Chief Information Officer conducts regular meetings with CDCR IT Department and Clinical Leaders to inform and coordinate efforts.
- Negotiated and obtained contracts for CDCR clinicians to access online medical reference tools ePocrates and UpToDate.
- Developed Requests for Proposals for consultants to assist the Receiver with assessment and planning in the laboratory, radiology and medical records departments. http://www.cprinc.org/projects_rfp.htm
- Developed a Request for Proposal for consultants to assist the Receiver with the creation of a Clinical Data Repository. http://www.cprinc.org/projects_rfp.htm
- Engaged University of Texas Medical Branch to assess CDCR's telemedicine program and provide recommendations to improve its use.
- Launched the IT infrastructure plan by connecting two prisons involved in the pilot of Maxor's Guardian pharmacy information system.
- Participation in case coordination efforts between representatives of the *Plata, Coleman, Perez, and Armstrong* Courts.
 - Led the case management program application for dental (*Perez*) and mental health (*Coleman*) cases. Directed the representatives of these cases to develop

⁵ Other examples include the Prescription Pharmacy Tracking System (PPTS), Health Care Management System (HCMS), Mental Health Tracking System (MHTS), and the Discharged Offender Record Management System (DORMS).

a system compatible with the Receiver's upcoming infrastructure, helped to craft the selection process for the RFP.

- Demonstrated the strengths and weaknesses of the DECS (*Armstrong*) patient tracking program to the court.
- San Quentin Project
 - Purchased and installed \$1.5 million digital phone system for San Quentin.
 - Installed a wireless network and a mental health network in San Quentin's Neumiller Building. Now clinicians in the institution's main health care delivery building can use laptops and personal computers on carts.
 - Supported mental health staff that had been waiting two years for CDCR to install IT network. Receiver's CIO did so in 30 days, enabling all appropriate mental health providers to have access to patient information online. The ability to reference data from multiple sites is critical to quality of care.
- Assisted in the implementation, trouble-shooting and staff training on the automated medical contracting project at headquarters, with pilots in four prisons. The purpose of this project is to ensure that outside providers are paid for their services within 30 days in order to assure access to specialty and hospital care.
- Provided process redesign support, including streamlining the existing scheduling system, for the specialty services pilot in two prisons.
- 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. The resulting policy memo was distributed by CDCR Office of Adult Institutions to all 33 facilities in September 2007.

B. Managing the Parameters and Standards of an Adequate CDCR Health Care IT System

1. Class Action Coordination

The Receiver's team is now beginning to bring progress to the CDCR health care IT system. For example, the federal judges responsible for the health care class actions placed the Receiver in a lead role implementing long-term IT remedial efforts in the *Coleman*, *Armstrong* and *Perez* cases, as well as the *Plata* case. Refer to Information Technology Initiative Appendix 1 – June 28, 2007 Court Order Approving Coordination Agreements. This action will result in the development of a coherent system of information management going forward. It also presents significant additional challenges and obligations for the Receiver's IT leadership.

2. The Multi-Disciplinary Healthcare Information Technology Executive Committee

In order to ensure that IT planning responds to a wide range of clinical, administrative and programmatic needs, the Receiver has developed the multi-disciplinary Healthcare Information Technology Executive Committee (HITEC). Refer to Information Technology Initiative Appendix 2 –

Healthcare IT Executive Committee Charter. HITEC is comprised of representatives from the medical, mental health, dental and disabilities disciplines to provide input, feedback and advice to our IT team about clinical, institution and system priorities as we work to craft a plan for how to meet the system's need for information, data management and analysis in an organized and methodical fashion.

3. Establishing IT Project Principles

The Receiver's overall IT effort is characterized by implementing a series of principles common to modern IT projects:

- a. IT supports the *entire* health care enterprise and is not a stand-alone function. CDCR executive leaders across all health care clinical and business divisions will play a role in determining and contributing to the IT projects governed by the Receiver. This practice already has begun with the formation of HITEC.
- b. CDCR has no capacity or capability to develop software and build and maintain hardware. Therefore, whenever possible, the Receiver will lease network connections, hardware, data centers, and software services from vendors that specialize in these functions.
- c. Whenever possible, IT projects will involve the staff (end-users) who will use the service from the earliest stages of project planning.
- d. IT projects will not be used to support or shore up broken, dysfunctional, and inefficient workflows and processes. Process redesign will be a critical component of every IT project.
- e. IT will be a strong proponent of data and process standardization across the enterprise.
- f. All systems installed will comply with all federal and state medical privacy laws.
- g. All IT projects will use nationally and internationally recognized standards to allow for communication among current and future applications. CDCR will be advised to follow these standards as well, ensuring interoperability between the Receiver's and CDCR's custody-oriented IT programs.
- h. Whenever possible, CDCR will adhere to the Governor's strategic plan for information technology in California.⁶

⁶ Governor Schwarzenegger issued an executive order known as the Broad Band Initiative in October 2006 that establishes a statewide task force to recommend "how California can take advantage of opportunities for and eliminate any related barriers to broadband access and adoption." The order further instructs State Agencies to lead by example in the effort to increase the use of information technology, including wireless connections and Internet access, making state government more efficient. Health care is one of the areas targeted for improvement. The executive order can be found at <http://gov.ca.gov/index.php?/press-release/4575/>

4. The Receiver's Utilization of Cost Effective Leased IT Infrastructure

These principles mirror ongoing changes throughout industry and government. IT is moving away from the use of in-house infrastructure -- hardware and apparatus -- and moving toward a system more familiar to the individual consumer. At home, if one has cable TV, telephone, Internet access and other high-tech features, all of the infrastructure -- the cable connection, networking, electrical demands -- are provided by a third party company such as ATT, Comcast, Verizon, etc. The individual simply becomes a client of that service, and plugs into it. The user remains free to choose what they will use (which services) and how (which applications) and must learn enough to make and benefit from those decisions.

This direction for IT -- to lease and consume, rather than purchase and build infrastructure -- is shared by leading organizations, industry and government such as Bank of America, Wells Fargo, Pixar Studios, Apple Computers and the State of California.

5. Utilization of Information Based Around the Patient

In addition to the infrastructure strategy, the standard in medicine is moving toward information based around the patient, made available to the clinician at the time and point of care. This approach mirrors that which is recommended by The Institute of Medicine, part of the National Academy of Sciences, and the American Health Information Community, a project of the U.S. Health and Human Services Agency⁷. Momentum is building at the state and federal level to bring health care information technology up to the standards already present in other industries, and to use it to enhance the quality of patient care while reducing cost.⁸ Often, this goal is expressed as the creation of an

⁷ The 16 members of the American Health Information Community (AHIC) include federal and state executives, company CEOs and representatives of the health care industry. The HHS Secretary is chairman of the panel, which was announced in June 2005. The work AHIC will perform to select interoperability standards is designed to advance the implementation of electronic health records, which promise to improve the quality of health care, reduce medical errors and cut costs. Refer to the Government Computer News: http://www.gcn.com/online/vol1_no1/36965-1.html

⁸ President Bush created the Office of the National Coordinator for Healthcare Information (ONC) which started in an advisory role to the president and was later made into a fully budgeted office that advises the President and Congress on how best to advance the adoption of clinical informatics, computerized clinical systems and advanced patient safety computer systems. ONC has been the President's and Congress' point leader to work on a national goal of a Electronic Medical Record for everyone in the U.S. by 2014. This is seen by Congress as not only a needed patient safety project but they

Electronic Health Record (EHR).⁹ From the Receiver's perspective, it is less important to decide right now whether an EHR, per se, will be implemented in CDCR, and more critical to commit to providing accurate, reliable, timely data to the providers at the time and point of patient care.

IT INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

A. Introduction: Planning for IT Implementation

The Receiver's IT team engaged in extensive diagnostic work and research to determine the best solution and starting point to address the impoverishment of CDCR's health care IT system. These preliminary investigations include numerous and detailed meetings with CDCR's IT leadership and staff, multiple prison site visits within California (the CIO has been to 18 CDCR prisons and the CMIO to 16), visits to see health care IT operations in Arizona and Texas prisons, and discussions with representatives of the *Coleman*, *Perez*, *Clark* and *Armstrong* cases about their experiences with CDCR IT and the demands and requirements imposed by their courts. The Receiver's CMIO also treats patients in clinics at the California Medical Facility and California State Prison, Solano, where he experiences first hand the physician's need for – and lack of – accurate patient information to guide decision making.

believe that it will significantly impact Medicare costs by reducing duplicate test, medications and drug adverse reactions. <http://www.hhs.gov/healthit/onc/mission/>

⁹ David Brailer, M.D., Ph.D. National Coordinator for Health Information Technology, Department of Health and Human Services, spoke on this topic at the First Annual Kaiser Permanente HealthConnect Users' Conference in California on August 2, 2005. An excerpt from his speech follows: "There're also a number of states who have as a state at the governor level or the legislature have taken on health IT as the new frontier of delivering health care services and insuring fairness and equity in efficiency and treatment... There are numerous private sector initiatives and new consumer groups involved in this, there are new advocacy groups. Everyone's re-tooling their thinking about health IT because it's an issue that has come and is here to stay, both at the policy level but more importantly at the doctor/patient level, and if you haven't seen the statistics of physicians registering their awareness about whether or not they should be involved in putting an EHR in their practice, they've just gone through the roof. Everyone knows at some point it needs to happen and that's because foundationally it's now a question of how and not when, it's a question of should and not if, it's really a question of how do we make sure that this life saving therapy is put into practice."
http://ckp.kp.org/kpindepth/archive/indepth_brailer.html

B. Inter-Prison IT Connectivity- Working With Governor Schwarzenegger's Broad Band Initiative

The criteria for successful reform includes a system that can be achieved timely and cost-effectively and that will meet the pressing needs of today while being flexible enough to expand and change to meet needs that will emerge in the future. Information technology is, by its nature, in a constant state of innovation and change as it seeks both to streamline and build capacity for the effective management and analysis of data. Initially, it was assumed that the Receiver's IT reform would entail the traditional bricks and mortar approach of purchasing and installing a new system – “wiring” the prisons.

After careful study, however, the Receiver's IT leaders have concluded that the best approach would be to join the Governor's Broad Band Initiative and utilize services provided by the State's Calnet II Master Service Agreement with Verizon Business.¹⁰ The State CIO is encouraging all agencies to make use of the Calnet agreement in order to move more nimbly in the direction of adopting full broad band access. This modern, cutting edge method will allow the Receiver to create secure *wireless* networks in the 33 prisons, reducing both the cost and length of time required to get the new system up and running.

As noted in the principles above, all systems installed will start with federal and state medical privacy laws as their foundation. The Receiver will incorporate all physical and data security tools that are the industry standard. The new IT-driven system will provide a much higher degree of patient privacy and confidentiality than today's paper method in which medical records are often misplaced or inappropriately shared.

