Achieving a Constitutional Level of Medical Care in California's Prisons

Ninth Quarterly Report of the Federal Receiver's Turnaround Plan of Action

September 15, 2008

California Prison Health Care Receivership

Vision:

As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

Mission:

Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and integrate the delivery of medical care with mental health, dental and disability programs.

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Section 1
Introduction and Executive Summary

During the June 15, 2008 through September 15, 2008 reporting period, significant progress continued toward attaining the Receiver's vision of providing "constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain." Furthermore, the Receiver's programs were implemented in a cost effective manner. For example, the Maxor program projects a pharmacy cost avoidance savings to California taxpayers of approximately $33 million in 2008. More important than improvements in staffing, fiscal saving, organization, public health programs, infrastructure, and access to care, however, is the fact that the Receiver's efforts have reduced prisoner mortality rates. Simply stated, the Turnaround Plan of Action has begun to have an impact exactly where intended, improving medical care for those prisoners most at risk.

This is the first Quarterly Report that incorporates the metrics developed to measure Turnaround Plan of Action progress. Over time, the metrics provided in this report will improve in terms of both quantity and quality as new measurement systems are implemented and necessary information technology systems are established in California's prisons. To assist the reader, this report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific Turnaround Plan of Action objectives are set forth in this report with the narrative discussion of the objective. Note that some objectives (e.g., the reception center element of the access to care clinical initiative) are in a development stage, and therefore it is premature to implement metrics. However, other programs (e.g., the hiring of clinical personnel) can be measured by very specific metrics.

2. *Appendices*: In addition to providing metrics, the report also references a number of documents, which are provided to the reader in the attached Appendices filed concurrently with this report.

3. *Web Site References*: Concerning two large documents referenced in the report, the McKenzie Stephenson Report regarding Diagnostic Imaging and the Navigant Report regarding Laboratory Services, an executive summary only is provided as an appendix. The entire report, however, is available on the Receiver's website. Likewise, a third large document, the Corrections Corporation of America healthcare related Corrective Action Plan for its facility at Tallahatchie, Mississippi, is also available on the Receiver's website.

   A chart summarizing the status of each of the six goals of the Turnaround Plan of Action is provided below. Objectives and actions' status shaded green are currently on schedule to be completed by the specified finish date. Objectives and actions' status shaded yellow are currently delayed slightly from the specified finish date. Objectives

and actions' status shaded red are currently delayed from the specified finish date. Discussion and explanations regarding delays are included in Section 3 under the respective objective and/or actions. Objectives and actions which have been accomplished are noted with a "check box."

Status of Turnaround Plan of Action Goals
September 15, 2008

9/15/08 Status			2008			2009				2010				2011				2012				2013	
			2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q
GOAL 1		**Ensure Timely Access to Care**																					
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	Act 2.2.1	Chronic Care Initiative																					
Obj. 2.3		**Emergency Medical Response System**																					
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	Act 2.3.2	Certification and Training																					
	Act 2.3.3	Standardize Emergency Equipment																					
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	Act 2.4.1	Utilization and Care Management Policies																					
	Act 2.4.2	Statewide Specialty Care Contracts																					
	Act 2.4.3	Specialty Care Invoice Payments																					

Status of Turnaround Plan of Action Goals
September 15, 2008

9/15/08 Status			2008			2009				2010				2011				2012				2013	
			2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q
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Status of Turnaround Plan of Action Goals
September 15, 2008

9/15/08 Status			2008			2009				2010				2011				2012				2013	
			2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q
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Section 2
The Receiver's Reporting Requirements

This is the Ninth Quarterly Report filed by the Receivership, and the third submitted by Receiver Clark Kelso.

The Order Appointing Receiver (Appointing Order) filed February 14, 2006 calls for the Receiver to file status reports with the *Plata* Court concerning the following issues:

1. All tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion of each task and metric.
2. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.
3. Particular success achieved by the Receiver.
4. An accounting of expenditures for the reporting period.
5. Other matters deemed appropriate for judicial review.

(Appointing Order at p. 2-3.)

In support of the coordination efforts by the four Federal Courts responsible for the major health care class actions pending against the CDCR, the Receiver now files his Quarterly Reports in four different Federal Court class action cases. An overview of the Receiver's enhanced reporting responsibilities is included below.

Plata, *Coleman*, *Perez* and *Armstrong* Coordination Reporting Requirements

The Joint Order filed June 28, 2007 in *Coleman v. Schwarzenegger* (mental health care), *Perez v. Tilton* (dental care) and *Plata v. Schwarzenegger* (medical care) approved various coordination agreements made between the representatives of the three health care class actions. (Order Approving Coordination Agreements Attached to Joint May 29, 2007 Order, hereinafter "Joint Coordination Order.") These coordination agreements provide for the *Plata* Receiver to assume responsibility for the following: (1) direct oversight of contracting functions for medical, dental, and mental health care; (2) implementation of long-term information technology (IT) systems to include the medical, dental and mental health programs; and (3) oversight of pharmacy operations serving the medical, dental, and mental health programs. (Joint Coordination Order at 2.)

The Receiver's assumption of these responsibilities is coupled with reporting requirements which mandate that the Receiver file quarterly progress reports addressing the following: (a) all tasks and metrics necessary to the contracting functions, implementation of long-term IT, and pharmacy services for mental health care and dental care, with degree of completion and date of anticipated completion for each task and metric; (b) particular problems being faced by the Receiver in accomplishing remedial goals; and (c) particular successes achieved by the Receiver in accomplishing remedial goals. (Joint Coordination Order at 2-3.)

Additional reporting requirements were subsequently placed on the Receiver following his assumption of the management of certain coordinated functions involving the delivery of

Americans With Disability Act (ADA) related services in California prisons. [August 24, 2007 *Armstrong v. Schwarzenegger* Order Approving Coordination Statements (hereinafter "*Armstrong* Coordination Order.")]

On February 26, 2008, the *Plata*, *Coleman*, *Perez* and *Armstrong* Courts issued an additional joint order which provides for the Plata Receiver to manage two major prison health care construction projects: (1) upgrades to improve health care delivery at the existing 33 CDCR institutions, and (2) the construction, on existing prison sites, of health care facilities for up to 10,000 patient-inmates [Order filed February 26, 2008 (hereinafter "Order Approving Construction Agreement")]. As with the prior coordination orders, the Receiver was ordered to file quarterly reports in each case "concerning developments pertaining to matters that are the subject of the construction agreement." (Order Approving Construction Agreement at 3:1-3.)

Integration of Coordination Related Reporting in This Quarterly Report

Pursuant to the mandates of the various coordination orders referenced above, the Receiver's remedial umbrella now encompasses the following: the overhaul of the health care contract function; the implementation of long-term IT systems; the oversight of pharmacy operations for medical, mental health, dental and ADA patient-inmates; and the oversight of health care prison construction projects. As such, when this Quarterly Report describes progress and challenges facing reform of contracting functions, IT systems, pharmacy operations, and construction, all such references are referring to mental health, dental, ADA and medical care for patient-inmates. Specifically, the Receiver's Coordination-related reporting is set forth in the following sections of this Report: Credentialing and Privileging of Health Care Providers (Goal 4, Objective 4.2); Contracts (Goal 2, Objective 2.4); IT Update (Goal 1, Objective 1.3; Goal 5, Objective 5.4); Telemedicine Reform (Goal 5, Objective 5.5); Coordination with Other Lawsuits (Section 7.A.); and Construction (Goal 6).

Reporting Related to the Order Waiving State Contracting Statutes

On June 4, 2007, the Court approved the Receiver's Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders issued since that date. As ordered by the Court, the Receiver provides a summary of each contract the Receiver has awarded under the substitute contracting process during the reporting period. The Receiver's contract waiver-related report is provided in Section 7.B.

Section 3
Status of Turnaround Plan Initiatives

Goal 1. Ensure Timely Access to Health Care Services

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation

The Reception Center Action in Context: When inmates first enter the correctional system, they receive an initial health screening at a reception center prior to endorsement to a mainline institution. Under optimum conditions and processes, this initial health screening allows health care providers to stratify patients based upon health risk and refer patients to timely and appropriate clinical services. Without effective screening at reception centers, the medical system fails to identify patients that may have immediate or chronic life-threatening medical conditions, disruptions in the continuity of care occur, such as failure to fill essential prescriptions, which can have life-threatening effects, and patients may be placed at institutions ill-equipped to accommodate patients' medical needs, among other negative outcomes.

A pilot program at San Quentin State Prison was initiated in 2006 to bring the existing reception screening process into alignment with national guidelines for health screening, provide screening on the same day as the inmate's arrival to prevent lapses in care, and integrate dental, mental health, and medical screening processes. The integrated screening included laboratory testing and medication review and administration. Implementation of the redesigned reception center process at San Quentin resulted in a reduction in sick call requests in all disciplines and a reduction in emergency care encounters and hospitalizations. The lessons learned at San Quentin are the basis for the development of standardized, measurable, and reliable screening processes which will be piloted, formally evaluated and revised, and then implemented statewide. The San Quentin Reception Center Intake Screen and Health Assessment Update is provided as Appendix 1.

Reception Center Progress During the Reporting Period: In July 2008, a Reception Center Core Team collaborated with staff at San Quentin State Prison to finalize a reception center redesign model that could be tested for reliability at another institution. During this reporting period, the Reception Center Core Team and an on-site team of subject matter experts and executives from Richard J. Donovan Correctional Facility prepared for implementation of the redesign model at Richard J. Donovan Correctional Facility. This redesign model is attached as Appendix 2. Their collaboration included a facility assessment, baseline data collection, and arrangements for necessary physical space modifications. The Richard J. Donovan Correctional Facility pilot commenced in August 2008 and is scheduled for completion in November 2008. This is the final phase in the reception center process redesign, culminating in a statewide policy to be submitted to the Receiver in January 2009 for review and approval and then to the Court for

approval. This action item is moving forward consistent with the scheduled time frames set forth in the Turnaround Plan of Action.

Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons

Following the anticipated approval of the new statewide policy in January 2009, the Reception Center Core Team will initiate implementation at all other reception centers statewide, scheduled for completion by January 2010. This action is on schedule to complete the projected statewide implementation by January 2010.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on health care access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution

Preliminary Operational Assessments

This action is ahead of schedule. Preliminary Operational Assessments have been completed at 32 California Department of Corrections and Rehabilitation (CDCR) institutions. Specifically, in this reporting period, the final three Preliminary Operational Assessments were completed at Calipatria State Prison, California Correctional Institution, and Chuckwalla Valley State Prison. The final three assessments resulted in the recommendation of 207.26 correctional officer positions for use as clinic officers, escort officers and transportation officers. An additional 38.54 supervisory/management positions were also recommended to provide the appropriate level of supervision.

During this reporting period, the Special Master in *Madrid* completed oversight of Pelican Bay State Prison. Pursuant to a Court-approved stipulation by the parties in *Madrid*, Pelican Bay State Prison is now within the purview of the *Plata* litigation and under the authority of the Receivership. This change will necessitate an additional prison Preliminary Operational Assessment, which is scheduled for January 2009.

Operational Re-Assessments

As reported in past Quarterly Reports, the initial eight Preliminary Operational Assessments lacked the scope and depth of review that prisons have received at the later reviews. In order to ensure the same methodology and analysis is utilized in all the Preliminary Operational Assessments, it has been determined that additional assessments of the initial eight institutions, excluding Avenal State Prison and Correctional Training Facility, Soledad, will be conducted. During this reporting period, Sierra Conservation Center was re-assessed. By December 31, 2008, the following six re-assessments are to be completed: Wasco State Prison, Ironwood State

Prison, High Desert State Prison, California Conservation Center, California State Prison-Solano and Richard J. Donovan Correctional Facility.

To summarize, all Operational Assessments will be completed on schedule by January 2009.

Action 1.2.2 By July 2011, the Receiver will have fully implemented Health Care Access Units and developed health care access processes at all CDCR institutions

The Health Care Access Units at the California Medical Facility and San Quentin State Prison continue to operate effectively and efficiently and are fully supported by the prisons administrative, clinical, and custody staff. Both San Quentin State Prison and the California Medical Facility continue to report a reduction in missed appointments and an increase in inmate access to health care. During July 2008, efforts were initiated to establish a Health Care Access Unit at the Correctional Training Facility, Soledad. Upon conclusion of the detailed analysis of custody health care operations inclusive of the planned construction of new clinical space, the recommendation is for 67 posts or 108.26 new positions. Of the positions, 48.72 positions or 50.42% are allocated for Hospital Guarding and 20.06 positions or 20.76% are allocated for Transportation. Activation of the Health Care Access Unit at Correctional Training Facility, Soledad is scheduled for completion by November 1, 2008.