Through Calnet, CDCR's medical system will have the ability to become an interconnected, on-line system within the next year, rather than the years it would take to do it in what is rapidly becoming the old-fashioned way. We anticipate that the statewide network connecting all prisons (known as a Wide Area Network or WAN) will be in place and that the individual institutions will each have their own functioning internal computer network (known as Local Area Networks or LAN) by the end of 2008¹¹. Verizon, responsible for creating and implementing the new infrastructure, has produced

¹⁰ The Calnet agreement went online in May 2007, and was designed to allow state agencies to implement the Governor's Broad Band Initiative more rapidly, at deeply discounted contract rates. The Calnet agreement is a DGS contract developed by the State's Department of Technical Services under the auspices of State CIO Clark Kelso. The State CIO's plan for Enterprise Architecture is very similar to the Receiver's IT plan for the prisons. The CIO's plan can be found at <http://www.cio.ca.gov/stateIT/enterpriseArch.html>

¹¹ Individual sites include all clinical and business operations sites in the 33 adult prisons, regional offices and headquarters. In order to provide IT to fulfill the requirements of the *Perez* and *Coleman* cases, these connections may expand to Department of Mental Health and California Youth Authority facilities.

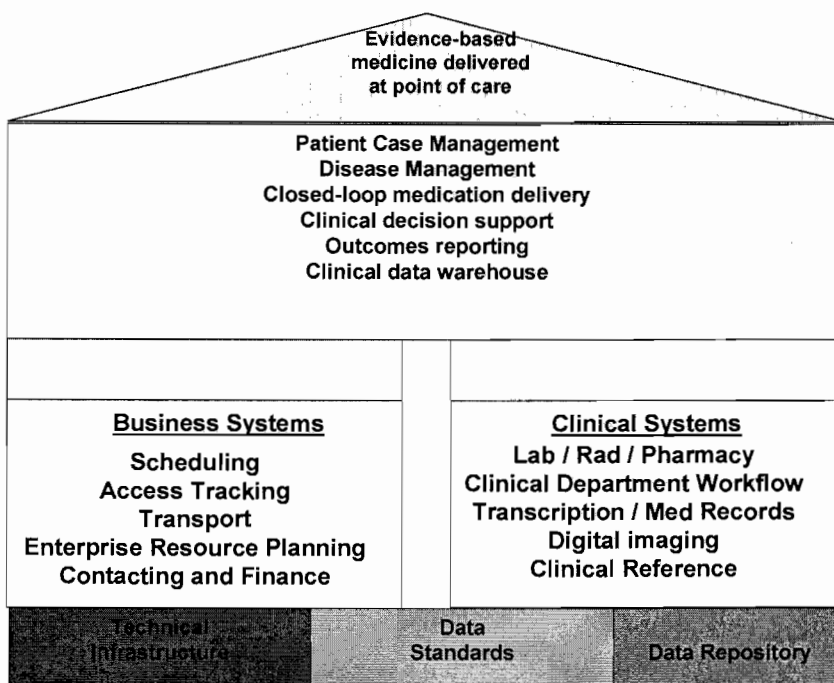
a plan for installing the WAN network and has already evaluated eight prisons for the LAN implementation as well. Refer to Information Technology Initiative Appendix 3 – CPR Network Design. Verizon and its subcontractors have also designed a modern data center for CDCR that will be installed in their server farm in Torrance, CA, and the corporation is currently engaged in site surveys for installation of the wireless LANs at each institution, with a particular eye to creating redundant network connections to ensure business continuity in the event of accident or disaster. Security is a top concern: the latest firewall and private network technologies are being implemented to ensure that the network is safe from viruses, attacks, or breaches. Verizon has contractually guaranteed CDCR a high level of service and reliability, reducing dependence on the State’s resources to maintain the network.

There are several advantages to the Receiver joining the Calnet agreement, including efficiency and cost savings that will allow the Receiver to make a greater investment in the new health care IT program without increasing the size of the already approved Fiscal Year 2008 budget. The Calnet approach should also: (a) reduce the time required to install the statewide (WAN) and local networks (LAN); (b) lessen the need for CDCR technical staff to maintain the network infrastructure, as that will be done by Verizon; (c) save money by using a wireless network that is less costly to install; and (d) be more economical and easier to maintain as the project moves forward.

C. Overview of the Receiver’s Health Care IT Program

1. Building a House – Starting With The Foundation

The Receiver’s IT program can be effectively summarized by the diagram below.



To use a somewhat simplistic analogy, constructing a comprehensive structure to deliver appropriate patient information to clinicians across a 33-prison medical system is a significant endeavor that must be done in an orderly manner to succeed -- similar to building a house. One does not start with the roof. The “foundation” of the Receiver’s IT plan is to secure the technical infrastructure – the statewide network (WAN) connecting all prisons to each other, and the intra-prison networks (LAN) connecting each prison internally, with appropriate security for the networks.

2. Foundations I – Creating a Standardized Data Infrastructure

This foundation, however, also must contain the data infrastructure -- requirements to standardize data so that the information flowing from and between prisons matches up – creating ‘apples to apples’ comparisons that simply do not exist today. The standardization must be supported by decisions about how the data will be gathered, who is in charge of it and where users will go for help – the operational and clinical infrastructure.

3. Foundations II – Creating the Data Repository

The Clinical Data Repository is also a key component to the foundation. This is the creation of a secure database containing verified patient information that will be available to providers via the web. As patients move throughout the system, the information will be equally available to appropriate providers in any institution, because it will already be centralized. As different categories of data – such as medication, lab results, etc. – become trustworthy, they will be added to the Clinical Data Repository. Refer to Information Technology Initiative Appendix 4 – Clinical Data Repository and Web Portal Solution Request for Proposals. Note that the repository is but a tool to enhance the use of good data, it is not an end in itself. It will be improved and expanded as the clinical and business operations are further developed and verified. As explained in the timeline below, the foundation will be completed during the next 12 months.

4. Supporting Walls – Core Elements of Information

Once the foundation is laid, the supporting walls go up. These contain the core elements of clinical and business information required to establish a constitutional medical care system.

a. Clinical Data

The first clinical areas targeted for improvement are laboratory, radiology and pharmacy, as these provide fundamental information for clinicians to make decisions about the patients they are treating. Overhauling the clinical operations in these three areas in concert with implementation of appropriate information systems will reduce medical errors and improve quality of care. IT’s role is to

design the method to make the improved clinical data available to clinicians at the time and place of patient care. It should be emphasized that projects to clean and collect pharmacy, laboratory and radiology records already are underway. Refer to Information Technology Initiative Appendix 5 – Lab Assessment and Planning Request for Proposals; Information Technology Initiative Appendix 6 – Radiology Assessment and Planning Request for Proposals; and Information Technology Initiative Appendix 7 – Health Records Best Practice Professional Services Request for Proposals. In addition, Maxor Corp. is currently engaged in a pilot at two prisons to test the automated Guardian pharmacy information system.

b. Business Data

Among the first business operations applications to be developed will be those dedicated to patient scheduling and tracking. (*See PoA objective D.4.5.*) This software application will require significant sophistication in order to address the extremely high rate of inmate movement in CDCR and the need to have patient information available at multiple sites.

c. Enhanced Telemedicine Services

Access to the above referenced categories of clinical data, combined with a functioning appointment system will allow the Receiver to increase use and effectiveness of telemedicine services, providing greater access to specialty care consultations at a lower cost. As explained in more detail in the Clinical Support Services Initiative, experts in correctional telemedicine from the University of Texas Medical Branch (UTMB) are currently working for the Receiver to develop an assessment and road map for CDCR's telemedicine program.

d. Core Clinical Systems

The Receiver will soon be receiving advice from consultants regarding future strategies for clinical support services in the areas of clinical labs, radiology, health information management and dictation/transcription (See the Clinical Support Services Initiative). Depending on the strategic approaches selected, these clinical divisions may require specialized IT support, such as radiology information systems or lab information systems.

5. The Upper Levels – Sophisticated Analytical and Clinical Tools

As the appropriate clinical systems (such as the clinical data repository, pharmacy, lab, radiology, etc.) fall into place, the Receiver plans to create a Clinical Data Warehouse. This tool will compile statistical data that will aid in the development of population-based care, using evidence to determine the most effective and efficient protocols for quality health care. The database will deliver numerous

benefits including the ability to analyze patient outcomes and provider performance, generate data required by the courts to measure compliance with remedial activities, determine savings that could be wrung out of the system and provide trend information about the health of the inmate population and the effectiveness of various treatment approaches. None of this ability exists in CDCR today. Ultimately, the use of health care information technology can create a system where providers have accurate, current information about the patient they are treating – at the time and place of care. Clinical and business leaders will have analytical information about how the system is performing – in terms of quality, safety, and cost. This vision represents the “roof” of the house.

IT timelines for 6, 12, 24, and 36 months are set forth below. It is critical to recognize that these timeframes are dependent on at least three factors.

1. HITEC will recommend the priorities given various IT projects, which will be responsive to shifting needs in the field, headquarters and of the court. Not all of these can be predicted at this moment.
2. IT installation will be impacted by infrastructure issues such as electrical capacity, hazardous material abatement and other obstacles not within the control of the Receiver.
3. There are significant cultural hurdles to overcome among staff when introducing new ways of working, new standards and requirements, new expectations – not to mention new machinery. As stated in the principles above, the Receiver’s IT team will not simply be computerizing the current broken systems. Staff will be expected to adopt new IT systems and adapt to new job duties, in many cases. This difficult task will require extensive training and awareness of the fine details of implementation. It is not possible to predict the amount of time that may add to the successful completion of the process. Existing bargaining unit contracts and the civil service system itself will be potentially monumental hurdles to overcome.

Six Month Objectives:

- 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, including hardware, installation, and set up
- 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. Consultants will determine if we can we rely on CDCR’s pre-existing IT systems to track our patients by inmate

numbers, or whether we need to create our own enterprise master patient index like most other health care systems.

- Purchase subscriptions to high quality online clinical reference tools such as ePocrates or UpToDate.
- Create a plan for the remediation of telemedicine services, including appropriate staffing

Twelve Month Objectives:

- Install wireless local area networks (WLANs) for healthcare areas at all remaining sites, including hardware, installation, and set up
- Utilize Microsoft enterprise license to roll out Microsoft Outlook and associated communication tools to all healthcare personnel
- Implement the following two clinical IT systems:
 - Clinical data repository (CDR): Database designed and optimized to store patient health information, such as current medications, lab results, encounter history, problems, etc., in a standardized manner. It will be the central “bridge” between all current and future CDCR patient data sources (such as Maxor’s pharmacy information system, outside lab results, etc.).
 - Clinical portal: Web browser-based application that will allow providers access to CDR information at the point-of-care. When implemented, a provider will for example be able to search for a patient and, when identified, view the patient’s list of current medications, most recent lab test results, etc.
- Present a project plan for online, shared clinical “groupware” workspaces to allow clinical leaders to jointly edit, review, manage, approve, and maintain clinical guidelines, protocols, and care plans. This tool will also be used for managing electronic clinical decision support tools and clinical documentation forms.
- Create a CDCR private web site that steers CDCR providers to online reference materials and clinical guidelines and protocols that have been purchased, designed by, or approved by CDCR leaders.
- Implement an information system to track credentialing and education requirements including Continued Medical Education (CME) and Continued Education Units (CEU).
- Implement contract management software that ensures prompt payment of local contracted healthcare providers within 45 days of invoicing.

Twenty-Four Month Objectives:

- Implement telephone, teleconference, and video conferencing systems, including wireless phones, pagers, and telemedicine equipment, using the Internet Protocol (IP) standard
- Complete roll out of the CDR and Clinical Portal to all 33 institutions

- Kick off a clinical data warehouse (CDW) project to create a single clinical archive that CDCR will use to perform data analysis across a broad spectrum of data derived from multiple systems, including the clinical data repository, accounting systems, and population demographics. The CDW will be used with analytical and business intelligence tools to create detailed reports and identify further areas for quality improvement.
- Create and implement a process and methodology for redesigning all clinical forms, flow sheets, and order sheets conform to common standards of design, usability, approval, and consistency with CDCR policies and clinical guidelines
- Implement a statewide scheduling and tracking information system that ensures medical, mental health and dental appointments are made and kept within parameters established by *Plata*, *Coleman* and *Perez* courts. Project charter will include workflow redesign, access-to-care reporting, health care needs prioritization, and coordination with custody ducat and transport processes.
- 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

Thirty-Six Month Objectives:

- Complete Maxor's deployment of their automated pharmacy delivery and information system ("Guardian") at all 33 institutions by providing network access, workstations, and technical support.
- 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.

IT METRICS

- **CalNet II Implementation**
 - CalNet II contract agreement filed.
 - First pilot institution goes live
 - Data center is available for healthcare services.
 - Healthcare IT support services are available.
 - Each prison and healthcare operations center is interconnected to the healthcare network.
- **CDCR Health Care Internet Telecommunications Project**
 - Microsoft Outlook 2007 is fully configured and available to all users

- All clinical providers have reliable access to a telephone
- **Clinical Data Repository (CDR) and Clinical Portal**
 - Fully operational, standards-compliant CDR live and accepting data feeds
 - Initial pilot of clinical portal allowing clinician access to CDR data
 - Full rollout of clinical portal to all end-users at all sites; 90% of all intended users trained and certified to use the system
- **Subscriptions to online medical reference web tools**
 - Signed contracts with at least one medical reference tool web site with audit logs demonstrating usage by CDCR clinicians
 - On-line subscriptions available to all CDCR clinicians at the point-of-care
- **Statewide provider credentialing application**
 - Used at all sites for medical contracting.

BARRIERS TO THE SUCCESS OF THE IT OBJECTIVES

1. Basic Infrastructure

An assessment of eight prisons conducted by the private companies Verizon, Nexus Integration Services and Cisco Systems in anticipation of implementing the CalNet agreement found that the two biggest problems facing the installation of statewide (WAN) and local (LAN) computer networks are a lack of sufficient power at the institutions and lack of telecommunications capacity.

The experience of the Receiver's team confirms these findings. We detailed earlier that San Quentin required an extensive new phone system in order to provide working phones to medical staff. In preparing to expand the pilot of the automated Guardian pharmacy information system to additional prisons, we have confronted this problem again. It may stretch the imagination, but at the California Institution for Women, Avenal State Prison, Wasco State Prison, California State Prison, Los Angeles County and Folsom State Prison, there are not enough phone lines to support the proposed pilot, which requires fax and phone capability. Even without the pilot, the lack of phone services has reached a crisis, with medical staff at CIW placing working phones as their top priority.

Traditionally in CDCR, IT has not been responsible for telecommunications, which has been under the control of Facilities Management. Under budget pressure, that department cut phone technicians, leaving CDCR without the ability to maintain or upgrade phone services. If the Receiver's IT team takes on telecommunications, it would be an area beyond the scope originally envisioned. However, it may well be necessary. The complete replacement of institutions' phone systems, for example, was not previously factored into the budget or timeline for IT reform.

The basic power infrastructure in most health care locations was not developed to support multiple advanced clinical information systems. In many cases our initial review of IT needs has shown a lack of AC power outlets, insufficient power loads and distribution to many locations.

Heating, ventilation and air conditioning (HVAC) needs have not been designed to support the needs of networking and advanced IT systems. An example of this is the current “network box” in the Folsom Prison health care building that currently houses all network equipment for the facility. There is no cooling or venting available in this steel three-foot-by-three-foot box that was attached to the end of a stairwell. This box has an ambient temperature on summer days above 115 degrees F, a temperature rated 20% higher than manufacturer’s warranty ratings of 105 degrees F. Deployment of the Receiver’s HIT network at Folsom will thus be delayed by the implementation of appropriate ventilation and air conditioning.

We anticipate that similar flaws in CDCR’s electrical infrastructure and physical plants – brought on by overcrowding, years of under-resourcing and the age of facilities in some cases – will deliver additional obstacles to the Receiver’s efforts to implement a modern IT system to support a constitutional medical care system in the state’s 33 adult prisons.

2. IT Staffing

Insufficient IT staffing is traditionally a chronic source of delays to major IT projects. With CDCR’s history of neglect and mismanagement of IT staffing, this will be a major hurdle to overcome.

The Receiver’s IT plan includes more than adequate Wide Area Network (WAN), Local Area Network (LAN) and network support that will significantly augment the local staff’s ability to support clinical IT projects. However, during the implementation period the local staff will continue to be short-staffed in comparison to industry IT support models.

In addition, CDCR’s local Associate Information Systems Analysts (AISAs) and Senior Information Systems Analysts (SISAs) have received little if any training on advanced IT tools and methodologies. This continues to diminish their productivity in a rapidly changing IT landscape.

Local IT staff also face a bewildering number of seemingly uncoordinated IT requests from a diverse set of stakeholders, including all healthcare disciplines as well as custody and custody support, with no additional support staff or assistance from CDCR Enterprise Information Systems. This has led to serious backlogs of work requests related to health care support.

The current State Personnel Board IT job classifications, duty statements, testing processes, and pay structure create an extremely unfavorable environment for

recruiting strong IT professionals to work in the prison setting. Local prisons in rural communities compete for this already scarce resource with local city, county and non-profit health care employers that offer superior pay scales, job duties and work environments.

3. Support of outdated versions of existing software

The Receiver's IT team has committed to support the current antiquated computer applications that keep health care barely functioning in the prisons. Due to many separate and stand alone versions of existing programs, the ongoing support is becoming a greater burden than anticipated upon health care IT support services.

In most cases these applications are running on versions of Microsoft Access, Oracle, Power Builder, and Windows that are years, even decades, out of date. These applications take up more time, effort and support costs due to the deteriorating applications and limited resources. In many cases the vendors no longer offer support to this "grandfathered" software.

4. Coordination with other health care disciplines

Information technology is one domain that the Receiver is managing on behalf of dental and mental health. Close coordination with dental and mental health leaders, and the *Coleman* and *Perez* courts, requires additional meetings and additional steps in the decision-making process.

5. Coordination with CDCR's non-health care IT efforts

CDCR is planning to embark on a multi-year, \$500 million project called the Strategic Offender Management System (SOMS) intended to unify all disparate custody computer systems. Health care and custody must coordinate closely on a multitude of information issues (such as the locations of inmates; whether an inmate has a communicable disease or special needs; etc.). Therefore it will be important for health care systems to interface with SOMS. Given CDCR's history of failure and mismanagement of large IT projects, we expect this to develop into a major barrier over the next 24-36 months, as the Receiver's time and resources are required to participate in this parallel effort.

MAXOR PHARMACY SERVICES INITIATIVE (POA GOAL B.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, “management of the prison pharmacy operations is ‘unbelievably poor’...At the individual institutions, the administration of medications is in various states of disarray.” *Findings* at 23: 12-13. The Court also recognized that, “There are serious, long-standing problems with dispensing medication, renewing prescriptions, and tracking expired prescriptions.” *Findings* at 23: 20-22.

Effective and efficient operation of pharmacy services is an integral component of any quality health care service delivery system. As such, one of the Receiver’s initial priorities following being appointed was to address the recognized issues related to CDCR’s pharmacies. The Receiver entered into a contract, commencing January 1, 2007, with Maxor National Pharmacy Services Corporation (Maxor) to provide pharmacy management consulting services for achieving necessary improvements to the CDCR’s pharmacies.

The Court approved pharmacy improvement program is described in Maxor’s “An Analysis of the Crisis in the California Prison Pharmacy System Including a Road Map from Despair to Excellence” (Road Map). Refer to Maxor Pharmacy Services Initiative Appendix 1 – Maxor Road Map. Maxor’s Road Map accurately recognized that “The CDCR pharmacy program does not meet minimal standards of patient care, provide inventory controls, or ensure standardization. The system focus is bureaucratic rule-driven and product-driven rather than patient-centered and outcome-driven.” (Refer to Road Map at Page 7.) In addition, the Road Map details Maxor’s short and long-term plans for achieving patient safety, evidenced based practice, and cost efficiency.

NOVEMBER 15, 2007 STATUS OF MAXOR’S PHARMACY IMPROVEMENT PLAN

A. Introduction – Maxor Accomplishments

Since commencement of the Receiver’s contract with Maxor on January 1, 2007, numerous key objectives have been accomplished. Key accomplishments of the Maxor pharmacy improvement initiatives include the following:

- The establishment of a central pharmacy services administration, budget and enforcement authority charged with implementation of the *Roadmap to Excellence*, including the recruitment and hiring of staff to fill central oversight roles and responsibilities, as well as continued efforts to address pharmacy staffing needs within individual institutions.

- In conjunction with the Office of the Receiver, development of a system for coordination of pharmacy related issues and concerns between the *Plata*, *Coleman* and *Perez* parties, to include membership and active participation in the revitalized CDCR Pharmacy and Therapeutics Committee. This vital coordination provides a consolidated interface between the three major health care cases and ensures the focus on improved patient safety and evidenced-based practices remains at the forefront of the decision-making process.
- The establishment and implementation of a reconstituted and revitalized CDCR Pharmacy and Therapeutics Committee that meets monthly and has:
 - taken active part in reviewing, updating and adding pharmacy related policies and procedures;
 - designed and implemented a process for the development of disease management medication guidelines;
 - developed, reviewed, and approved disease management medication guidelines for:
 - Hypertension and Hypertension Urgency
 - Asthma (acute and chronic)
 - Diabetes (type 1 and type 2)
 - Hyperlipidemia
 - HIV
 - Seizure (acute and chronic)
 - Hepatitis C (reviewed and pending coordination with CDCR at this time)
 - Schizophrenia (prepared and pending initial review)
 - developed an ongoing system for therapeutic category utilization reviews;
 - developed and adopted a standardized Correctional Formulary, including processes for the ongoing review and updating of the Formulary
- A clinical pharmacy service to assist health care providers with formulary compliance, appropriate medication management, and patient intervention has been developed and implemented and is now in operation at approximately one-third of the facilities.
- As a result of Maxor's comprehensive and ongoing staffing evaluation and recommendations, 10 new pharmacist and 3 new technician positions have been approved by the Office of the Receiver. Efforts to replace registry Pharmacists-in-Charge (PIC) with State employees are progressing well.
- Development and implementation of a pharmacy services "drop-in" team designed as a strike team to provide immediate and intensive attention to facilities experiencing significant pharmacy system issues. To date, "drop-in" Maxor staff has assisted 17 of the 33 facilities on-site to address a variety of pharmacy management concerns.
- A Pharmacy Nursing Liaison position has been developed and approved by the Receiver to assist in coordination of medication management issues in conjunction with the Receiver's Nursing leadership.
- A number of key management and reporting tools have been developed and implemented to assist in the development and continuous improvement of

evidence-based practices within the pharmacy program including most significantly:

- A monthly dashboard of pharmacy related information that provides key performance, utilization and workload data for each facility; and,
- A stoplight grid and facility inspection tool. A baseline inspection has been completed for each facility to assess adherence to regulations, standards and related concerns.
- The facility pharmacy inspection process was created and implemented as a beneficial quality improvement tool for facility level staff. Approximately one-third of the facility pharmacies have shown marked improvement through September 2007.
- In conjunction with the Receiver's information management and related medical process strategies, the selection and implementation of Guardian ® as an interim pharmacy operating system; the pilot testing of the system at the Folsom State Prison and Mule Creek State Prison and implementation at California Men's Colony; and the implementation of a coordinated system rollout strategy involving multi-disciplinary training and preparation for all aspects of the medication management process.
- The implementation of *MC Strategies*, a software educational and tracking tool for pharmacy employees. Training programs and policy revisions are deployed in the software and in use. As disease management medication guidelines are approved by the P&T Committee, training modules have been added to the program. The products assure deployment and verifies competency in important procedural changes, educational information and other key information. To date, 27 lessons have been deployed and currently in use.
- Implementation of a number of enhanced communication mechanisms designed to disseminate the Roadmap objectives and improvements including the institution of quarterly Pharmacists-in-Charge meetings, the development and publication of a monthly pharmacy newsletter, *Pharmacy Horizons*, to disseminate policy changes and new disease medication management guidelines, and establishment of clear lines of authority for pharmacy staff.
- Established dialogues with several California colleges of pharmacy to explore opportunities for involvement in enhancing correctional pharmacy services, assistance in recruitment, and continuing education of pharmacy staff.
- Assumption of responsibilities from the Department of General Services, on behalf of the Receiver's Office, for managing the purchasing and procurement of pharmaceutical products for the CDCR population:
 - By working closely with the Pharmacy & Therapeutics Committee to identify favorable contracting opportunities, Maxor has negotiated with manufacturers on therapeutic categories. All are designed to result in improved continuity of patient care and significant cost savings.
 - Procedures have been implemented to compare purchases with dispenses to enhance accountability and identify potential diversions or misuse.