As discussed in the last Quarterly Report the Receiver approved 134.2 new positions for the activation of the Health Care Access Unit at Avenal State Prison, scheduled to activate July 1, 2008. The Health Care Access Unit at Avenal State Prison was activated on August 11, 2008. Custody Support staff will continue to monitor the progress of the Avenal State Prison Health Care Access Unit and remedy issues as they arise.

This action items remains on schedule. Health Care Access Units will be established at California Institution for Men, California Rehabilitation Center, California Institution for Women, and Mule Creek State Prison by June 30, 2009. This action item is also on schedule to complete implementation of Access Units statewide by July 2011.

<u>Monthly Health Care Access Quality Report - Data Collection Instrument</u>

The purpose of the Access Team concept is to ensure prisoner access to medical, mental health, and dental care in a timely and cost-effective manner. To verify this result, an audit instrument was developed during the previous reporting period to formally measure access team performance. Pilot measurement programs to implement the instrument, the "Monthly Health Care Access Quality Report" were established at San Quentin State Prison, California Medical Facility, California State Prison-Corcoran and Avenal State Prison as of July 1, 2008. All prisons were to implement the instrument developed by the pilot as of October 1, 2008, following training that should have been provided on August 7, 2008. Because of the State budget crisis, however, travel for CDCR staff was suspended and the training did not take place. Training is now scheduled for September 24-25 2008, subject to passage of a State budget. The new implementation date is November 1, 2008. A draft version of the Monthly Health Care Access Quality Report is attached as Appendix 3.

Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System

Action 1.3.1. Work with CDCR to accelerate the development of the Strategic Offender Management System with a scheduling and inmate tracking system as one of its first deliverables

Status of Work with CDCR Re Offender Management and Tracking: A system for the scheduling and tracking of medical appointments for patient-inmates is an essential element of providing timely access to care. Prisoner scheduling and movement control within the CDCR's 33 prisons will be handled by the Strategic Offender Management System (SOMS). SOMS will include four components that are critical to the success of the prison health care system: a unique identification number for each offender; real-time location information for each offender; demographic information on each offender; and a master offender schedule and scheduling prioritization system.

The SOMS project is in the vendor evaluation and selection stage of procurement. A Request for Proposals (RFP) has been issued to select a system integrator and a commercially available software product for the project. Proposals submitted in response to the RFP are currently being reviewed. A contract award is scheduled to be made by early 2009. The first phase of the SOMS implementation is scheduled for early 2010.

Status of Development of an Adequate Health Care Scheduling System for Medical, Mental Health and Dental Needs: Commercial Off-The-Shelf offender health care management products that were reviewed by the Receiver's staff and by mental health and dental clinician/managers did not appear to be sufficiently robust to handle the more complex needs of a health care scheduling system necessary for 33 distinct institutions. Therefore the State employees who report to the Receiver in the California Prison Health Care Services Department (CPHCS), working with representatives of the mental health and dental disciplines, have initiated a project to identify health care scheduling needs, re-engineer processes to the extent necessary, and procure or develop software to manage health care scheduling (medical, mental health, dental, and disability related scheduling). It is essential that the proposed Health Care Scheduling System (HCSS) that will be implemented be able to integrate completely with SOMS on a near real-time basis. Consequently, CPHCS staff and consultants are closely involved in the SOMS RFP process as evaluators and subject matter experts.

The HCSS project is currently in the initial stages of procurement. CPHCS has recently executed, on a competitive basis, a contract with Gartner, Inc. to define the requirements and parameters, including interfaces with other information technology systems, for a system that will comprehensively encompass prison medical, dental, mental health, and other health care appointment scheduling. The new system must also accommodate all ancillary scheduling needs, such as custody officers, equipment, transportation, special care personnel, prison scheduling, offender location, and other constraints on patient-inmate movement. CPHCS will prepare, by the end of the year, an RFP for an HCSS product and implementer, including necessary modifications and enhancements.

Both the SOMS and HCSS projects are on schedule.

Objective 1.4. Establish A Standardized Utilization Management System

Action 1.4.1. By January 2009, open long-term care units at one facility as a pilot project to assist in developing plans for other long-term chronic care facilities

This initiative was established in the Turnaround Plan of Action as a bridge to increase the available medical beds until the Receiver's first facility of the 10,000 medical bed project is completed in 2011. The additional beds will provide new treatment options and allow clinical staff to effectuate a number of clinical "sweeps" of Correctional Treatment Centers and other prison medical units and thereafter transfer those patients who appear the most at risk to a high level of care. The California Medical Facility was identified as the pilot site for this project and planning was initiated on May 20, 2008.

During the reporting period, a number of interdisciplinary meetings have occurred including California Medical Facility executives, CPHCS clinical leaders, the Receiver's Custody Support Team and Vanir Construction Management, Inc. As a result of these meetings, a final proposal was drafted and agreed to on August 19, 2008 by the Warden, Health Care Manager/Chief Medical Officer, Director of Nursing, Associate Warden of Health Care Services, CEO of Medical Services for the Receiver, Regional Administrator, Regional Director of Nursing, and Regional Medical Director.

The proposal entails the renovation of 31 existing Outpatient Housing Unit (OHU) beds on the first floor "H" Wing; the conversion of 100 General Population beds on both the second and third floors of "H" Wing to 39 OHU beds for each floor (78 new OHU beds total); and improvements to the physical plant in order to meet Fire Marshal and ADA requirements. This will result in a total of 109 OHU beds in "H" Wing at a projected cost of $3.3 million. The proposal will create appropriate nursing exam/treatment space, clean/soiled rooms, medication prep rooms, and other medical support spaces, replacement of 10 Administrative Segregation cell doors, a nurse call system, toilet/sink combo replacement, shower area conversions, and patch and painting of various walls, floors and ceilings.

Presently, this plan is pending approval by CDCR executive staff and the Receiver. Once approved, a construction plan will be finalized to open the beds as soon as possible due to the immediate need. It is estimated that the project will take between 8 and 11 months to complete once construction begins. However, because defendants failed to fund both the Receiver's 10,000 new bed project and the prison upgrade project, the money needed for this program is not available. Because of defendants' failure, this project is no longer on schedule and it will not be completed by January 2009. The Receiver has filed a motion to hold State officials in contempt concerning their failure to fund this element of the remedial plan, and a hearing is calendared for October 6, 2008.

Action 1.4.2. By October 2010, establish a centralized Utilization Management System

In July 2008, a Chief Medical Officer was hired to establish and administer a new Utilization Management (UM) Program. The vision for the new UM Program moves away from the current disorganized system that is focused on "gate keeping," lacks adequate clinical criteria, and fails to provide useful planning information and moves toward the use of criteria-driven approval processes, and at the same time incorporates care management systems to identify and manage the patient subpopulations that drive specialty care and acute care referrals.

Specialty Care Pilot

The UM CMO heads the Specialty, Infirmary, and Acute Care (SIAC) Core Team under the Access to Care Initiative, which includes staff with UM expertise in nursing, physician, correctional, information systems, and analytical disciplines. In July 2008, the SIAC Core Team prepared to establish a third specialty care pilot site. The third pilot site will build upon accomplishments at California State Prison, Los Angeles County (LAC) and California Correctional Institution (CCI) which have seen significant improvements in appointment access, cancellation rates, and overall specialty availability through their systems changes. These successful strategies include implementation of criteria-based referrals, pre-appointment confirmation forms, improved coordination with custody escort staff, and a shift in the UM/specialty care/chronic care nursing role towards local care coordination and a centralized case management model. This role redesign and cross-training among nursing staff in the Access to Care Initiative directly supports the Receiver's vision for a patient-centered health care delivery system. At a third pilot program at Folsom State Prison, the Core Team will develop a sustainable specialty care referral process that expedites patients' access to specialty services, incorporates InterQual criteria in decision-making, and minimizes appointment backlogs and cancellations.

Concurrent with the establishment of a pilot specialty care program at Folsom State Prison, the SIAC Core Team will train institutions in the use of InterQual. Training will begin in October 2008 and conclude in December 2008. Use of InterQual criteria will help to standardize the basis for specialty care referrals. InterQual also will compel providers to complete thorough patient evaluations and follow appropriate evidence-based alternatives prior to making a referral for specialty care. The InterQual evidence based clinical decision support criteria are endorsed by all Joint Commission (JCAHO) accredited hospitals. The criteria have served as the standard lexicon regarding decisions about appropriate referrals and quality of care and also contain an extensive library of clinical literature and citations available for organizational support and reference.

Bed Access Pilot

Over utilization of expensive acute care hospital beds often can be attributed to lack of inpatient beds in the overcrowded prisons that can accept discharged hospital patients. There are no utilization criteria such as InterQual for bed management in the correctional health care industry. The SIAC Core Team has completed the groundwork to establish a bed access pilot program focusing initially on institutional beds within the CDCR and is scheduled to commence in November 2008. This pilot is a short-term remedy to address inappropriate bed utilization in

the institution while the 10,000 bed project is still under construction. Using a multi-disciplinary team approach with staff from Headquarters and the field, this pilot program will test strategies to develop an efficient, appropriate, and standardized system to monitor in-patient bed utilization in the correctional setting. This system will refer patients to/from infirmary and acute care beds, integrate standardized definitions of medical necessity, and utilize InterQual criteria and possibly other screening and assessment tools from the long-term care industry.

The Specialty Care Pilot and Bed Access Pilot are on schedule.

Goal 2. Establish A Prison Medical Program Addressing The Full Continuum of Health Care Services

Objective 2.1. Redesign and Standardize Access and Medical Processes for Primary Care

Action 2.1.1. By July 2009, complete the redesign of sick call processes, forms, and staffing models

During this reporting period, Sick Call Core Team staff prepared for implementation of Phase I of a three-phased process to redesign the sick call program and staffing model. Sick call program redesign is on track for completion by the target date of July 2009.

As noted in the Receiver's Turnaround Plan of Action, access to primary care services in California's prison system is generally accomplished through a "sick call" process. Through sick call, patients submit requests for health care services, the requests are triaged, and the patient is scheduled to see a provider in accordance with timeframes specific to the acuity of the patient's medical complaint. In his Turnaround Plan of Action, the Receiver found the current sick call process to be "plagued by inconsistent local processes involving too many forms, handoffs, and opportunities for error." Additional problems included out-of-date nursing protocols, an inefficient system for diagnostic testing and follow-up, lack of access to patient records for providers evaluating patients, and insufficient scheduling and tracking mechanisms that lead to gaps in care and do not allow for effective program monitoring and evaluation.

To accomplish the Receiver's objectives pertaining to reform of the sick call process, Access to Care executives will implement a three-phased strategy. In Phase I, the Sick Call Core Team will pilot a new sick call program and staffing model at one institution. In Phase II, the Sick Call Core Team will refine the program based upon the findings and lessons learned from the pilot program and will expand the pilot to encompass two additional institutions. At the conclusion of Phase II in July 2009, the Sick Call Core Team will submit a new sick call policy, forms, and a staffing model to the federal court for approval. In Phase II, the Sick Call Core Team will implement the approved sick call program at all CDCR institutions by July 2010.

Sick Call Redesign Progress During the Reporting Period: During this reporting period Access to Care executives began Phase I, establishing a workgroup of staff with clinical, administrative, correctional, information systems, and project management expertise referred to as the Sick Call Core Team. By the end of August 2008, Access to Care executives had selected a clinical manager, administrative team lead, correctional expert, nursing practice expert, and analysts to staff this new Sick Call Core Team. Core Team members conducted site visits at Mule Creek State Prison, California Correctional Institution, Richard J. Donovan Correctional Facility, and California State Prison, Los Angeles County to map out current sick call processes and staffing models; researched health care access programs at health care organizations such as Kaiser and the Department of Veterans' Affairs and correctional systems such as Federal Bureau of Prisons and the Texas correctional system; and began to develop pilot site criteria. Members of the new Sick Call Core Team also received training in the rapid-cycle quality improvement processes that will be applied in the Sick Call Pilot.

During the remainder of Phase I, the Sick Call Core Team will establish new sick call processes and staffing models to be tested at pilot sites, as well as appropriate performance measures and program reports. The first pilot site is anticipated to launch in December 2008, which will allow for the completion of Phase I and II by July 2009.

Action 2.1.2. By July 2010, implement the new system in all institutions

The redesigned sick call process action plan is on schedule for statewide implementation by the target date of July 2010.

Objective 2.2. Improve Chronic Care System to Support Proactive, Planned Care

Action 2.2.1. By April 2009, complete a comprehensive, one-year Chronic Care Initiative to assess and remediate systemic weaknesses in how chronic care is delivered

As detailed in previous Quarterly Reports, one of many failures of the original *Plata* remedial plan involved attempts to implement complicated clinical programs in a simplistic, and subsequently ineffective, costly, and unsustainable manner. Concerning chronic care, for example, the original remedial program called for development of chronic care policies and procedures, which were then provided to staff (assuming that adequate staffing was available) with little or no training, and without a formalized *program model or system* to adequately manage chronic care. The Receiver's Chronic Care Initiative approaches chronic disease in an entirely different manner by establishing a cost effective continuum of care program via an integrated chronic care team (of different clinicians, e.g. primary care providers and nurses). Thus, this Action calls for *both* a new patient management system and the application of adequate policies and procedures.

The focus of the two-phased Chronic Care Initiative is to build the infrastructure for both an effective chronic care system and an ongoing quality improvement process at each CDCR institution using a learning collaborative model. Under this initiative, each institution will learn how to establish critical elements of an effective chronic care management model, including the identification of patient subpopulations, care management and coordination, use of evidence-based treatment protocols, and implementation of patient education programs. To commence the learning process, asthma patients were selected as the sample subpopulation. For Phase I, selected pilot prisons will engage in learning "collaboratives" (workgroups that meet periodically to share strategies, compare outcomes, and receive technical assistance and training).

Chronic Care Initiative Progress During the Reporting Period: Phase I of the Chronic Care Initiative commenced during the reporting period. It includes six pilot institutions to be enrolled in the chronic care learning collaboratives. The six pilot institutions, consisting of two institutions from each of the major geographical regions, are as follows: Folsom State Prison, Mule Creek State Prison, Central California Women's Facility, California Men's Colony, California Institution for Women, and Richard J. Donovan Correctional Facility. At the first learning session in July 2008, the six pilots received intensive training on rapid-cycle quality improvement, the chronic care model, and evidence-based treatment guidelines.

Following this first learning session, the six Phase I institutions began to experiment with new approaches to managing asthma patients, such as implementing group appointments for patient education and creating forms and questionnaires to help providers accurately diagnose patients' asthma severity. These experiments are referred to as "rapid-cycle improvement" – the changes tested by the Phase I institutions are implemented, studied, and modified as necessary over the course of a few days, in most circumstances. In July and August 2008, Phase I institutions completed 74 improvement cycles, or more than 12 program modifications per institution. By the end of July 2008, all six Phase I institutions had implemented at least one element of the chronic care model. At the close of August, all of the six institutions had implemented at least three elements, and four of the six institutions had implemented all six elements. This is significant because studies show a direct relationship between the number of chronic care model elements implemented and the quality of patient care; the more elements of this model that are implemented, the more likely providers are to provide high quality chronic care. The six Phase I institutions will convene in September 2008 for a second learning session to share strategies, identify best practices, and receive additional training in care management concepts and quality improvement techniques.

At the close of Phase I, from November 2008 to January 2009, Access to Care staff will finalize polices and forms to establish a statewide Chronic Disease Management Program. This program will be introduced to *all* CDCR institutions during Phase II, scheduled to begin in January 2009. In Phase II, the remaining 27 institutions in the state will begin implementation of the Chronic Disease Management Program by utilizing the approved polices and forms, which includes establishing a patient registry, redesigning clinical roles to put a care management system in place, and placing new emphasis on patient education and evidence-based treatment protocols. Each institution will also participate in a learning collaborative – one collaborative per region, with nine institutions in each collaborative – and each institution will begin monthly reporting of performance measures. While these 27 institutions initiate implementation of the chronic care model, the six pilot institutions from Phase I will expand the focus of their chronic care program beyond asthma patients into other disease states. By the close of Phase II in October 2009, all institutions will have developed a mature chronic care program, with the capacity to manage a variety of chronically-ill subpopulations.

Modifications to the Chronic Care Initiative: The initial strategy contemplated by the Receiver's staff concerning this Action involved launching one learning collaborative of six institutions, and a traditional roll-out of the chronic care model to the field by April 2009. It is now clear, however, based on the experience gained by the six Phase I institutions, that the clinical staff (both primary care providers and nurses) at the other 27 CDCR prisons will benefit significantly from participating in a learning collaborative. In other words, the remaining 27 institutions will have much better chances of establishing sustainable programs if provided with the intensive technical assistance and training, problem-solving, and peer support found in a learning collaborative. Indeed, the conclusion has been reached that to limit the collaborative process to six prisons will create an unacceptable risk of duplicating the level of unsustainability that characterized the pre-Receivership *Plata* chronic care remedial program. In order to provide necessary learning collaboratives for all 33 prisons, and not just for a pilot group, the projected completion date for this initiative has extended by eight months to December 2009.

Objective 2.3. Improve Emergency Response to Reduce Avoidable Morbidity and Mortality

The original *Plata* emergency care remedial plan suffered from similar defects as described above concerning chronic care. Not only were the policies and procedures inadequate, there was simply no real emergency care "system." Here again, therefore, the Receiver's goal concerning necessary emergency related improvements calls for an entirely new multi-faceted model for emergency care: the Emergency Medical Response Initiative (EMRI).

A standardized Emergency Medical Response System (EMRS) will provide prisoners and staff within the California prison system with an adequate level and quality of emergency medical care. Once implemented, the EMRS will improve care and response times within the prison setting, improve clinical outcomes, and decrease preventable deaths. The initiative is broken into the following five phases: Phase I - Establish emergency response policies and procedures; Phase II - Pilot the initiative at two institutions; Phase III – Modify policies and procedures based on feedback and lessons learned at the pilot institutions and from stakeholders; Phase IV – Train each institution on the new policies and procedures; and Phase V – Sustain the initiative through quarterly reviews of adherence to policy.

EMRS policies and procedures will be adopted across all institutions through a systematic rollout of the EMRI. The initiative will implement a standardized approach to emergencies at all prisons, including documentation, equipment, and certifications to ensure timely response to medical emergencies.

Action 2.3.1. Immediately finalize, adopt and communicate an Emergency Medical Response System policy to all institutions

Phases I, II and III of the EMRI were completed during the reporting period. An initial version of the policies and procedures was provided to the pilot institutions on June 12, 2008. The EMRS was then implemented at Chuckawalla Valley State Prison and Richard J. Donovan Correctional Facility on June 23, 2008, and July 27, 2008, respectively. Emergency policies and procedures were revised following the pilot to reflect input from the pilot institutions, stakeholder groups (including counsel, and representatives from the *Coleman*, *Perez*, and *Armstrong* class actions), and executive committees. The revised policies and procedures were approved by the Receiver on September 5, 2008 and are attached as Appendix 4.

To assure appropriate implementation, the revised policies will be rolled out to all prisons pursuant to a time-phased training and deployment program. The schedule for implementation is attached as Appendix 5. However, the preparation of policies, the roll out of policies, and training on policies is only the first of several necessary steps to ensure real life establishment of the Receiver's emergency care system. Two other critical elements involving certification and emergency equipment must also be implemented, as explained below.

Action 2.3.2. By July 2009, develop and implement certification standards for all clinical staff and training programs for all clinical and custody staff

To ensure that all clinical staff have the requisite skills to provide basic life support in the event of a medical emergency, all clinical providers working in or intermittently assigned to the Triage and Treatment Area (TTA) will be Advanced Cardiac Life Support (ACLS) trained, and all first responders to a medical emergency will receive Basic Life Support (BLS) training. During September 2008, a survey of all institutions will be conducted to determine the ACLS and BLS training needs. Following the survey, a training plan will be developed and a directive to the field will be distributed. The EMR Implementation team has also confirmed that custody staff will receive BLS training, as part of the standard block training required of all correctional officer staff. While this program is on schedule to be completed by July 2009, the scope of implementation is daunting, requiring a wide range tasks that must be completed to effectuate the process, including organizing the training effort both internally and with CDCR, negotiating with impacted bargaining units, scheduling, follow-up reviews, and so on.

Action 2.3.3. By January 2009, inventory, assess and standardize equipment to support emergency medical response

Inventorying, assessing, and standardizing emergency response equipment and supplies at 33 prisons, each of which, in the past, dealt with emergency planning in different ways, presents a complex challenge. The task has proven especially difficult because there are no health care property managers assigned to the prisons. Therefore, to move forward in a timely and cost effective manner with Action 2.3.3, three focus areas were designated concerning inventorying, assessing and standardizing the emergency response medical equipment and supplies.

1. Emergency medical response bags

Significant progress was made during the reporting period concerning Emergency Response Bags. Eight institutions were audited concerning inventory and need, and the new, standardized Emergency Response Bag was deployed on a pilot basis to four institutions. While this element of the emergency program is off to a good start, initial evaluations determined that if this program element continues at its present pace, the deployment of standardized Emergency Response Bags may not meet the January 2009 deadline. Therefore, this program is in a redesign process to ensure the fastest possible roll out of standardized bags -- consistent with appropriate training and fiscally responsible inventory control.

2. Defibrillators

Defibrillators and Automatic External Defibrillators (AED) are critical medical equipment components to the Receiver's emergency response initiative. A statewide audit of all defibrillators was completed during the reporting period, consistent with plans to replace the defibrillators with a standardized unit that meets appropriate standards. Preferred standardized equipment has been identified, and work has commenced with procurement to purchase this equipment. The initial estimated cost for statewide roll-out is $1.6 million.

While this program element is on schedule to meet a January 2009 date to *begin* procuring standardized Defibrillators and AED's for the institutions, far too many risk factors may impact this schedule. Furthermore, it should be possible to speed up the necessary statewide roll out of this equipment. Therefore, this element of the emergency system remedial plan is also under redesign at this time.

3. Other Emergency Response Equipment and Supplies

While the initial focus is appropriately on the equipment cited above, an effective emergency system will also require certain other equipment and supplies (e.g. emergency gurneys), and in some situations (given significant differences in institution age and design) specialized equipment for selected prisons. Assessing needs, conducting inventories, and establishing an adequate standardized list of additional supplies presents a wide range of challenges, including establishing prison specific liaisons with correctional officials, and conducting accurate inventories when needed property managers do not exist. Therefore, the decision was made to centralize this effort, and to establish an interdisciplinary team to approach this problem in a manner similar to the program cited in Goal 1 concerning the development of access to care correctional teams. A time-phased program and progress to date report concerning this enhanced element of the Receiver's emergency response system will be provided in the next Quarterly Report.

Objective 2.4. Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality

Action 2.4.1. By June 2009, establish standard utilization management and care management processes and policies applicable to referrals to specialty care and hospitals

Progress related to the establishment of a Utilization Management program is summarized under Goal 1, Objective 1.4, Action 1.4.2.

Action 2.4.2. By July 2009, establish on a statewide basis approved contracts with specialty care providers and hospitals

Overall Contract Processing System

Ten institutions have been rolled into the ProdAgio contracting system. An additional six institutional programs are scheduled to be implemented into ProdAgio during September and October 2008. The implementation of the remaining institutional programs is scheduled for completion by March 2009. Full implementation of the Prodagio contracting system was anticipated for February 2009, and this target date was reported in the previous Quarterly Report. A one month delay is due to longer time required for site assessments than planned, staffing shortage among the ProdAgio technical team, and time required to resolve technical limitations at the target institutions.

Contract Processing Timelines

Restructuring the Contracts Branch. In order to meet the expected timeframes for processing contracts, the Contracts Branch intends to restructure and transition to a best practices model as

called for by the April 21, 2008 Navigant contract study. This report was attached to the Eight Quarterly report as Exhibit 6. To summarize, the existing duty statements and job levels for contracts personnel is simply not adequate to ensure that the State is properly represented during contract negotiations with hospital, registry, and specialty providers, some of which carry multi-million dollar price tags. CPHCS will enter into a contract with CPS Human Resource Services within 45 days to identify more fiscally appropriate classifications, staffing levels, and business model.

Streamlining the State Contract Boilerplate. During this reporting period, Contracts Branch staff also worked to revise the health care contract language boilerplate. The revised language reflects changes to align it with the healthcare industry while at the same time protecting the interest of the State. Staff implemented a website which contains links to allow providers easy access to download standardized contract exhibits. This enhancement reduced the number of hard copy pages required in each contract by an estimated 45 pages. These changes should streamline the negotiation and approval process, by shortening the contract process and creating consistency with contract provisions.

Comparison data and timeframes will be provided in the next Quarterly Report, identifying the number of contracts fully executed under the new process.