- An agreed-upon process for standardizing order-entry and processing orders for compliance with contracts has been implemented to ensure that the best value contracted item is purchased and is in stock.
- To date cost avoidance from purchasing and procurement oversight and monitoring has averaged more than \$150,000 per month.
- Comprehensive pharmacy-related savings or cost avoidances have begun to be realized. Pharmacy and Therapeutic Committee initiatives are beginning to show significant cost savings through therapeutic category reviews and selection of preferred formulary agents. For example, a decision to remove Lipitor[®] from the formulary and use generic Zocor[®] as the preferred statin has resulted in a cost avoidance of approximately \$380,000 per month. Selection of a preferred generic nasal steroid has also resulted in a cost avoidance of approximately \$149,000. These cost avoidances are ongoing and are anticipated to continue with enhanced formulary management. Cost savings will continue to increase as the formulary is fully implemented and contracts on additional preferred agents are finalized.
- A comprehensive Request for Proposals for a new Pharmacy Wholesaler was prepared and issued. Responses have been received and selection of a new Pharmacy Wholesaler is undergoing extensive evaluation at this time for planned award and initiation by January 2008.
- Evaluation of potential locations for a centralized pharmacy is ongoing and coordination with DGS has been initiated.

B. Modifications to the Maxor Road Map

As anticipated, a limited number of modifications to the Road Map have proven to be necessary. Three factors generated the majority of these changes: (1) Modifications to align the Road Map with the Receiver's Plan of Action (POA); (2) modification requested by the Receiver for changes in or enhanced services; and (3) modifications to provide for more realistic deadlines to overcome barriers to major projects such as establishing a centralized pharmacy operations and establishing a pharmacy information technology system in all 33 CDCR prisons; While changes have taken place, there is no misalignment in mission, vision, primary objectives, and long term objectives. Adjustment to Maxor objectives are summarized below, and are presented again in a more complete manner in a chart illustrating Maxor's revised objectives. Refer to Maxor Pharmacy Services Initiative Appendix 2 – Maxor Road Map Objectives Timeline and Tracking Grid.

Road Map Objectives to be Deleted:

Road Map Objective F3 and all sub-objectives should be deleted. This objective refers to the evaluation of Vista A and the procurement of a state-of-the-art pharmacy operating system. It was decided that Maxor would provide Guardian Rx Carepoint to the CDCR as an interim solution for pharmacy operating software and that the Vista A project would be discontinued.

Road Map Objectives with Timeline Modifications:

Through early discussions with the Receiver, it was determined that the concept of centralization with implementation of Guardian were important to prioritize in the Road Map timeline. Other timeline changes were made to align with the Receiver's POA or as a result of barriers to change.

MAXOR PHARMACY SERVICES INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

The major projects to be implemented are listed below in time frames required by the Order of September 6, 2007.

Six Month Objective:

- B.3 - Develop and implement effective and enforceable Disease medication Management Guidelines.

Twelve Month Objective:

- A.3 - Update and maintain system-wide pharmacy policies and procedures.

Twenty-Four Month Objectives:

- A.4 - Establish key performance metrics used to evaluate the performance of the pharmacy services program.
- A.5 - Establish standardized monitoring reports and processes designed to continually assess program performance.
- E.2 - Design, construct and operate a centralized pharmacy facility.
- F.2 - Identify and solve connectivity issues throughout all pharmacies to ensure that web-based software, reporting, and data can be easily accessed at each facility.
- C.4 - Consolidate and standardize pharmacy purchasing through development of a centralized supply procurement system.
- F.4 - Transition each institution to a uniform interim pharmacy information management system (Guardian Rx).
- F.5 - Develop and implement reporting tools to facilitate clinical, operational, and fiscal management of the CDCR pharmacy operation.

Thirty-Six Month Objectives:

- B.2 - Establish methodologies and schedules for tracking and monitoring formulary compliance and prescribing behavior.
- C.2 - Develop process to monitor inventory shrinkage.
- C.3 - Implement process to ensure that the best value contracted item is used.
- D.1 - Hire and train new employees as needed to replace registry personnel.
- D.2 - Complete skill set inventory of State and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing employees.
- C.5 - Evaluate feasibility of achieving 340 B preferential pricing on all drug purchases.
- D.4 - 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.
- F.6 - Integrate pharmacy information management system with auxiliary technologies such as central supply management, physician order entry, electronic MAR, and barcode checking.
- G.1 - Establish CDCR commitment to pursue accreditation and determine the accrediting organization standard to be followed
- G.2 - Develop a readiness grid identifying the standards and assigning assessment responsibilities to members of the team.
- G.3 - Complete mock audit using credentialed audit for target credentialing body.
- E.1 - Prior to centralization, implement standardized operations in all existing institution level operations to correct problems identified in audits.
- G.4 - Apply for accreditation audit at one or more institutions. Expand audits to all institutions on a defined schedule.

MAXOR PHARMACY SERVICES METRICS

As indicated above, Maxor will establish key performance metrics to evaluate the performance of the pharmacy services program within the next twenty-four months.

BARRIERS TO THE SUCCESS OF MAXOR PHARMACY SERVICES' ROAD MAP SIX TO THIRTY-SIX MONTH OBJECTIVES

1. Class Action Coordination

The initial need to establish a central, statewide review and approval process for activities such as the formulary, procedures and standardization was critical to success in assuring multidisciplinary participation and support at the level of deployment. However, creating this infrastructure has contributed to delays in meeting Road Map objective timelines.

2. Lack of Consistent Prison Pharmacy Programs

The enormous variance in operational processes between the facilities has required extensive direct oversight to implement changes in policy & procedure, the formulary and the implementation of the interim pharmacy software solution Guardian Rx. Coupled with inmate overcrowding, physical plant challenges and limited formal management training and experience of many facility level managers, implementation of process change has required significantly more oversight than anticipated, resulting in the protracted deployment. Indeed, this has been further complicated by the CDCR's culture, entrenchment and resistance to change.

3. Increased Procurement Responsibilities

For a variety of management control, patient safety, and fiscal savings reasons, as reported in the Quarterly Reports, the Receiver has instructed Maxor to assume directly responsibility for almost all CDCR health care procurement processes. Thereafter Maxor commenced direct negotiations for the procurement of medications, and as a result have obtained improved pricing for the CDCR. Navigating the State's contracting requirements has created an initial workload on Maxor staff that was not anticipated at this stage of the pharmacy remedial process. Nevertheless, with time, these processes are expected to improve and will become more efficient and effective.

4. Scope of the Guardian IT Rollout

The selection of Guardian Rx as the interim pharmacy software solution has allowed CDCR to move toward a new system at a substantially reduced cost. However, the original Road Map Objectives included oversight of a transition to new software, but did not include staffing to complete the implementation and training. These activities would normally be supported by a vendor providing the software as part of the purchase or lease costs. In addition, a lack of consistent nursing policies, physical plant problems at almost every prison, and the existing shortfalls of the CDCR IT staffing has rendered this project more difficult to accomplish than originally anticipated. Maxor has worked with the Receiver to remedy this barrier by establishing additional implementation teams. In addition to Guardian implementation, these teams will address the continuing process and operational oversight needs identified at the CDCR sites.

**PILOT PROJECT INITIATIVE
(POA OBJECTIVE B.2)**

INTRODUCTION AND BACKGROUND

Given the complexity of the remedial challenges faced by the Receiver, and the need to proceed in both a timely yet thoughtful manner, the Receiver has adopted as one of his strategies as the use of various pilot projects. As of November 15, 2007 there are four major pilot projects in various stages of implementation:

1. The San Quentin pilot project
2. A specialty care pilot project at the California Correctional Institution and California State Prison - Los Angeles County.
3. A quality-related pilot project providing for clinically driven investigations concerning prisoner/patient deaths.
4. A quality-related pilot project for monitoring prison specific compliance with Plata injunction requirements.

The San Quentin and specialty care pilots are discussed below. The quality related pilots are discussed in the Clinical Quality Measurement and Evaluation Initiative. The Receiver emphasizes that additional pilots will be developed and implemented as necessary and he will report to the Court concerning those pilots in both his Quarterly Reports and future iterations of the POA.

SAN QUENTIN PILOT PROJECT (POA OBJECTIVE B.2)

BACKGROUND AND INTRODUCTION

A. Medical Care Delivery at San Quentin on April 18, 2006

On the day following his appointment, the Receiver, his staff of three people, and invited guests from the State and the Court toured San Quentin State Prison. A viable medical care infrastructure was non-existent, the facility itself was in a state of severe deterioration with structures built in the mid-1800's standing alongside more recent buildings with piecemeal upgrades, all in all a prison that was grossly inadequate to adequately care for the number of inmate-patients residing at the institution. In addition to the lack of sufficient treatment space, the decrepit state of the prison's infrastructure, and dangerously unhygienic conditions, the Receiver found basic medical equipment and supplies severely lacking. No appropriate and systematic process was in place for inmate-patients to request and receive proper, timely medical treatment (either routine or urgent). The Treatment and Triage Area (TTA) which served as the institution's emergency trauma room was the size of a closet, unclean with paint peeling off the walls, and surrounded by correctional officers who often crowded the doorway conducting their escort duties, intruding upon clinicians' ability to function as well as upon patient privacy. Medical examinations performed in the East Block were conducted in a small converted cell located directly below the prisoner shower facilities on each of the four floors above it. As such, inmate-patients and providers were forced to walk through a deluge of shower run-off in order to access the plastic sheet covered exam room. Many clinic areas had no hand washing facilities or working sinks, and in one instance a leaking sewer pipe dripped over an exam table. Severe clinical understaffing, a lack of qualified manager, and shortages of qualified medical professionals prevailed at every level and in every medical department, including medical records, pharmacy, special medical housing, the Outpatient Housing Unit, and the prison's Reception Center ("RC"). Nursing, the foundation of health care delivery in a prison, lacked around the clock management and basic staffing for continuous coverage. Nursing services were primarily delivered through contract registry, private nurses who had neither the direction, responsibility nor investment to run or manage the chaotic, failing San Quentin nursing operation.

B. July 2006 - The San Quentin Pilot Program

Following his tour at San Quentin, the Receiver announced that San Quentin was to be put "under the microscope," and through a special Receiver initiated project, it would receive the resources, staffing, expert assistance necessary to address the more serious daily operations problems which prevented the provision of adequate access to quality of medical care.

In July 2006, after the Office of the Receiver had hired the staff to manage such an effort (for example, a Chief of Staff, physicians, nurse consultants, correctional

consultants, etc.) the San Quentin Pilot was commenced. The initial length of the Pilot was established as 90 days. It is important to emphasize that, as was stated by the Receiver at the time, the Pilot was not designed to “fix” San Quentin. The general state of disrepair, severe shortages of correctional officers, lack of information technology and other factors will require years of effort to effectuate all of the needed corrections. Instead, the Pilot was created to help San Quentin with its most egregious shortcomings and, as important, to help the Receiver and his staff understand the nature of systemic issues and deficiencies which applied to all prisons, not just San Quentin. In effect, the project was viewed as practical research with San Quentin serving as the laboratory. The project focused initially on the following critical areas related to the provision of medical services:

1. Reception Standards and Compliance
2. Outpatient Housing Unit (OHU)
3. Equipment
4. Medical Records
5. Specialty Services
6. Laboratory
7. Diagnostic Imaging
8. Patient Complaints/Grievance Process
9. Clinical Space
10. Facility Maintenance
11. IT, Communications and Power
12. Sanitation/Janitorial
13. Custody & Clinical Relations
14. Organizational Structure
15. Staffing
16. Salaries
17. Internal and External Communications

During the course of the last 21 months, some of these initial projects have been modified. For example, the Reception Center project, at first limited to developing standards and ensuring compliance with those standards, has evolved into an interdisciplinary project which has led to restructuring and improving the entire reception process, providing the beginnings of a model that can be emulated, over time, at other CDCR reception centers. Extensive work has been accomplished, and important changes are being developed and implemented concerning improvements in clinical space at San Quentin. Construction for San Quentin is contained in the San Quentin Construction Initiative.

To effectuate necessary corrective action, the San Quentin Pilot Team conducted weekly meetings at the prison, engaging the help of on-site staff to support major initiatives and develop an initial Plan of Action. It was recognized that each specific clinical area and discipline needed overhauling before the medical delivery system could function as an integrated whole. In addition, all stakeholders agreed that the lack of permanent medical staff and managers was a fundamental barrier to raising the level of

care up to constitutional levels and staffing must be a priority. Each of the major project areas was assigned a San Quentin staff and Receiver staff as the project leads, and target dates for accomplishing tasks were set. In the meantime, short term, crisis management solutions were implemented to sustain patients, address emergencies, and provide essential care on a day-to-day basis. Projects were tracked through a project matrix. Refer to San Quentin Pilot Project Initiative Appendix 1 – San Quentin Project Matrix. The Receiver has reported the progress of the San Quentin Pilot in each of his Quarterly Reports.

C. July 2006 to November 2007 Pilot Project Progress

Given the seriousness, the scope, and the interconnectivity of the problems encountered at San Quentin, the Pilot lasted far longer than the original projection of 90 days. Indeed, it was not until early 2007 that the weekly meeting process was discontinued. Over time, however, the clinical leadership at the prison (with assistance from the Office of the Receiver) has started to assume a more active, independent, and effective role concerning management of the changes called for by the Pilot. For example, an Executive Steering Committee was formed to strategically restructure the San Quentin Health Care System, prioritize achievable activities, and develop the local plans, based on the Receiver's project plan. The role of the San Quentin Quality Management Committee was also redefined to ensure effective and efficient local implementation with documented tracking for the Plan of Action. These committees now function relatively effectively, and have begun to produce reports which document their activities, clinical productivity, and an initial form of quality evaluations. San Quentin specific project teams have been formed to redesign clinical services and support areas including the Reception Center, Triage and Treatment Area, Outpatient Housing Unit, Primary Care, Specialty Care, Scheduling, Health Care Records, Diagnostic Studies, Pharmacy, Medications, and Appeals. Teams have also been assigned to review, revise, develop, and pilot policies and procedures, protocols, referral criteria, forms, orientation and training materials, clinical monitoring tools, databases, and standard reports. A significant number of project teams, led by managers and supervisors, continue to meet regularly to deal with designing, implementing, evaluating, and improving clinical processes and programs consistent with the Pilot plan. In many important ways the original Pilot has matured into a program that is becoming much more sustainable with a significant reduction in day to day support by the Office of the Receiver. Even today, however, the Receiver maintains a Project Manager and nurse consultant at San Quentin, and all major personnel and administrative decisions are made by his Chief of Staff.

NOVEMBER 15, 2007 STATUS OF SAN QUENTIN STATE PRISON'S MEDICAL CARE SYSTEM

Over the past year and a half, the Receiver and San Quentin have made significant progress in transforming a completely dysfunctional health care system into a patient-centered, evidence-based, primary care system of health care delivery, conducted by a team of qualified and dedicated medical professionals. Because of these remedial efforts, prisoners are now far more likely to receive an appropriate and timely intake evaluation,

ongoing primary care (including preventive and chronic care services), and to be connected with community providers upon parole.

The following are examples of progress made at San Quentin to date:

- Established a multidisciplinary Reception Center (RC) Subcommittee.
- Performed an intake population analysis (i.e., number of admits per day, time of admit, and age on admission) to balance intake population on most days.
- Developed an RC intake screening criteria and disposition based on evidence-based practices and constitutional standards.
- Identified RC staffing needs for comprehensive health screening and assessment which includes Registered Nurses, Primary Care Providers, Certified Nursing Assistants, Office Technicians, Mental Health staff, and Laboratory Technicians.
- Developed an intake process integrating medical, mental health, laboratory, and dental services and integrated all physical plans and designs with custody to ensure success and cooperation.
- Defined RC and Triage and Treatment Area (TTA) scope of responsibilities to guide RC RNs and Providers when making TTA referrals.
- Revised the CDC 7277, Initial Health Screening Form, and developed the San Quentin Pilot Initial Health Screening form.
- Developed a new two-page Primary Care Intake Form for providers to replace eight existing CDCR chronic care intake forms.
- Developed RC indicators to track data and measure program success.
- Developed health information in an Access database as a temporary solution to track and report indicators in lieu of limited automation.
- Identified need for automation to assist in tracking the CDC 128Cs (chronos) necessary to transfer inmates to other facilities. A scanning process was put in place to eliminate the need for lost chronos to be generated.
- Developed inmate health educational materials in English and Spanish. A Health Education binder is currently available in the Inmate Library and all clinics.
- Coordinated with Centerforce in the development of the inmate orientation video.
- Revised the inmate orientation handbook reflecting the new RC process.
- Developed "Access to Services" poster in English and Spanish. The poster will be displayed in the new Reception Center, Inmate Library, and all housing units.
- Held a coordination meeting with local county jails in May 2007. The meeting was attended by medical, mental health, and custody representatives from 12 county jails.
- Conducted multiple sessions on RC general orientation training to all health care and RC custody staff.
- Conducted oral screening training for all RNs and Providers by an outside dental correctional expert.
- Identified and ordered necessary office and medical equipment to implement comprehensive Reception/Intake program
- Designed and piloted primary care provider staffing model including consistent coverage of patient populations based on housing assignments, clinical service area and reception status, physician-mid-level practitioner partnerships, lead

physicians, job descriptions, productivity and referral guidelines, and performance expectations.

- Formed inter discipline care teams with provider, custody, and scheduling staff to improve continuity, collaboration, coordination, and communication.
- Identified a significant gap in care on weekends, holidays and afterhours ;created nursing staffing package to cover gaps in access and/or time and extended provider hours on weekdays and added Saturday provider..
- Recruited and hired qualified primary care physicians, the majority of whom were trained at UCSF.
- Recruited and hired four mid-level practitioners.
- Performed intensified practice (peer) reviews weekly and monthly as part of the Probationary and Annual Performance Evaluations and for educational purposes.
- Recruited and hired additional Supervising Registered Nurses to oversee and serve as liaisons for designated program areas such as Primary Care Clinics and housing units, RC, TTA, OHU, Medications, Public Health, Appeals, Specialty Care, Mental Health, and Health Care Records.
- Hired more than 100 RN and LVN staff to realign and assign consistent staff to service areas. One hundred percent of RN positions and ninety-five percent of LVN positions are currently filled.
- Participated in the design and pilot of centralized custody Health Care Access Team.
- Identified and established additional interim clinic space in several housing units as well as provider work space.
- Obtained and distributed PDA, laptop, and dictation equipment, reference materials, and Quest lab access codes to primary care providers.
- Enhanced equipment such as glucometers, peak flow meters, and blood pressure cuffs to clinic areas.
- Designed and piloted the primary care intake processes including template, encounter log, , disease codes, database, and standard reports, which is the beginning of improved but rudimentary disease registries.
- Designed and piloted a Diabetes Group in North Block, spearheaded by UCSF to empower patients to improve self-management.
- Designed and piloted a Geriatric Clinic including mentoring roles for CDCR and UCSF physicians, primary care interns, and standardized functional assessment tool.
- Designed and piloted a pre-discharge planning program with CDCR, UCSF, and Alameda County representatives for high-risk patients including standardized transfer form, medication continuity, and contacts with community transition clinics for follow-up care.
- Developed RN Review Protocols on Colonoscopy, Ophthalmology/Optometry, Physical Therapy, and Podiatry Services to eliminate need for physician orders for routine services.
- Improved timeliness and access to laboratory and radiology services and availability of consultation reports through Health Records.
- Laboratory tests are completed within seven days (100%) and reports are filed in the medical record promptly. East block lab draws increased from 50% to 100%

by sending lab techs to the units; this also improved the “no show” rates to less than 1%, eliminating long wait times for prisoner patients,.

- X-ray orders (majority) are completed within 72 hours and reports are returned within 14 days to provider and to medical record within 30 days. All emergent orders are processed within one day.
- Participated in a UC Davis pain management program and designed a comprehensive assessment tool in coordination with primary care providers.
- Modified formulary changes and pharmacy order procedures.
- Obtained videos on HIV, Hepatitis C, Sexually Transmitted Diseases, and Tuberculosis for inmate viewing in the RC holding areas.
- Acquired three TV monitors in the RC to view patient information.
- Established links with sub-specialists to co-manage patients with HIV infection and subsets of patients with high-risk chronic conditions and developed on-going data base.
- Designed and implemented a strategic case-based professional development program for primary care providers that focuses on evidence-based practices for CV risk management such as Diabetes Mellitus, Hypertension and dyslipidemia, Asthma/COPD, HIV, HCV, and other communicable diseases or STDs.
- Implemented Maxor guidelines for dyslipidemia and hypertension.
- Designed and implemented with UCSF initial diabetes outcome study.
- Developed routine evaluations of ambulance transfers as part of the Emergency Response Review Committee.
- Redesigned the Chronic Care Program including review and revision of high-risk criteria, policies, procedures, protocols and forms, and decision support tools.