Status of Chancellor Group Hospital and Associated Physicians Contract Negotiations

The Chancellor Consulting Group (retained by the Receiver to re-negotiate hospital and associated physician group contracts) has successfully negotiated and executed 21 hospital letters of agreement, and 6 letters of agreement with medical groups containing 892 physicians, and 152 individual physician letters of agreement. Significant fiscal savings will be generated through these new contracts, compared to the cost of the State contracts entered into prior to the Receivership. At present, Chancellor Consulting Group is on schedule to complete their planned negotiations by July 2009; however, the primacy of the focus of the Chancellor Group's efforts involve three considerations that are more important than meeting projected dates for this project: (1) establishing contracts using a Medicare-based percentage industry standard in contrast to the prior, more cumbersome and more costly State generated rate structure; (2) entering into contracts that achieve significantly lower overall rates for hospital care for patient-inmates; and (3) working to establish an interim statewide hospital network that makes fiscal sense (replacing an existing system that is both chaotic in structure and unnecessarily expensive).

Action 2.4.3. By July 2009, ensure specialty care and hospital providers' invoices are processed in a timely manner

Roll Out of the ProdAgio Invoicing System

Twelve institutions are currently in the centralized ProdAgio invoicing system. An additional six institutional programs scheduled to be implemented into ProdAgio during September and October 2008. The implementation of the remaining institutional programs is scheduled for completion by March 2009. Like the Prodagio contracting system, full implementation of the Prodagio invoicing system was anticipated for February 2009, and this target date was reported

in the previous Quarterly Report. The additional one month delay is due to longer time required for site assessments than planned, staffing shortage among the ProdAgio technical team, and time required to resolve technical limitations at the target institutions.

Progress Concerning Invoice Processing During the Reporting Period

Numerous factors influence the time necessary to process provider invoices: accuracy of submitted invoices, completeness of required information, submission to correct address, adherence to contract terms, etc. These factors in turn impact the overall average time required for processing invoices. Therefore, during the reporting period efforts continue on a variety of fronts including the following: educating providers concerning invoicing requirements; design and implementation of improvements to ProdAgio and the Contract Medical Database (CMD); increasing staff resources; and the further consolidation and centralization of invoice adjudication and processing operations.

Current Status of Invoice Processing Time. Nevertheless the time required for processing invoices statewide in both the ProdAgio and the non-ProdAgio payment systems increased during the reporting period. Specifically, the processing time for adjudication and data entry of invoices during this period increased from about 15 days to more than 22 days for the two systems. Refer to Table 1 below. Several factors contributed to this increase, including the following:

1. Because field personnel (invoicing staff who work in the prisons) have been informed that the invoice function will transition to the ProdAgio computerized invoice process, and thereafter it will centralized in Sacramento, many current field invoice staff have, not surprisingly, moved to transition to new prison assignments. These employee moves created a higher percentage of vacant positions and, in some cases, required the transfer of work previously done in the field to the Central Office.
2. Transition to ProdAgio and centralization has, at the same time, necessitated an extensive hiring program at the Central Office in Sacramento. Orientation and training new invoice clerks has created a temporary reduction in productivity. At the same time contract unit managers have taken steps to improve training and the knowledge base of all invoice processors. Indeed, recognition of the value and importance of training in improving the skills and efficiency of invoice processing staff has resulted in a number of initiatives. For example, all newly hired staff will receive initial invoice adjudication, processing, and data recording training in a comprehensive training program as a graduated workload is assumed. The branch is also closely collaborating with Plata Human Resources to develop a training regimen for all employees for purposes of staff and organizational development.
3. The State fiscal year budget crisis has also had an adverse impact on invoice management and control, including an increased burden of work responding to payment related inquiries by specialty providers and hospitals.

4. The instability and limitations of the pre-Receiver CMD document systems and the sporadic performance of ProdAgio (temporary in nature, driven by the system's roll out) has also created processing delays during the reporting period.

To some degree these conversion related issues were anticipated, and invoice managers remain confident that the conversion to ProdAgio and centralization will, over time, lead to faster and more accurate invoice processing. Furthermore, despite the dip in invoice payment time for this reporting period, invoice processing remains far more efficient and timely compared to the unacceptable conditions that existed at the start of the Receivership.

Table 1.

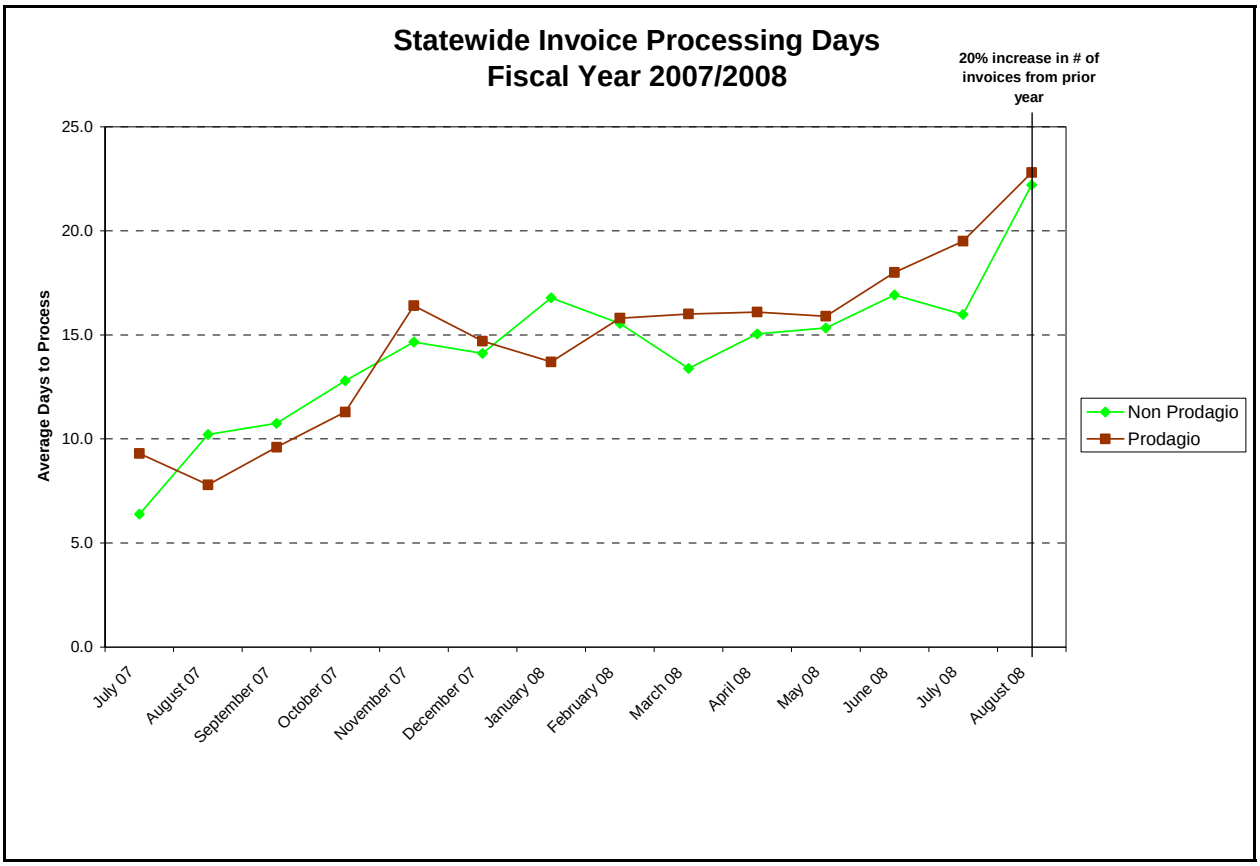


Table 1 Results Explanation: *Data represents invoices processed for FY07/08; however, analyst(s) continue to process invoices received from contractors for prior fiscal years. Total number of Invoices for FY06/07 303,574, Prodagio 39,603, Non Prodagio 263,971. Total number of invoices for FY07/08 365,825, Prodagio 135,188, Non Prodagio 230,637.*

Status of Contract Database System Upgrades. Important (for utilization management and fiscal purposes) medical data and payment information is at present entered into the CMD, a pre-existing CDCR contract data and invoice payment database, in order to capture industry standard data for reporting and rate modeling purposes. Historically, the CMD was decentralized and was available to each institution; however, this created efficiency problems such as the inability to access real-time data centrally. To address this problem, the CMD is currently being upgraded

and centralized. The upgrade will speed-up data entry and reduces data entry errors by allowing multiple concurrent users. In addition, it will functionally consolidate 33 separate prison Access databases into a central SQL server for increased system reliability and storage capacity. (SQL is a database computer language for querying and modifying data and managing databases.) To support management decision making, the upgrade will provide real-time data and timely, on-demand data reporting. The upgrade project began in May 2008, is expected to be rolled out in November 2008, and is scheduled to be completed by December 2008.

The sporadic performance of ProdAgio has created the need for continuous monitoring and adjustments by the software consultants. Additionally, given the need to receive paper bills and then data enter the billing amounts, ProdAgio, standing alone, may not have the capacity to achieve the processing objective of an average of 45 days from when an invoice is received to the contractor having a check in hand. Therefore, the decision has been made to begin to explore utilizing the services of a third party adjudicator for processing some or all invoices, and transitioning the work of invoice processors to more of a review and audit function.

Despite the challenges reported above, the Invoice Processing Branch remains on schedule to achieve Action 2.4.3 by July 2009.

Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1. Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

Action 3.1.1. By January 2009, fill 90% of nursing positions

Recruitment efforts continued to focus on physicians and nurses during the reporting period. The results have been very positive. As of July 30, 2008, approximately 88 percent of nursing positions are filled (this percentage is an average of all six State nursing classifications) which is within 2 percent of the statewide goal of having 90 percent of nursing positions filled.

Furthermore, the goal of filling 90 percent of the Registered Nurse (RN) positions has been achieved at 22 institutions (67 percent of all prisons), and 10 prisons have filled 95 percent or more of their RN positions. Ten more institutions (30 percent) have filled 80 to 89 percent of their RN positions. The goal of filling 90 percent of the Licensed Vocational Nurse (LVN) positions has been achieved at seventeen institutions (52 percent); nine of these institutions have filled 90 percent or more of their LVN positions. Seven institutions (21 percent) have filled 80 to 89 percent of their LVN positions. Ten institutions (30 percent) have achieved the goal of filling 90 percent of their Psychiatric Technician (Psych Tech) positions, and four of these ten institutions have 95 percent or more of their Psych Tech positions. Thirteen institutions have filled 80 to 89 percent of their Psych Tech positions.

The following hiring related initiatives continue during the reporting period: (1) focused recruitment continues statewide for LVNs and Psych Techs; (2) presentations at nursing schools statewide; (3) advertisements in local papers, professional trade magazines, and online; and (4) mass mailers target LVN classifications. A mailer is planned for Psych Techs during the next quarter. Additionally, there continues to be a push at all institutions with nursing vacancies to schedule interviews on a weekly basis and interview all interested applicants expeditiously.

Action 3.1.1 is on schedule to achieve the 90 percent fill rate for nursing positions by January 2009.

For additional details related to vacancies and retention, refer to the Plata Vacancy and Retention Report for June 2008. This report is attached as Appendix 6.

The following metrics are included: Table 2 summarizes nursing filled percentages by prison; Table 3 summarizes nursing turnover rates by prison (refer to Objective 3.3 for explanation); and Table 4 summarizes nursing filled percentages and turnover rates by prison.

Table 2.