SAN QUENTIN PROJECT INITIATIVE: NOVEMBER 2007 TO NOVEMBER 2010

Over the next three years, the Receiver and San Quentin medical staff will accomplish the following:

Six Month Objectives:

- Refine the primary care intake processes including template, disease codes, database, and standard reports.
- Reduce unnecessary and avoidable TTA or Community Hospital transfers due to chronic care condition 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.

Twelve Month Objectives:

- Formalize the primary care management model that includes a prisoner/-patient classification system and appropriate levels of services and resources based on classification with measurement tools to monitor and report services and resource utilization.
- Refine and replicate Diabetes Group in H Unit and measure outcomes. A1C levels (a measure of how well the blood sugar is controlled) was measured in a recent report to indicate that the majority of diabetic patients were prescribed appropriate medications to treat diabetes and other cardiovascular risk factors.
- Train staff to give accurate and consistent educational messages during reception processing and at key patient encounters.

Twenty-Four Month Objectives:

- Implement a collaborative primary care management model which will include care managers/coordinators, case managers, and support staff, working together to coordinate patient care, continually problem-solve, and improve coordination, communications, continuity and patient outcomes.
- 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.

Thirty Six Month Objectives:

- Transfer the clinical expert role to State employed providers to strengthen the internal team.
- Design and institute professional development programs in several areas including, the collaborative primary care management model, evidence-based primary care and chronic care, case management, information management, as well as medical management and leadership.

As the Receiver's team continues its work over the next 36 months, much of the reform projects tested at San Quentin will be able to be replicated at other California prisons.

SAN QUENTIN PROJECT METRICS

The following Reception Center related clinical and access to care metrics for San Quentin will be tracked:

- Obtain at least 90% compliance for prisoner/patients with chronic diseases or high risk medical conditions, including age-related, according to established criteria and time frames.
- Reduce to no more than 10% unnecessary and avoidable TTA or community hospital emergency department transfers for prisoner/patients with chronic/high risk conditions within the first 30 days of a prisoner-patient's admission to San Quentin.
- Obtain minimum 90% compliance for prisoner/patients on essential medications and with verifiable documentation receive their medications by the next day of arrival at San Quentin. The past several months of data shows 100% compliance.
- Continue to complete all lab orders including reports within seven days and x-ray orders within 72 hours.
- Continue to complete all loose medical records filing within one day.
- Track availability of medical record for provider encounters which continues to improve with no significant problems.
- Monthly TTA statistics and monitoring of emergency runs will be coordinated with custody data to evaluate emergency response time and continued reduction and evaluation of emergency transports.

BARRIERS TO THE SAN QUENTIN PILOT PROJECT'S SIX TO THIRTY-SIX MONTH INITIATIVES

Despite staff enthusiasm for change and the optimism inspired by the tangible successes that have been realized in a year and a half of Receivership intervention, barriers to achieving the Receiver's thirty-six month objectives exist. They include the following:

1. Staffing:

Continued progress at San Quentin will require additional hiring to fill vacancies, implementation of retention strategies for clinical and administrative staff, and implementation of staff development activities. A dedicated Nurse Instructor or Staff Developer will be needed to provide training to new hires. Nurse managers, who have inherited the bulk of responsibilities for the implementation of new programs, have not had the time to complete their own orientation. Nevertheless, they are required to train new staff, while managing a nursing staff and handle personnel problems. As a result nurse managers are inconsistently applying supervision, feedback and discipline, and are on occasion delinquent in performing probationary evaluations due to large number of new hires in a very short time period and varying levels of comfort and competence in holding staff accountable. These issues are not insurmountable, but they will require resources, expert assistance, and time to overcome.

2. Juggling remedial priorities

Numerous architectural building and redesign projects compete for staff time and divert medical staff from patient care activities and duties. The design of the Central Health Services Building and renovation of the TTA have required significant staff time. This workload has, at times, affected that ability of key clinical and management staff to tend to patient care and other management responsibilities. Given the challenges ahead, managing priorities will itself remain a priority during the next thirty-six months.

3. Staff burnout

The bulk of the Receiver's remedial effort is, at present at least, managed by a few key individuals. Although it is anticipated that this will change as new staff are oriented and gain experience, the danger of staff burnout remains very serious.

4. Coordination efforts-other health care services

Coordination with the needs of *Armstrong*, *Coleman*, and *Perez*, while very important, have at times an adverse impact on the progress remediating medical concerns.

5. Information Technology

The lack of adequate IT and software program(s) to assist in collecting, storing, and reporting data, and to schedule and track patient care will restrict, for the near future at least, efforts to bring the medical delivery system at San Quentin up to sound correctional standards.

**SPECIALTY SERVICES PILOT AT CALIFORNIA STATE PRISON – LOS ANGELES COUNTY AND CALIFORNIA CORRECTIONAL INSTITUTION
(POA OBJECTIVES B.2 AND B.3)**

BACKGROUND AND INTRODUCTION

A. Introduction

In the Findings of Fact and Conclusions of Law re Appointment of Receiver (“Findings”) filed October 3, 2005, the Court found that “[d]efendants have failed to provide patients with necessary specialty services. Patients with very serious medical problems often wait extended periods of time before they are able to see a specialist due to unnecessary and preventable delay...In one instance a patient with a colonoscopy referral had to wait ten months before his appointment, by the time he was seen the mass in his colon was so large that the colonoscope could not pass through...Even when patients do see a specialty consult, medical staff often do not follow-up on the specialist’s recommendations.” *See* Findings at 24: 19-28. This section discusses the pilot program to improve specialty care at two prisons.

The CDCR’s failure to provide adequate specialty care was caused by a number of interrelated and serious infrastructure problems, including the following:

1. The failure to hire competent clinicians at every level.
2. The State’s long history, caused by inadequate pay and poor working conditions, of relying upon registry personnel instead of competent State employees.
3. The States failure to manage its specialty provider and hospital contracts.
4. A custody driven prison management culture which failed to consider the needs of prisoner/patients.
5. Inadequate correctional officer staffing to effectuate out-of-prison specialty appointments.
6. Inadequate prison construction program which failed to provide the appropriate space for in-prison specialty care, a problem aggravated by double ceiling and overcrowding.
7. Inadequate number of patient transportation vans and escort vehicles.
8. An absence of information technology systems necessary to schedule and track specialty care appointments and to ensure that specialty care follow-up is effectuated.

The Receiver is in the process of addressing each of the underlying problems which created the CDCR’s unconstitutional specialty care services problem. Until each of the needed infrastructure shortfalls is corrected, specialty care will not be inadequate, although improvements will be made on an incremental basis as the POA programs referenced above are put into place. Instead of waiting for each infrastructure remedial program to reach completion, however, the Receiver is also taking steps to examine short term solutions, as well as to examine the processes needed for improvements and potential pitfalls to specialty care remedial programs. The goal of the Specialty Services Coordination Pilot is to develop and implement policies and practices that will reduce cancellations and missed appointments, eliminate backlogs, and improve provider relations with an end result of providing timely access to specialty services for all patients at the California Correctional Institution (“CCI”) and the

California State Prison, Los Angeles County (“LAC”). The project began because of problems encountered after State officials implemented an alleged “contract” with Medical Development International (“MDI”), a program which failed and placed the specialty care program at CCI and LAC in jeopardy.

B. Problems Created by MDI at CCI and LAC

In March 2007, the relationship between MDI and CDCR for provision of specialty services at LAC and CCI was terminated by the Receiver because of MDI’s failure to produce proof of a license to operate in the State of California. In addition, an audit ordered by the Receiver revealed MDI’s poor management had resulted in a breakdown of prisoner-patient access to necessary specialty care, placing the health of prisoner-patients at risk.

Under the direction of the Receiver’s Chief of Staff, an evaluation team was established and met bi-monthly, providing LAC and CCI with the tools, processes, staff, and contract providers necessary to ensure timely access to quality specialty services on-site, off-site, and via telemedicine. The team evaluated the remedial measures taken by each institution for quality and efficiency, reviewing every request for specialty services. The goal of the team was to replace and improve the functions previously performed by MDI and to enable LAC and CCI to independently and effectively manage specialty services.

NOVEMBER 15, 2007 STATUS OF THE SPECIALTY SERVICES PILOT AT LAC AND CCI

A. Introduction

The majority of specialty services have improved at both institutions. With the approval of additional staff and other resources for both institutions, LAC and CCI began to implement solutions for the scheduling and tracking of specialty care; ensure adequate numbers of trained staff are available to schedule appointments, escort and transport patients, and assist with telemedicine services; ensure adequate numbers of contract physician specialists are available to provide specialty services on-site and in the community; implement a Fast-Pay system, which includes retrospective reviews to ensure contract physician specialists are paid in a timely manner; augment current local vehicle pools to ensure vehicles are available for patient transportation to off-site specialty care appointments; and improve Telemedicine services.

B. Successes

The following are successes that have ensued since establishing the Specialty Services Coordination Pilot:

- Cancellations of appointments for off-site specialty services have dramatically decreased in the first three months of the projects.¹ Refer to Specialty Services Coordination Pilot Initiative Appendix 1 – Off-site Cancellation Table.
 - LAC Off-site Cancellation Improvements: In the first 3 months of the project, LAC cancellations decreased approximately 75% and the average number of visits provided off-site increased 490%.
 - CCI Off-site Cancellation Improvements: In the first 3 months of the project, CCI cancellations decreased approximately 78% and the average number of visits provided off-site increased 160%.
- Medical and custody staff are working together cohesively to accomplish the task at hand and to resolve issues that arise in a proactive manner. Use of the comprehensive Off-Site Appointment Cancellation form has forced staff to analyze and find solutions to problems that arise reducing the overall number of incomplete referrals. Refer to Specialty Services Coordination Pilot Initiative Appendix 2 – Off-site Appointment Cancellation Form.
- Combining all five primary components of specialty services (including Utilization Management (UM), Telemedicine, Specialty Services, In-House Scheduling, and Community Scheduling) under one umbrella created opportunities for better communication. The resultant improved communication, brainstorming, and troubleshooting have increased the efficiency and effectiveness of specialty services. Staff are more aware of other's responsibilities and are cognizant of potential pitfalls as well as the ramifications of their actions.
- Use of only one scheduling and tracking system, entitled "Inmate Medical Scheduling and Tracking System" (IMSATS), versus multiple systems has caused some improvement in the referral process.
- The specialty Service Coordination meetings are bringing staff from custody and medical together to find effective solutions.
- In-service training at the beginning of the project, as well as continual retraining and reminders, has directly affected the success of the project. The more staff who are aware of the goal, the more likely the goal will be achieved.

C. Improved Coordination

In addition, important improvements in coordination have been achieved by the project, including the following:

- Specialty Service preparations, including the need for a patient to be NPO (nothing by mouth), is an ongoing issue. Customized specialty preparation "cheat sheets" are being

¹ Cancellations are described as any appointment not successfully completed within 24-hours of the scheduled appointment.

developed to help ensure that all needs are addressed prior to the appointment, with the goal of minimizing unsuccessful appointments through effective preparation and planning. This planning element also includes education of the patient, confirmation of all appointments with Transportation and the Provider prior to the day of the appointment, and obtaining copies of all pertinent medical information including reports, lab, radiology reports and/or films.

- Evaluating quality measures by monitoring the number of pending/scheduled and cancelled appointments from week to week is continuing. The number of scheduled appointments is going up; the number of pending should go down and the number of cancellations should decrease as quality improvement processes are put into place.
- The roles and responsibilities of the Specialty Service Coordinator (Utilization Management Registered Nurse) have been identified and the duty statement has been completed.
- Protocols for specialty services are being evaluated and modified to ensure referral is medically necessary and appropriate.
- Efforts to more effectively use clerical and nursing staff are being implemented to improve specialty service referrals.
 - Clerical staff are being tasked to perform scheduling functions, including IMSATS, making the actual appointment with the provider, completing transport paperwork, etc. Nursing is providing clinical functions, ensuring preps are dispensed properly, providing patient education where necessary etc.

D. On Going Challenges to Effective Specialty Care Services at LAC and CCI

The specialty care services at each institution, however, remains volatile and the improvements need continued monitoring and effort until they are more fully institutionalized. Examples of problems which remain include the following:

Operational dysfunctions common to both LAC and CCI:

- Frustration among staff due to poor coordination in arranging and completing specialty care service referral.
- Lack of clerical support resulting in nurses spending time on paperwork rather than patient care.
- Redundant referral process for Optometry and Podiatry requiring patients to see Primary Care Provider (PCP) first to get a referral to the specialist.
- Inadequate electronic technology for scheduling and tracking specialty care referrals and for quality management systems to evaluate the referral process's efficiency and effectiveness.

Space problems common to both LAC and CCI:

- Cramped spaces: Too many people trying to work in too small a space.
- Proximity: All staff involved in the process are not in close proximity.

LAC-Specific Issues:

- The mission for LAC during this period was changed dramatically. LAC became a much larger Reception Center. Reception Center facilities usually produce unpredictable

patient populations, resulting in greater demands on health care in general, and specialty services in particular.

- Telemedicine operated in a congested and noisy examination room behind the nursing station. The staging area for holding patients waiting for appointments was inadequate. The holding cells were not always available as they were used for mental health crisis evaluations.
- Lack of escort officers for telemedicine appointments. Telemedicine operated in a small examination room located in the main healthcare complex. Patients with telemedicine appointments must be escorted from each of five housing facilities to the telemedicine room. There was no dedicated custody staff to perform these escorts.

CCI-Specific Issues:

- CCI has had extraordinary turnover in health care management. CCI has had three different Health Care Managers during this period and, as a result, experienced a lack of clinical leadership. In spite of these circumstances, significant progress has been made at CCI, although more progress could have been made if not for the unsteady health care leadership. At present, both the Regional Medical Director and the Regional Nursing Director have been actively involved in providing clinical leadership.
- Telemedicine was set up to function in three areas: the Level II yard and two Level IV yards creating inefficiencies for the telemedicine nurse due to need to travel between them.
- The equipment at IV-B was out of service due to flood damaged telephone lines.
- The Medical Hold Policy and Procedure was not followed resulting in approximately fifty (50) scheduled appointments to be cancelled because the patient had been transferred. The specialty care staff only received one or two days notice of a patient's scheduled transfer.
- Internal transportation for on-site specialty services: Transporting high custody inmates to the Level II yard is a custody concern beyond the control of medical staff. The need to escort patients to the telemedicine clinics resulted in patients arriving late.
- External transportation issues:
 - Lack of transportation vehicles for off-site specialty appointments. The CCI Transportation Unit had only six vehicles available for all transportation requirements (i. e. out-to-court, mental health crisis bed transport, ambulance chase, and medical specialty services). Specialty care appointments were cancelled and rescheduled because there were no available vehicles resulting in noncompliance with court mandated medically necessary time frames or within department policy mandates.
 - Lack of dedicated medical transportation officers. The transportation staff performed all off-site transportation functions, and could not always provide transportation services for off-site medical appointments.
 - Lack of support staff for the Transportation Unit. The Transportation Unit supervisors spent an inordinate amount of their time performing clerical functions such as answering phones, requesting and locating Central files for review, obtaining signatures, preparing forms, and coordinating schedules.

SPECIALTY SERVICES PILOT INITIATIVES: NOVEMBER 2007 TO NOVEMBER 2010

A. The Pilot Team

The development of an effective and efficient specialty services program requires intervention in three different aspects of the referral program: 1) telemedicine, 2) on-site Specialty services, and 3) off-site specialty services. To ensure that the programs are developed and implemented effectively, the specialty Services Pilot Team will continue to conduct regular meetings for vigorous discussion of current conditions, current problems, proposed modifications of remedial efforts (by both medical and custody staff) in an effort to improve access and reduce barriers to specialty care for patients. The Pilot Team consists of statewide, regional, and CCI and LAC institutional staff.

- Regional staff facilitate and ensure the inter-institutional transfer of best practices between CCI and LAC, and help mitigate intra-institutional barriers to achieving pilot objectives by fostering collaboration and effective communication among institutional administrative, custody, and health care staff.
- CCI and LAC institutional staff provided direct operational implementation of the pilot program, conduct quality improvement measurement, and recommend effective interventions for statewide replication once the pilot is concluded.

B. The Pilot Initiatives

The following pilot initiatives describe key time-referenced targets to ensure an effective and efficient program is implemented to improve specialty services provided through Off-site, On-site, and Telemedicine consultation. The initiatives for this project is closely linked to the critical path activities for the scheduling and tracking project being developed by the Receiver's informatics/IT staff and the Facility Improvement Construction Initiative. At this time, effort focuses on the off-site specialty services component because it is the least constrained by these other two major projects. The initiatives are more complete and predictable for this effort. As the Informatics and Facility Improvement Construction Initiative begin to implement structural and functional changes in the institutions, the initiatives for the on-site and telemedicine components to the specialty services coordination program will be more clearly and specifically defined.

Off-site Specialty Services:

The major focus of the first four months of this pilot has been examining the factors creating a backlog of specialty services that are provided off-site. Refer to Specialty Services Coordination Pilot Initiative Appendix 3 – Specialty Services Coordination Project Summary of Actions. The team building effort and establishment of Specialty services Coordinators at LAC and CCI have provided the framework for improving this critical access to care problem.

Six Month Objectives:

1. Review and evaluate the progress made in reducing cancellation of appointments, especially related to patient decisions to cancel.
2. Evaluate the effectiveness of improved patient education in reducing appointment cancellations.
3. Complete hiring and training of essential staff including clerical, nursing, and transportation to improve access to off-site specialty services.
4. Increase communication and meetings with off-site providers to identify and reduce barriers to efficient provision of specialty care.
5. Continue regular meetings of the Pilot Team including Specialty Service Coordination efforts. Refer to Specialty Services Coordination Pilot Initiative Appendix 4 – Specialty Status Report.
6. Establish regular communication with the Receiver’s informatics/IT staff regarding the scheduling and tracking project now being developed. This project will utilize rapid cycles of process improvement combined with focus information technology interventions and will focus on scheduling, referral tracking, authorization, and compliance with court mandates for health care access including:
7. Evaluating current methodologies for the metrics to this project for adjustments to reflect changes in business practices produced by the scheduling and tracking project being developed by the Receiver’s informatics/IT staff, as needed.

Twelve Month Objectives:

1. Evaluate staff satisfaction with new processes and identify areas for renewed focus to ensure Pilot Team continues to make progress on implementing effective referral services.
 - o Implement process to improve staff satisfaction through regular meetings, trainings, and addressing staff recommendations for improvement as part of the CQI process.
2. Evaluate the timeliness of referral reports being submitted after off-site specialty services are provided.
3. Identify improvement efforts that have been most effective.
 - o Prepare findings and outcomes to date for this phase of the Pilot program.
4. Identify criteria for selecting other institutions to establish similar Specialty Services Coordination efforts, focusing on Off-site referrals only.
5. Develop regular report (or newsletter) to introduce project to other institutions to build interest in the effort and alert them to future planned changes. Provide periodic updates.

Twenty-Four Month Objectives:

1. Plan the transition from a “pilot” program to a routine referral services for off-site specialty care beyond the LAC and CCI programs.
2. Develop criteria to select “early adopter” institutions to begin to implement methods from this pilot in these institutions.

3. Establish a Specialty Services Project Team at the selected new institutions and implement new programs through technology transfer of best practices developed and perfected at LAC and CCI.

Thirty-Six Month Objectives:

1. Continue to disseminate Off-site specialty referral services through Care Coordination teams in all CDCR institutions.
2. Finalize and submit the evaluation of the Specialty Care Coordination Pilot.

On-site Specialty Services: As space is improved for clinical services, the capability to improve on-site specialty services will improve. Overall direction of space improvement is being managed by another team. Refer to Construction Initiatives. Once the space issues are resolved, contracting or hiring additional Specialty Service providers will be possible. At that time, management strategies will be developed to effectively and efficiently integrate these specialists into the institution.

Six Month Objectives:

1. Establish regular communication with the Receiver's informatics/IT staff regarding the scheduling and tracking project now being developed. This project will utilize rapid cycles of process improvement combined with focus information technology interventions and will focus on scheduling, referral tracking, authorization, and compliance with court mandates for health care access including: Actively participating in rapid cycles of improvement activities as they are rolled out;
2. Evaluating current methodologies for the metrics to this project for adjustments to reflect changes in business practices produced by the scheduling and tracking project being developed by the Receiver's informatics/IT staff, as needed.
3. Identify barriers that are not related to IT or Space issues for providing on-site specialty services and develop plans for reducing them.
4. Begin "planned change process" by involving key staff in the planning for improved on-site specialty services consultation.

Twelve Month Objectives:

1. Determine which specialty services are best provided off-site and on-site.
2. Continue planning with IT and Space Improvement Teams in preparation of offering on-site specialty services.
3. Evaluate current charting systems and medical record processes in relation to changes being made in information technology.
 - o Design and implement improved systems, as appropriate.
 - o Develop and provide training for staff on these new systems.
4. Develop orientation for new specialty consultants to ensure they understand constraints and opportunities for practicing in a prison setting – to improve collaboration and communication among specialty consultants and institutional staff.

5. Evaluate the quality of potential on-site specialists, the contracting process, and the payment process to ensure best business practices are in place.
 - o Determine minimum type and number of on-site specialists required to meet health care needs of patients.
 - o In anticipation of needed specialists within a year, plan the recruitment of specialists and mechanisms to ensure responsiveness in the provision of the consulting reports within acceptable timeframe.

Twenty-Four Month Objectives:

1. Implement the new on-site specialty services component of the Pilot using new IT programs in newly constructed or designated clinic space designed to accommodate specialty providers.
 - o Develop and offer orientation to current staff on new information systems, charting processes, and patient flow for on-site specialty services.
 - o Ensure business practices are in place for prompt payment and prompt reporting by providers after specialty visit is completed.
2. Orient on-site specialists to providing health care within the prison setting.
3. Evaluate the methodology for the Specialty Services Coordination Pilot metrics and adjust based on coordination efforts with IT and patient flow improvements.
4. Plan dissemination of redesigned on-site specialty services for other institutions.

Thirty-Six Month Objectives:

1. Implement dissemination of Pilot findings to other institutions including the hiring and orientation of Specialty Services Coordinators for each institution.
2. Finalize evaluation report from Pilot project.

Telemedicine Initiative: Efforts are currently underway to improve the IT infrastructure that must be in place to expand telemedicine capabilities. These efforts are being managed by a different team and are included in the Clinical Support Services Initiative.