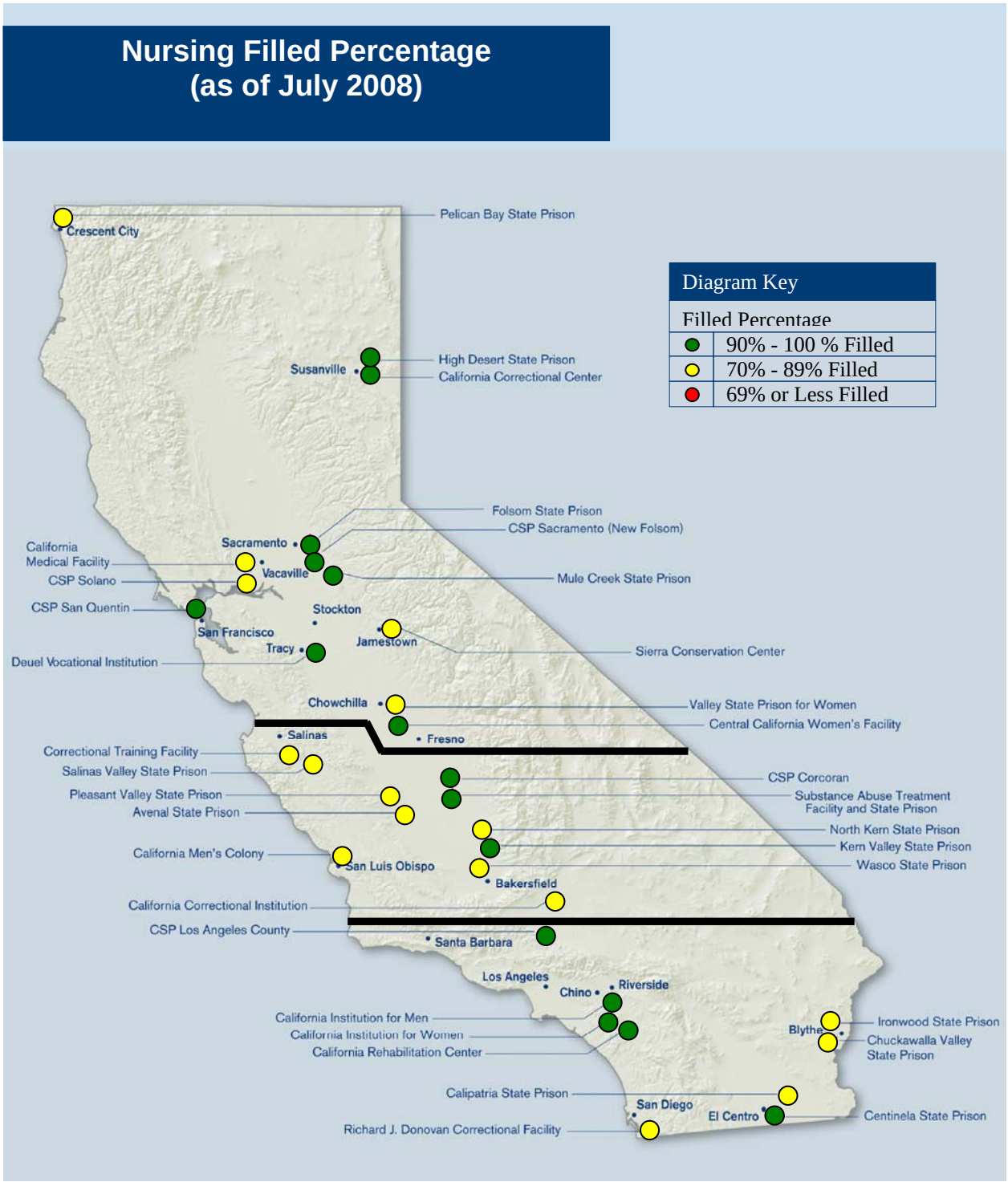

Nursing Filled Percentage
(as of July 2008)
Diagram Key
Filled Percentage
90% - 100 % Filled
70% - 89% Filled
69% or Less Filled
Crescent City
Pelican Bay State Prison
Susanville
High Desert State Prison
California Correctional Center
Folsom State Prison
CSP Sacramento (New Folsom)
Sacramento
California Medical Facility
Vacaville
CSP Solano
Mule Creek State Prison
CSP San Quentin
Stockton
San Francisco
Jamestown
Tracy
Sierra Conservation Center
Deuel Vocational Institution
Chowchilla
Valley State Prison for Women
Central California Women's Facility
Salinas
Fresno
Correctional Training Facility
Salinas Valley State Prison
CSP Corcoran
Pleasant Valley State Prison
Substance Abuse Treatment Facility and State Prison
Avenal State Prison
North Kern State Prison
Kern Valley State Prison
California Men's Colony
San Luis Obispo
Wasco State Prison
Bakersfield
California Correctional Institution
CSP Los Angeles County
Santa Barbara
Los Angeles
Chino
Riverside
California Institution for Men
California Institution for Women
California Rehabilitation Center
Blythe
Ironwood State Prison
Chuckawalla Valley State Prison
Calipatria State Prison
San Diego
El Centro
Centinela State Prison
Richard J. Donovan Correctional Facility

Table 3.

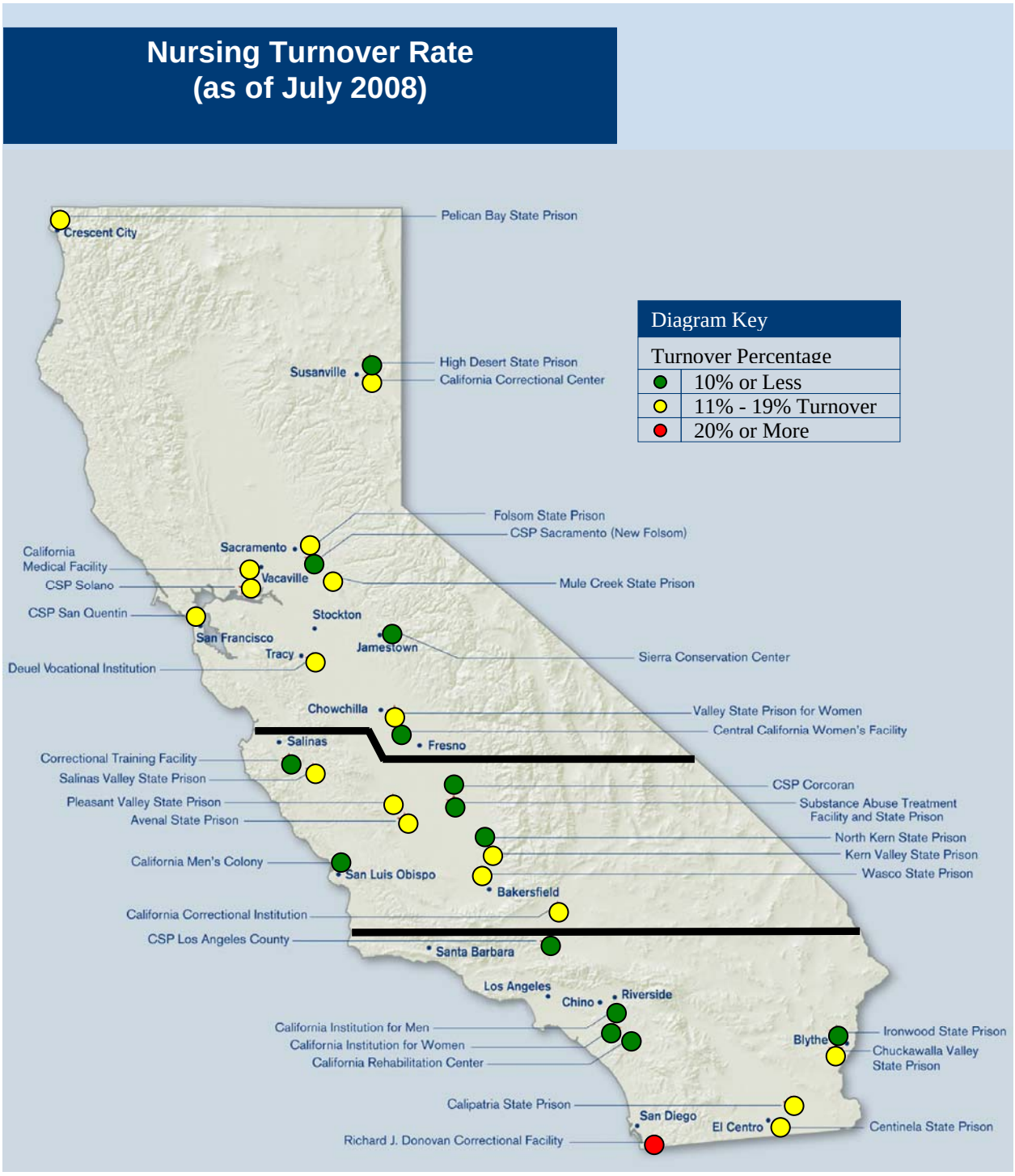
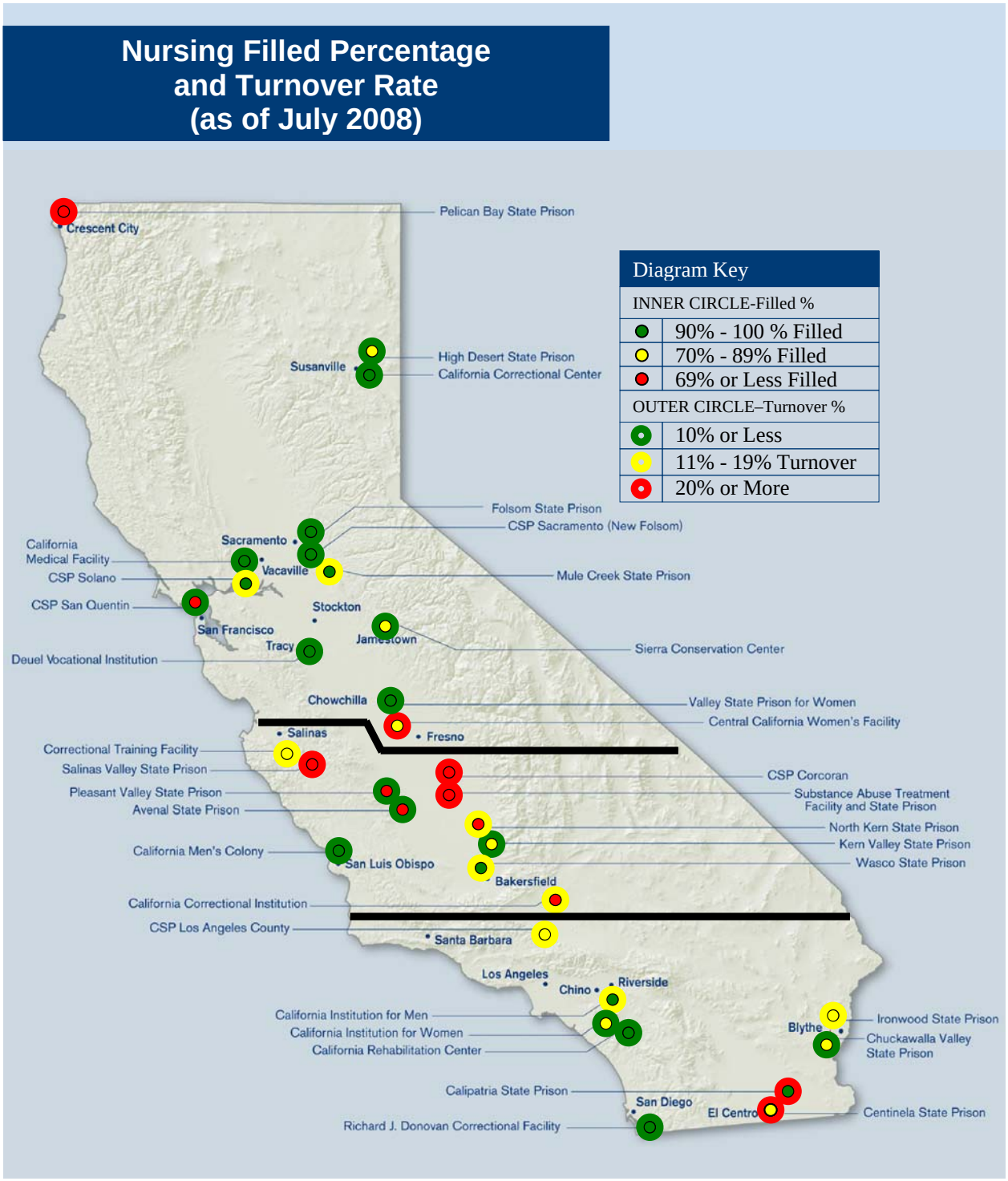

Nursing Turnover Rate
(as of July 2008)
Diagram Key
Turnover Percentage
10% or Less
11% - 19% Turnover
20% or More
Crescent City
Pelican Bay State Prison
Susanville
High Desert State Prison
California Correctional Center
Folsom State Prison
CSP Sacramento (New Folsom)
Sacramento
California Medical Facility
Vacaville
CSP Solano
Mule Creek State Prison
CSP San Quentin
Stockton
San Francisco
Jamestown
Tracy
Sierra Conservation Center
Deuel Vocational Institution
Chowchilla
Valley State Prison for Women
Central California Women's Facility
Fresno
Salinas
Correctional Training Facility
Salinas Valley State Prison
CSP Corcoran
Pleasant Valley State Prison
Substance Abuse Treatment Facility and State Prison
Avenal State Prison
North Kern State Prison
Kern Valley State Prison
California Men's Colony
San Luis Obispo
Wasco State Prison
Bakersfield
California Correctional Institution
CSP Los Angeles County
Santa Barbara
Los Angeles
Chino
Riverside
California Institution for Men
California Institution for Women
California Rehabilitation Center
Blythe
Ironwood State Prison
Chuckawalla Valley State Prison
Calipatria State Prison
San Diego
El Centro
Centinela State Prison
Richard J. Donovan Correctional Facility

Table 4.


Nursing Filled Percentage
and Turnover Rate
(as of July 2008)
Diagram Key
INNER CIRCLE-Filled %
90% - 100 % Filled
70% - 89% Filled
69% or Less Filled
OUTER CIRCLE–Turnover %
10% or Less
11% - 19% Turnover
20% or More
Crescent City
Pelican Bay State Prison
Susanville
High Desert State Prison
California Correctional Center
Folsom State Prison
CSP Sacramento (New Folsom)
Sacramento
California
Medical Facility
Vacaville
CSP Solano
Mule Creek State Prison
CSP San Quentin
Stockton
San Francisco
Jamestown
Tracy
Sierra Conservation Center
Deuel Vocational Institution
Chowchilla
Valley State Prison for Women
Central California Women's Facility
Salinas
Fresno
Correctional Training Facility
Salinas Valley State Prison
CSP Corcoran
Pleasant Valley State Prison
Substance Abuse Treatment
Facility and State Prison
Avenal State Prison
North Kern State Prison
Kern Valley State Prison
California Men's Colony
San Luis Obispo
Wasco State Prison
Bakersfield
California Correctional Institution
CSP Los Angeles County
Santa Barbara
Los Angeles
Chino
Riverside
California Institution for Men
California Institution for Women
California Rehabilitation Center
Blythe
Ironwood State Prison
Chuckawalla Valley
State Prison
Calipatria State Prison
San Diego
El Centro
Centinela State Prison
Richard J. Donovan Correctional Facility

Action 3.1.2. By January 2009, fill 90% of physician positions

Physician recruitment efforts focused on "hard-to-fill" institutions during the reporting period. This focus is appropriate because most urban institutions have now hired their full component of primary care providers. These focused efforts have proven successful. For example, Avenal State Prison, which historically has had difficulty staffing their physician positions, recently hired four physicians. Correctional Training Facility and Salinas Valley State Prison, both with a long-term history of serious hiring problems, have collectively hired ten physicians since the centralized hiring process began. Pelican Bay State Prison, which also experienced serious shortages of primary care providers until recently, is now fully staffed with physicians and mid-level providers.

As of July 30, 2008, approximately 85 percent of physician positions are filled (this percentage is an average of all three State physician classifications). This is within 5 percent of the statewide goal of having 90 percent of physician positions filled. One hundred percent of the Chief Medical Officer positions are filled; 85 percent of the Chief Physician and Surgeon positions are filled; and 82 percent of the Physician and Surgeon (P&S) positions are filled. Thirteen institutions (39 percent) have achieved the goal of filling 90 percent of their P&S positions and twelve of these institutions have filled at least 95 percent of their P&S positions. Seven institutions (21 percent) have filled 80 – 89 percent of their P&S positions. With the exception of San Quentin State Prison, all institutions still proving to be "hard-to-fill" are located in the Central Valley region.

Specialized recruitment efforts for physicians continue with advertisements placed in professional periodicals, newspapers, online, direct mailers, conferences, and visits to residency programs. In addition, efforts are underway to contract with a search firm that can assist in finding candidates for the hard-to-hire locations.

Action 3.1.2 is on schedule to achieve the 90 percent fill rate for physician positions by January 2009.

For additional details related to vacancies and retention, refer to the Plata Vacancy and Retention Report for June 2008. This report is attached as Appendix 6.

The following metrics are included: Table 5 summarizes physician filled percentages by prison; Table 6 summarizes physician turnover rates by prison (refer to Objective 3.3 for explanation); and Table 7 summarizes physician filled percentages and turnover rates by prison.

Table 5.

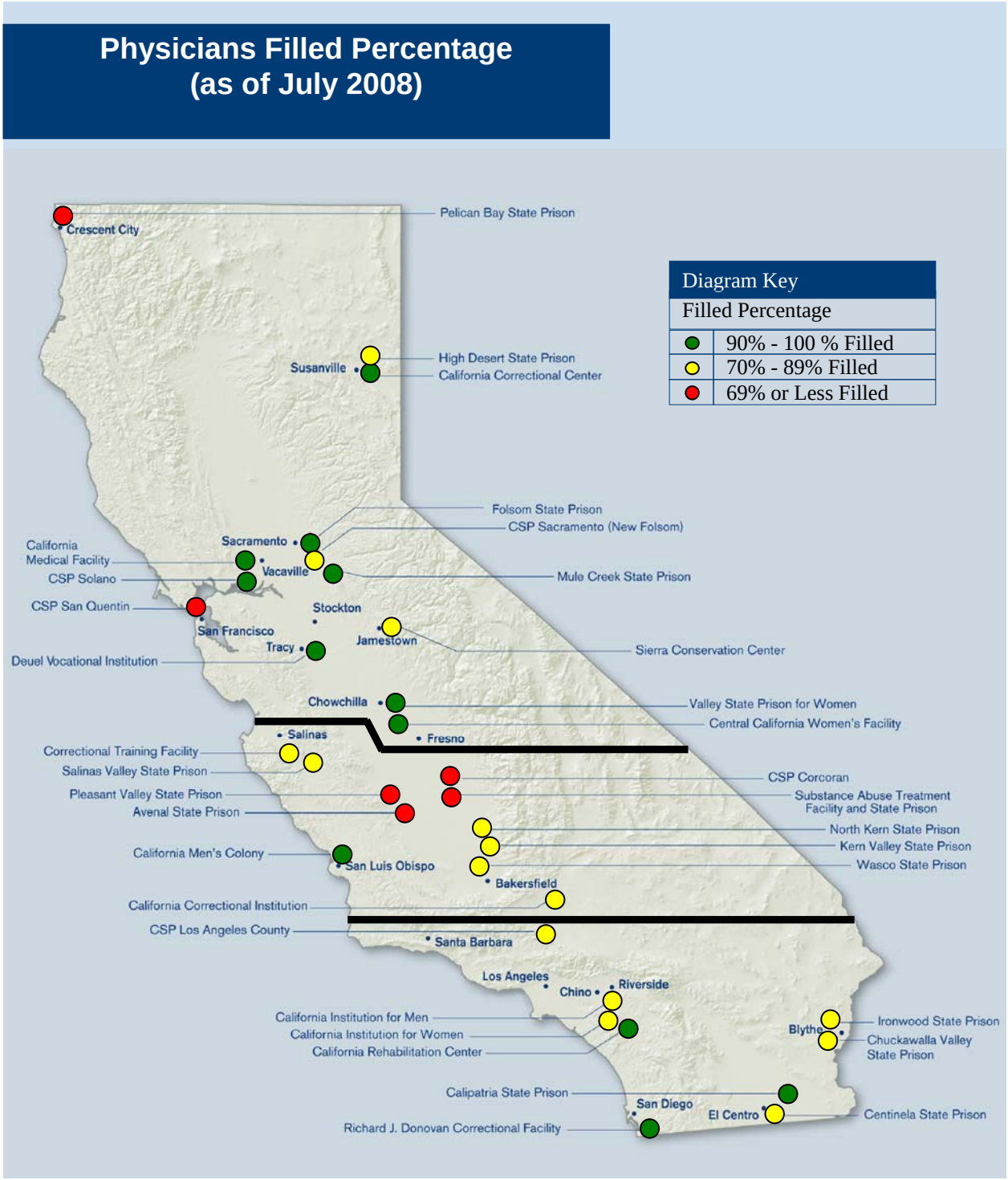

Physicians Filled Percentage
(as of July 2008)
Diagram Key
Filled Percentage
90% - 100 % Filled
70% - 89% Filled
69% or Less Filled
Crescent City
Pelican Bay State Prison
Susanville
High Desert State Prison
California Correctional Center
Folsom State Prison
CSP Sacramento (New Folsom)
Sacramento
California Medical Facility
Vacaville
CSP Solano
Mule Creek State Prison
CSP San Quentin
Stockton
San Francisco
Jamestown
Tracy
Sierra Conservation Center
Deuel Vocational Institution
Chowchilla
Valley State Prison for Women
Central California Women's Facility
Fresno
Salinas
Correctional Training Facility
Salinas Valley State Prison
CSP Corcoran
Pleasant Valley State Prison
Substance Abuse Treatment Facility and State Prison
Avenal State Prison
North Kern State Prison
Kern Valley State Prison
California Men's Colony
San Luis Obispo
Wasco State Prison
Bakersfield
California Correctional Institution
CSP Los Angeles County
Santa Barbara
Los Angeles
Chino
Riverside
California Institution for Men
California Institution for Women
California Rehabilitation Center
Blythe
Ironwood State Prison
Chuckawalla Valley State Prison
Calipatria State Prison
San Diego
El Centro
Centinela State Prison
Richard J. Donovan Correctional Facility

Table 6.

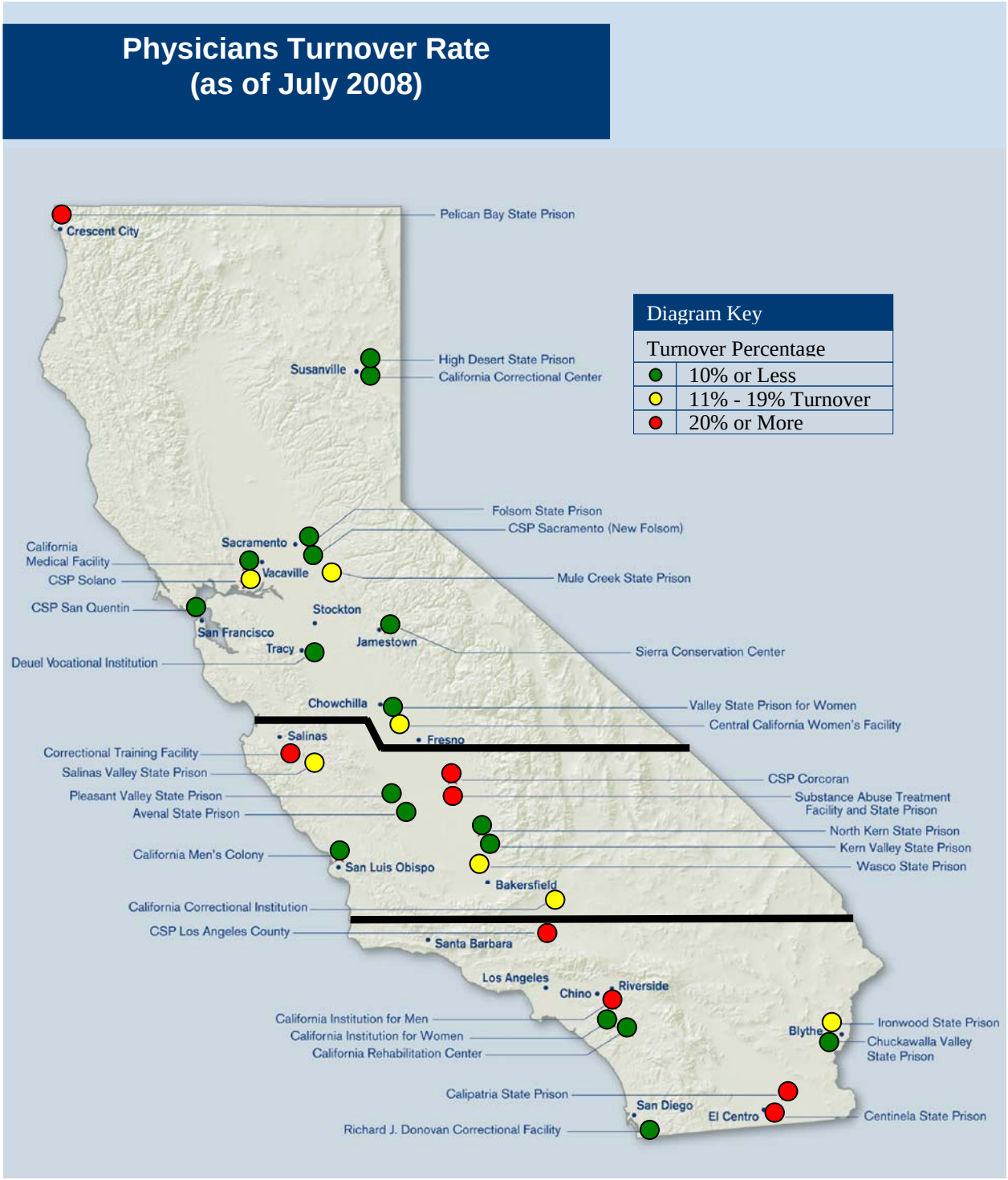
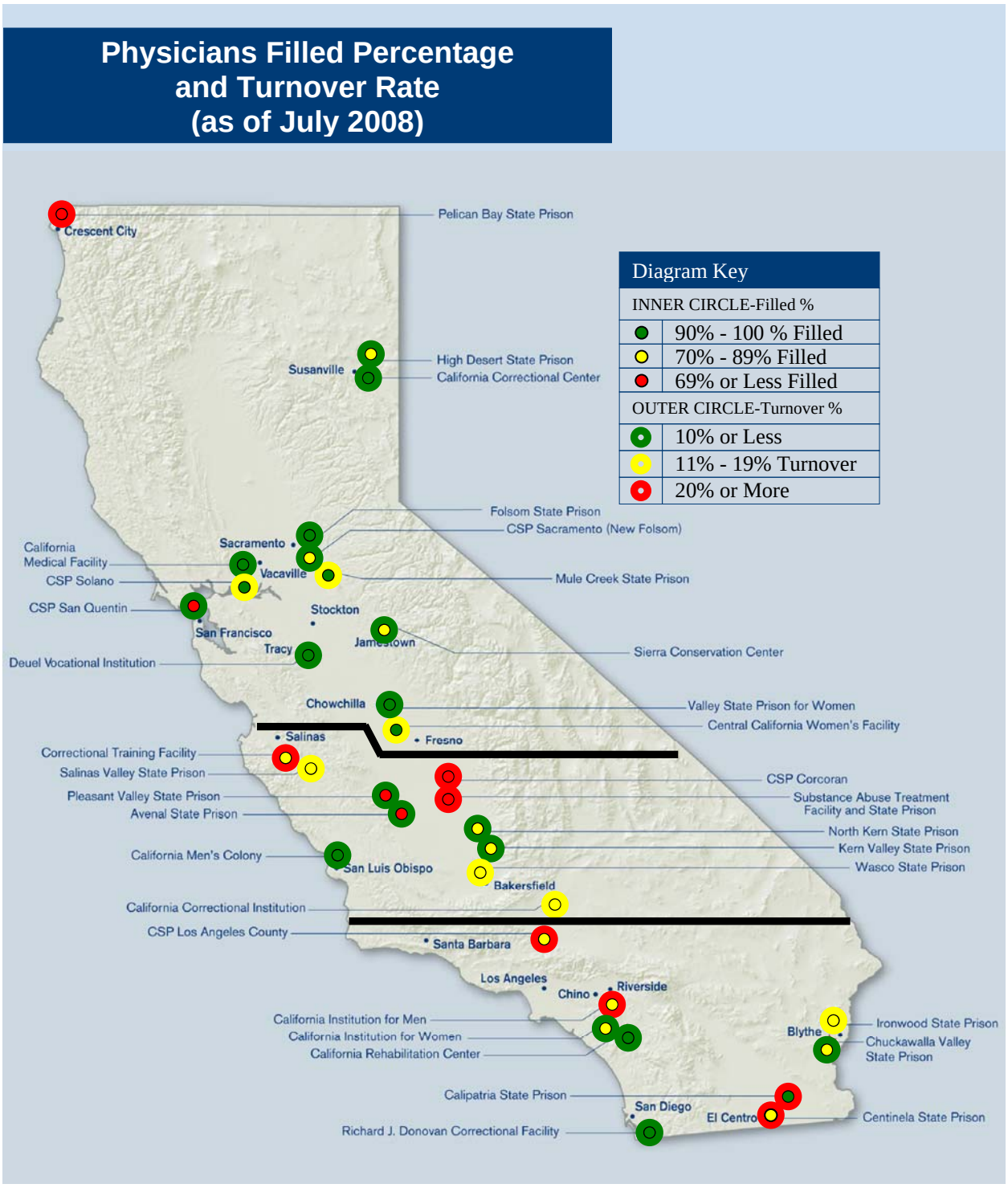