SPECIALTY SERVICES PILOT INITIATIVE METRICS

A. Introduction

Five metrics will be implemented to evaluate the pilot's effort to improve access to specialty services through off-site providers. As the on-site and telemedicine specialty service components of the Pilot are implemented, the metrics and methodologies will be evaluated and modified, if necessary to incorporate new business practices that will likely operate at that time. Currently, the five metrics are as follows:

1. Prisoner/patient's Timely Access to Specialty Services
2. Prisoner/patient Specialty Services Appointment Cancellations
3. Timely Payment to Specialty Care Providers
4. Timely Consultation Reports from Specialty Care Providers
5. Transfer Issues (Coordination of Specialty Care for Transferred Inmates)

B. Measuring Timely Access to Specialty Care

Metric: By December 2008, 80% of Off-Site Specialty Care Consultant appointments will be completed on their scheduled date at CCI and LAC regardless of the nature of the specialty appointment.

Metric Definition: To improve the quality of access to specialty care, this measure will evaluate how many patients receive care on the initial appointment date for specialty services.

Methodology: Each institution will track performance on this measure by completing and submitting weekly the Specialty Status Report. Refer to Refer to Specialty Services Coordination Pilot Initiative Appendix 4 – Specialty Status Report. Note that the number of pending specialty care appointments that have been ordered by clinicians are listed, both scheduled and unscheduled, and those that are outside the 14/90 day turnaround mandate² are documented. The Specialty Status Report also includes the service delivery type (on-site, community, telemedicine), how many are scheduled, not scheduled, seen that week, and cancelled that week. Each institution is to submit a description of effective changes that they made that resulted in improvements on this measure. These changes will help identify and promote best practices and used in the future for the efficient transfer of this technology to other institutions.

C. Measuring Patient Specialty Services Appointment Cancellations

Metric: By June 2009, no more than 5% of Specialty Care Service appointments will be cancelled. Specifically,

- a. For those appointments that are cancelled, no more than 2% will be because of patient directed cancellations.
- b. For those appointments that are cancelled, no more than 1% each will be for clinical, custody or patient-location reasons.

Metric Definition: The *Off-Site Appointment Cancellation* Form was developed to capture the primary reasons that were the patient did not receive the specialty care appointment. The form includes 16 possible reasons and specific details for each for use in developing a plan of

² The 14/90 day mandate requires that any request for an urgent specialty care appointment must be provided and completed within 14 days of the order being written and for any request for routine specialty care appointments must be provided and completed within 90 days of the order being written.

corrective action. The form also provides demographic information about the inmates, their housing unit, type and date of specialty appointments, and the names of the persons completing the form. This measure groups the reasons for the cancellation based on the degree that they can be prevented and identifies whether the cancellation occurred due to a failure on the part of custody staff, health care staff, or the inmate patient.

- a. Reasons related to the patient's refusal of specialty services: While the patient has the right to refuse care, it is our obligation to provide additional information about the consequences and benefits of keeping their appointments. Additional information and education for the patients' involved will be provided.
- b. Reasons related to clinician decisions or care coordination.
- c. Reasons related to custody decisions.
- d. Reasons related to the patient no longer at the institution: At the time of the appointment, the patient was being paroled, transferred, hospitalized, or had expired and the appointment should have been cancelled, to the degree possible.

Methodology: The *Off-Site Appointment Cancellations* form is completed for every patient who misses a Specialty services appointment. The percent of cancelled appointments is calculated by dividing the total number of cancelled appointments by the total number scheduled and is reported monthly. These data are further broken down by reason for the cancellation. The percent of cancellations based on the reasons related to patient refusal, clinical decisions, custody issues, or patient no being longer in the institution (see above) are calculated using the number of cancelled appointments as the denominator and the number in each "reason" as the numerator – calculating four different percentages.

D. Measuring Timely Payment to Specialty Care Providers

Metric: By December 2008, 95% of the invoices for providers of specialty services will receive prompt payment within 30 days of receipt of the properly submitted, undisputed invoice (15 days less than required by Government Code 927 et seq., California's Prompt Payment Act).

Metric Definition: The 30 day standard has been provide to those specialty providers who serve LAC and CCI as one element of the Receiver's program to secure additional specialty providers following the ouster of MDI.

Methodology: The Accounting Unit will use existing accounting records/mechanisms or develop a spread sheet that lists all specialty care invoices, the date they are received, whether they are valid and payable, and the date paid. Quarterly, a report will be generated that identifies those that have not been paid within the 30 calendar day deadline, the penalty assessed, and the actual payment date. The percent of invoices paid promptly will be calculated and reported quarterly. Baseline data will be established during the first quarter and corrective action plans will be developed, implemented and evaluated and updated quarterly.

E. Measuring Timely Consultation Reports from Specialty Care Providers

Metric: By December 2009, the Specialty Care Provider will submit required consultation reports for:

- a. Urgent care referrals within 24 hours of the appointment date 90% of the time.
- b. Acute care referrals within 3 days of the appointment date 80% of the time.
- c. Chronic care referrals within 7 days of the appointment date 70% of the time.
- d. 95% of all referral reports must be submitted within 10 days of the appointment.

Metric Definition: Essential to inmate access to care is the timely submission of specialty care reports by providers. Without the written reports and verbal consultations, recommended care will not be instituted creating a greater likelihood of poor outcomes for the patient.

Methodology: A report log will be developed that includes the specialty referral, when it was ordered, the type of referral (urgent, acute, chronic care), and the date the service is provided, and the date that the written report was submitted and received by the ordering clinician. The percent of effective specialty report receipt will be determined by dividing those received within the established time range by the total number requested by type of referral.

A report will be generated that includes the above data and a rank order list of specialty care provider who are out of compliance with this metric, ranked by number of days out of compliance, number of reports not submitted in a timely manner, and an explanation from the provider and staff at the institution. A corrective action plan will be developed for both the provider and institution; updated and submitted quarterly. This information will be related to the contract section to strengthen contract negotiation and ensure timely reports are provided.

F. Transfer Issues (Coordination of Specialty Care for Transferred Inmates)

Metric: By June 2009, for inmates with Specialty Care appointments that are already scheduled and who are slated to be transferred to another institution,

- a. 80% of urgent care appointments are to be completed prior to transfer. The inmate is to be put on a medical hold and not transferred until the appointment is completed.
- b. 70% of acute care appointments are to be completed prior to transfer. The inmate is to be put on a medical hold and not transferred until the appointment is completed.
- c. 70% of chronic care appointments are to be completed prior to transfer.
- d. The CMO may determine on a case-by-case basis whether the inmate should be on a medical hold and the appointment completed or if transfer and follow up the receiving institution is medically acceptable.
- e. 90% of specialty care appointments that are not completed due to inmate transfer are to be reported to the CMO at the institution receiving the inmate for follow up by that institution's medical care staff.

Metric Definition: Currently, locating an available specialist and scheduling a referral appointment takes time. Urgent, acute, and chronic care appointments must be completed

within the specified timeframe to meet compliance measures and to ensure the inmate gets timely consultation and care services.

Methodology: Inmates with a scheduled appointment for urgent or acute care referral services are to be put on a medical hold and not transferred until the appointment is completed. Inmates with chronic care appointments that can be rescheduled by the receiving institution within the compliance timeframe, may be transferred but their specialty care appointment must be provided through oversight and arrangement by the receiving institution in a timely manner.

To implement this metric, a data collection instrument will be developed that includes the type of appointment, the specialty provider, the date ordered, the date and reason for the transfer order, evidence of a medical hold, date the referral was completed. Referrals that were not provided because the inmate was transferred to another institution will be investigated, the reason for the transfer and delay in care identified and a corrective action plan developed. Baseline data will be collected the first quarter and updated and submitted quarterly. This information will be provided regularly to the Regional Medical and Nursing Directors for their appropriate follow up.

BARRIERS TO THE SUCCESS OF THE SPECIALTY SERVICES PILOT SIX TO THIRTY-SIX MONTH OBJECTIVES

At this time, structural and functional barriers persist and provide a drag on ensuring that timely specialty services are provided to patients. The Pilot Team continues to implement strategies that will incrementally eliminate these barriers in conjunction with other major efforts being implemented under the Receiver's direction. These barriers are as follows:

1. Inadequate prison construction programs which failed to provide the appropriate space for in-prison specialty care; a problem aggravated by double celling and overcrowding:
2. The lack of space for specialty providers to see patients on-site has delayed efforts to bring these services into the institution and hence, to improve access to specialty care.
3. An absence of information technology systems necessary to schedule and track specialty care appointments and to ensure that specialty care follow-up is effectuated. The lack of a contemporary electronic scheduling system has direct impact on the ability to build a more efficient referral process for specialty services. The current IMSATS is not the most efficient or effective scheduling and tracking program, but it does contain many vital components. It is the only scheduling system currently available that also tracks services. It is imperative that IMSATS be kept current and the data valid, until it is replaced by a better system.
4. The State's failure to manage its specialty provider and hospital contracts has been compounded by a failure to hire competent clinicians at every level.
 - o Availability of Specialty Providers is an ongoing issue and hiring and/or contracting for them is a priority for institutional and central office staff.
5. The State has a long history of not hiring competent clinicians, caused by inadequate pay and poor working conditions, and relying upon registry personnel. .

6. Constant clinical leadership changes at CCI resulted in a lack of consistent direction on this project and interfered with staff efforts to provide improved specialty services.
7. Staff turnover is very problematic, particularly in clerical scheduling.
8. The quality of data being entered into the scheduling and tracking system requires constant vigilance and knowledgeable staff – high turnover negatively affects this effort.
9. The quality of the actual request for services, both in its completeness and inclusion of medical necessity requirements continues to be inadequate and requires staff education.
10. Obtaining timely reports from Consultant Providers is often difficult.
11. Problems with timely Transfer processes, Receiving and Release processes, Medical Hold processes, and Medical and Return processes directly affect the success of the Specialty Service system.
12. Inadequate institutional management and custody issues have contributed to preventing improvement in the specialty services program.
13. A custody driven prison management culture which failed to consider the needs of prisoner/patients.
14. Inadequate correctional officer staffing to effectuate out-of-prison specialty appointments.
15. Inadequate number of patient transportation vans and escort vehicles.

CLASS ACTION COORDINATION INITIATIVE

Since March 2007 the Receiver conducted seven formal coordination meetings with the *Armstrong, Coleman, Perez* court representatives. The propose of these meetings is to take into consideration the myriad of court orders from these cases and coordinate the operational impact on the CDCR health care system. These meetings became a forum for an open exchange between the Receiver and the Court representatives to address common and systematic problems affecting the medical, dental, and mental health programs.

Through the efforts of all the Court representatives, agreements have been developed and approved by the Courts. These agreements called for the *Plata* Receiver to assume responsibility for direct oversight of contracting functions; implementation of the long-term information technology program; and oversight of pharmacy operations serving the medical, dental, and mental health programs. The Receiver will also assume responsibility for the credentialing and privileging functions for medical, dental and mental health programs. In addition, these meetings provide opportunities for the Receiver to both inform the representatives of operational issues and allow them to participate in decisions that impact their areas of responsibility.

The Receiver intends to continue regular coordinating meetings with the court representatives with the following objectives:

Six Month Objectives:

- 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

Twelve Month Objectives:

- Develop a one-page agreement on health care custody escorts and obtain approval from the Courts.
- 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.

Twenty-four and Thirty-Six Month Objectives:

- These objectives will be developed as part of the on-going coordination process among the court representatives.