Physicians Turnover Rate
(as of July 2008)
Diagram Key
Turnover Percentage
10% or Less
11% - 19% Turnover
20% or More
Crescent City
Pelican Bay State Prison
Susanville
High Desert State Prison
California Correctional Center
Folsom State Prison
CSP Sacramento (New Folsom)
Sacramento
California Medical Facility
Vacaville
CSP Solano
Mule Creek State Prison
CSP San Quentin
Stockton
San Francisco
Jamestown
Tracy
Sierra Conservation Center
Deuel Vocational Institution
Chowchilla
Valley State Prison for Women
Central California Women's Facility
Fresno
Salinas
Correctional Training Facility
Salinas Valley State Prison
CSP Corcoran
Pleasant Valley State Prison
Substance Abuse Treatment Facility and State Prison
Avenal State Prison
North Kern State Prison
Kern Valley State Prison
California Men's Colony
San Luis Obispo
Wasco State Prison
Bakersfield
California Correctional Institution
CSP Los Angeles County
Santa Barbara
Los Angeles
Chino
Riverside
California Institution for Men
California Institution for Women
California Rehabilitation Center
Blythe
Ironwood State Prison
Chuckawalla Valley State Prison
Calipatria State Prison
San Diego
El Centro
Centinela State Prison
Richard J. Donovan Correctional Facility

Table 7.


Physicians Filled Percentage and Turnover Rate (as of July 2008)
Diagram Key
INNER CIRCLE-Filled %
90% - 100 % Filled
70% - 89% Filled
69% or Less Filled
OUTER CIRCLE-Turnover %
10% or Less
11% - 19% Turnover
20% or More
Crescent City
Pelican Bay State Prison
Susanville
High Desert State Prison
California Correctional Center
Folsom State Prison
CSP Sacramento (New Folsom)
Sacramento
California Medical Facility
Vacaville
CSP Solano
Mule Creek State Prison
CSP San Quentin
Stockton
San Francisco
Tracy
Jamestown
Sierra Conservation Center
Deuel Vocational Institution
Chowchilla
Valley State Prison for Women
Central California Women's Facility
Fresno
Salinas
Correctional Training Facility
Salinas Valley State Prison
CSP Corcoran
Pleasant Valley State Prison
Substance Abuse Treatment Facility and State Prison
Avenal State Prison
North Kern State Prison
Kern Valley State Prison
California Men's Colony
San Luis Obispo
Wasco State Prison
Bakersfield
California Correctional Institution
CSP Los Angeles County
Santa Barbara
Los Angeles
Chino
Riverside
California Institution for Men
California Institution for Women
California Rehabilitation Center
Blythe
Ironwood State Prison
Chuckawalla Valley State Prison
Calipatria State Prison
San Diego
El Centro
Centinela State Prison
Richard J. Donovan Correctional Facility

Objective 3.2 Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2009, establish and staff new executive leadership positions

Action 3.2.2. By January 2009, establish and staff regional leadership structure

Actions 3.2.1 and 3.2.2 are being addressed simultaneously; therefore, the response below refers to the progress of both.

CPS Human Resource Services has completed salary surveys for these positions, and the Department of Personnel Administration (DPA) has accepted the recommended salaries as well as the new concept of individual pay based on performance; education and experience; work assignment and location; and longevity. DPA will issue the official pay letter to formally establish the pay band in early September 2008 and establish a pay differential for the performance component by late September 2008. A fourth RCEA classification, Clinical Executive, will be responsible for all other licensed disciplines including rehabilitation, pharmacy, laboratory, radiology, optometry, podiatry, and dietary services. The classification specification for this RCEA position has been developed, sent to the SPB for approval, and was approved effective September 3, 2008. From the perspective of Receivership efforts and necessary analysis by DPA, this project was on schedule.

However, delays have arisen because of processing failures on the part of the State Personnel Board (SPB). Implementation of three new clinical executive classifications (Medical Executive, Nurse Executive, and Chief Executive Officer, Health Care) was scheduled at three pilot locations (San Quentin State Prison, Mule Creek State Prison, and California State Prison, Sacramento/Folsom State Prison) for September 1, 2008. However, significant delays implementing the automated examinations of the exams for these three RCEA classifications have taken place because of SPB's failure to handle the automation process in a timely manner. Because of SPB's delays, the "go live" date for this critical pilot continues to be delayed. Refer to Section 5 for a summary of how SPB continues to delay important Receivership programs.

Given SPB's problems and the Board's apparent inability to manage the automated exam process in a timely manner, it is difficult at this time to determine whether the RCEA positions will be fully staffed by January 2009, as this is dependent upon a number of factors including the ability of the control agencies to meet reasonable timeframes to complete necessary processes prior to hiring for vacant positions.

Meanwhile, however, the Receiver's efforts to prepare for RCEA recruitment have continued. For example, professional advertisements have been designed and a media plan has been developed and is ready to be implemented once the pay letter is issued and automation of the examinations are complete. Advertisements will run primarily in professional journals aimed at health care administrators and clinical and nursing leaders. Some online advertisements will also reach out to this audience. In addition, in order to determine whether the Executive leader model and the resultant organization structure are effective, a contract was executed between CPHCS

and CPS Human Resource Services to assess the organization of the new model. CPS Human Resource Services will provide briefings every 60 days on the status of the assessment.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2009, establish statewide organizational orientation for all new health care hires and institution-specific clinical orientation through a nursing preceptor or proctoring program

Until recently, CDCR has not had a consistent orientation program or practice for its new health care employees, and none of the individual facilities had a formalized preceptor or proctoring program. These basic elements in establishing a culture of organizational quality in a health care program are underway.

Status of New Employee Orientation and Training

The Health Care New Employee Orientation (HCNEO) has evolved from a single pilot site to three regional HCNEO locations. Clinical staff from each institution travel to the nearest regional HCNEO site for training within the first week or so of their hire date. Effective September 2008, Education and Training Unit (within Human Resources' Workforce Development Branch) will assume responsibility for conducting the HCNEO. Previously, the Nursing Services Branch has been coordinating the training. This responsibility, in addition to conducting the training, will include ongoing curriculum development, training event coordination, registration, and tracking. Also, in collaboration with Human Resources' Education and Training Unit, the Education and Professional Development Unit will be expanding its focus to support other required clinical training such as BLS, ACLS, and other Continuing Medical Education (CME) programs.

A performance measure that has been closely monitored is the turnover rate of new hires who attend the HCNEO versus those who did not attend. One percent of clinical staff who attended regional HCNEO separated from State service within the first year of employment. Eleven percent of those new hires who did not attend regional HCNEO separated within the first year of employment. While these results will require constant monitoring, they represent a very significant improvement over pre-orientation turnover rates, reducing the turnover rate by ten percent. General data related to employee turnover is included in Tables 3 and 6.

Status of the Proctoring/Mentoring program

The proctoring/mentoring program for new health care clinicians has been developed, and implementation will begin in September 2008. This didactic and clinical program will provide new clinicians the opportunity to work under every day correctional work conditions, build rapport, and be mentored by experienced staff members. Following the four-day initial classroom orientation, each new employee will be assigned a preceptor/proctor who will be the new employee's contact and support during the clinical orientation. In each of the practice settings, a designated, experienced clinician will be assigned to orient/mentor the new employee to that area. Implementation of this program will be completed within all 33 institutions by December 2008.

Action 3.3.1 is on schedule to establish a statewide organizational orientation for all new health care hires and institution-specific clinical orientation through a nursing preceptor or proctoring program by January 2009.

Action 3.3.2. By January 2009, win accreditation for CDCR as a CME provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education

In an effort to maintain and enhance the level of clinical competencies with educational programs, the Office of the Receiver has established a CME Committee. The CME Committee has been established and has met monthly since February 2008. The committee membership is representative of clinicians providing health care services within CPHCS from each licensed practitioner group, including physician, psychiatrist, nurse, nurse practitioner and psychologist. The primary objective of the CME Committee is to obtain accreditation for CPHCS as a CME provider, recognized by the Institute of Medical Quality (IMQ) and the Accreditation Council for Continuing Medical Education. The CME Committee will also oversee the planning of all CME activities.

The Interdisciplinary Professional Development (IPD) Unit within the Clinical Operations Support Branch, Professional Development and Review (PDR) Section, is providing administrative support for the CME Committee. The IPD Unit is currently preparing the application for accreditation, including a description of the history of the program, its purpose and mission, and detailed descriptions of how the CME program complies with standards for commercial support. Policies and procedures are also being drafted which must be available for IMQ to review during the on-site survey which is targeted to occur in early December 2008. The application will be submitted to IMQ no later than September 30, 2008. In addition to obtaining accreditation, the IPD Unit will be responsible for the operation and administration of the CME program once accreditation has been obtained.

One component of the accreditation application is to plan and present CME activities to establish a "track record." The purpose of this process is to demonstrate CPHCS's understanding of the CME requirements and readiness to become an accredited provider of CME activities. The IPD Unit submitted an application to IMQ entitled "Primary Care Introduction to Hepatitis C" which will be reviewed by the IMQ Committee at its September 9, 2008 meeting. Once the activity has been approved, CPHCS providers may receive one hour of CME credit for attending. CPHCS's second CME "track record" activity, "Primary Care Introduction to Chronic Pain Management," is under development and will be presented to providers in the institutions during September and early October 2008. The IDP Unit has completed a Service and Expense Order with IMQ for joint sponsorship and consulting services, including a physician liaison to CPHCS's CME Committee.

Action 3.3.2 is on schedule to establish a statewide organizational orientation for all new health care hires and institution-specific clinical orientation through a nursing preceptor or proctoring program by January 2009.

Goal 4. Implement Quality Improvement Programs

Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program

Action 4.1.1. By July 2011, establish sustainable quality measurement, evaluation and patient safety programs

During this reporting period, the Quality Improvement Section completed planning activities to ensure that the CPHCS is able to establish sustainable quality measurement, evaluation, and patient safety programs by July 2011. These planning activities involved securing a partnership with a major research organization, as part of the process for establishing performance and outcome measures. The awarding of the contract is expected to be accomplished during the next reporting period.

Action 4.1.2. By July 2009, work with the Office of Inspector General to establish an audit program focused on compliance with Plata requirements

This action plan was divided into two phases. Phase I included program development and pilot implementation, and Phase II included statewide roll-out and implementation. This objective is on schedule with statewide Office of the Inspector General (OIG) implementation scheduled for September 2008.

As of the conclusion of the reporting period, the OIG completed Phase I of the Medical Inspection Program. During Phase I, the OIG developed the inspection instruments in a collaborative process with the CDCR, Prison Law Office (PLO) CPHCS staff and other stakeholders. The OIG conducted pilot medical inspections at five institutions, including Mule Creek State Prison, Calipatria State Prison, California State Prison at Corcoran, Centinela State Prison and California Institution for Men. The final pilot medical inspection was completed on June 12, 2008.

As a result of the lessons learned during the pilot phase, the OIG provided proposed revisions to the medical inspection instrument to all of the stakeholders in August 2008. The stakeholders subsequently provided comments to the OIG for modifications to the inspection instrument. On August 19, 2008, a stakeholders' meeting was held to discuss the proposed revisions to the medical inspection instrument. During the August 19, 2008 meeting, discussions took place regarding the loaning of CPHCS physicians to the inspection team as well as reporting and automation and the commencement of Phase II of the statewide inspections.

In September 2008, the OIG will initiate Phase II of the Medical Inspection Program. Phase II includes annual medical inspections at all 33 adult prisons with the potential of follow-up inspections at poor performing prisons. To support the implementation of the statewide Medical Inspection Program, the Receiver will provide clinical expertise to OIG inspection teams and will continue to collaborate closely with the OIG to provide input to refine the indicators used in medical inspections as CPHCS's policies and procedures are updated.

Objective 4.2. Establish a Quality Improvement Program

Quality improvement is a hallmark of a well-run health care system. Using information from measurement and evaluation systems, as well as self-assessment and other sources of ideas for improvement, the health care system works on a continuous basis to improve both its efficiency and its outcomes. Improvements in clinical processes will also require updating of clinical policies and procedures.

The Office of the Receiver established a quality-based program to administer the CPHCS healthcare credentialing and privileging function as part of the Quality Improvement Program. Status of this Unit will be discussed below and prior to the status of the three specific Quality Improvement Program actions specified in the Turnaround Plan of Action.

Credentialing and Privileging Unit

As a first step in establishing and implementing a Quality Improvement Program, the Office of the Receiver established the CPHCS health care credentialing and privileging function. The Credentialing and Privileging Unit is responsible for implementation of a credentialing software program to facilitate the initial credentialing, and ongoing tracking of required licenses, certification renewals and continuing education for all licensed independent practitioners practicing within the prison system.

The Credentialing and Privileging Unit has completed a review of the Unit's original August 2007 policies, and the policies have been updated to reflect the Unit's current practice, which conform to community health care standards. The revised policies are scheduled for review and approval at the September 2, 2008, Credentials Committee Meeting. The Unit has also completed a comprehensive policy that meets community standards (JCAHO) that is currently under review by legal counsel. Once the Credentialing and Privileging Unit's policies have been approved through the committee structure, they will be forwarded to the Office of the Receiver for final review and approval.

The Credentials Committee's policies have been reviewed by legal and were approved by the Credentials Committee on August 11, 2008 and the PPEC on August 20, 2008. These policies are scheduled for review and approval by the Medical Governing Body on September 8, 2008 and the Dental-Mental Health Governing Body on September 15, 2008.

On June 20, 2008, a credentialSmart training was conducted for the Credentialing and Privileging staff. Following this training session, staff began the data entry process of converting the existing paper credential files to the electronic profile. The data conversion implementation plan includes all current civil service CPHCS Physician and Surgeons, Psychiatrists, Dentists, Psychologists, and Social Workers. The conversion plan was then split into the following four phases based upon the institution's licensing status: Phase I: Conversion of Headquarters and Regional practitioners; Phase II: Conversion of all practitioners assigned to the Outpatient Housing Units; Phase III: Conversion of all practitioners assigned to the institutions that are licensed as a Skilled Nursing Facility or Correctional Treatment Center; and Phase IV: Conversion of the practitioners assigned to the General Acute Care Hospital. All phases are

expected to be completed by December 2008. As of this reporting period, Phases I and II are complete and Phase III is more than 90% complete. It is anticipated that Phase IV will begin by mid-October, and the December deadline for completion will be achieved.

In addition to the file conversion for the above practitioners, the Credentialing and Privileging Unit began the verification and profile establishment of the Nursing classifications. To date, there are 76 Nurses (RN and LVN) entered into the credentialSmart system. The Nursing component has been added to assist in the Emergency Medical Response Plan, as described under Goal 2, Objective 2.3. The implementation schedule for this aspect of the action is under development and will be outlined in the next reporting period.

Action 4.2.1. By September 2009, train and deploy a cadre of quality improvement advisors to develop model quality improvement programs at selected institutions.

The Quality Improvement Section is on track to deploy a cadre of quality improvement advisors to develop model quality improvement programs at selected institutions in accordance with the Receiver's September 2009 timeframe. Satisfying this objective requires hiring and training nurse consultant quality advisors and establishing a working model for institution-level quality improvement.

In July 2008, a Chief Medical Officer for Quality Improvement was appointed and began staffing the Quality Improvement Section. Four nurse consultant quality advisors were hired. In addition, analytical and clerical staff were hired during this reporting period to support these advisors.

In July and August 2008, in collaboration with Health Management Associates (an independent national research and consulting firm specializing in complex health care program and policy issues), contractors that specialize in process improvement and care management, and Kent Imai, M.D., Medical Consultant with the Office of the Receiver, the Quality Improvement Section staff began to develop a curriculum for regional and statewide quality advisors that includes care model expertise, fundamental concepts in rapid cycle improvement, and activities that build mentoring and facilitation skills.

Quality advisers will receive initial training in this curriculum during the upcoming reporting period. Quality Improvement Section staff will revise and refine the curriculum further in 2009 as part of the ongoing statewide learning collaborative. (Refer to Goal 2, Objective 2.2). The Quality Improvement Section is also collaborating with the Clinical Support Unit, as an existing unit of regional-level technical assistance physician and mid-level providers, to implement process improvement interventions in the field. Also, in the upcoming reporting period, Quality Improvement Section staff will assess process improvement infrastructure and functioning at institutions statewide and will begin the process of designing quality management policies and procedures that define the new process improvement process.

Action 4.2.2. By September 2009, establish a Policy Unit responsible for overseeing review, revision, posting and distribution of current policies and procedures.

To accomplish this action item, an action plan was established and divided into two phases. Phase I includes the development of the organization structure and program concept, the recruitment and hiring of staff, and staff training. Phase II includes the development of policies and procedures and the procurement of a policy tracking system. This objective is currently on schedule.

As of the conclusion of this reporting period, CPHCS Management has completed the development of the program concept, identified the appropriate organizational structure and advertised the positions on the SPB website. Additionally, research has been conducted to procure a policy management system which will enable the Policy Unit to standardize policy format; accelerate the review and approval process; track and archive all policy revisions; and electronically notify employees of new policies and or revisions.

During the upcoming reporting period, the hiring and training process will be completed and the Policy Unit will begin work on Phase II. This objective is on schedule to be accomplished by September 2009.

Action 4.2.3. By January 2010, implement process improvement programs at all institutions involving trained clinical champions and supported by regional and statewide quality advisors

With regard to Action 4.2.3, the Quality Improvement Section continued to build infrastructure for process improvement programs through the design and implementation of four Access to Care Initiatives. For example, one of the initiatives, the Chronic Care Initiative, uses a learning collaborative model and assists institutional pilot sites in incorporating rapid-cycle improvement and performance measurement into day-to-day operations. Quality Improvement Section staff inform the development of all learning collaborative curricula and assist in the establishment of relevant performance indicators. Quality Improvement Section staff will continue to serve this advisory function for all Access to Care domains, ensuring that rapid-cycle improvement concepts, performance measurement, and program reporting are embedded in the implementation of all pilot programs. Through the collaboration between Quality Improvement Section and Access to Care staff, the Quality Improvement Section will simultaneously build statewide capacity for ongoing process improvement while the redesign of the health care service delivery system spreads in the field.

The Quality Improvement Section is on schedule to implement process improvement programs at all institutions by January 2010.

Objective 4.3. Establish Medical Peer Review and Discipline Process to Ensure Quality of Care

Action 4.3.1. By July 2008, working with the State Personnel Board and other departments that provide direct medical services, establish an effective Peer Review and Discipline Process to improve the quality of care

This action item is completed in part, and delayed in part. The establishment of an effective Peer Review has been accomplished while the establishment of an effective Disciplinary process is still being addressed.

On July 9, 2008, the Court issued the "Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency." Delay with implementation has taken place, however, because SPB has been unable to develop and implement a program to effectuate PPEC due process hearings in a timely manner. As a result, the initial implementation of this program has defaulted to the Receiver. Implementation activities have now begun, including establishing new processes, modifying notifications to physicians subject to peer review investigation, providing training on policy implementation, and developing a contract with the Institute of Medical Quality for Judicial Review Committee. The implementation of the new process is more than 90% complete as of the end of the reporting period and is anticipated to begin within 30 days.

During this reporting period, the old version of PPEC met eight times and reviewed 38 allegations of clinical misconduct. To protect patient-inmate safety, the committee summarily suspended the clinical privileges of four providers, implemented or continued 12 monitoring plans and closed the cases of 12 investigations. The Governing Body issued Notices of Proposed Final Actions to revoke the privileges of three providers and a Final Action for a fourth provider. During this reporting period, three licensed independent practitioners separated from State service following a peer review investigation.

A graphical display of PPEC outcomes for the second calendar quarter of 2008 is presented in Tables 8 and 9.

Table 8.

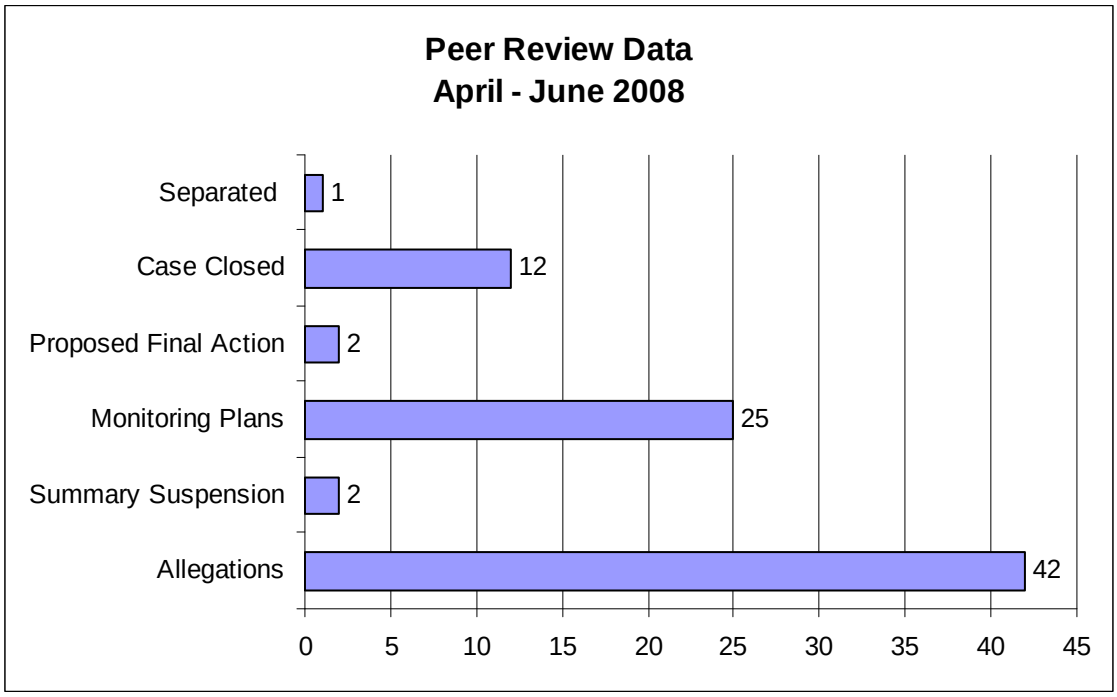
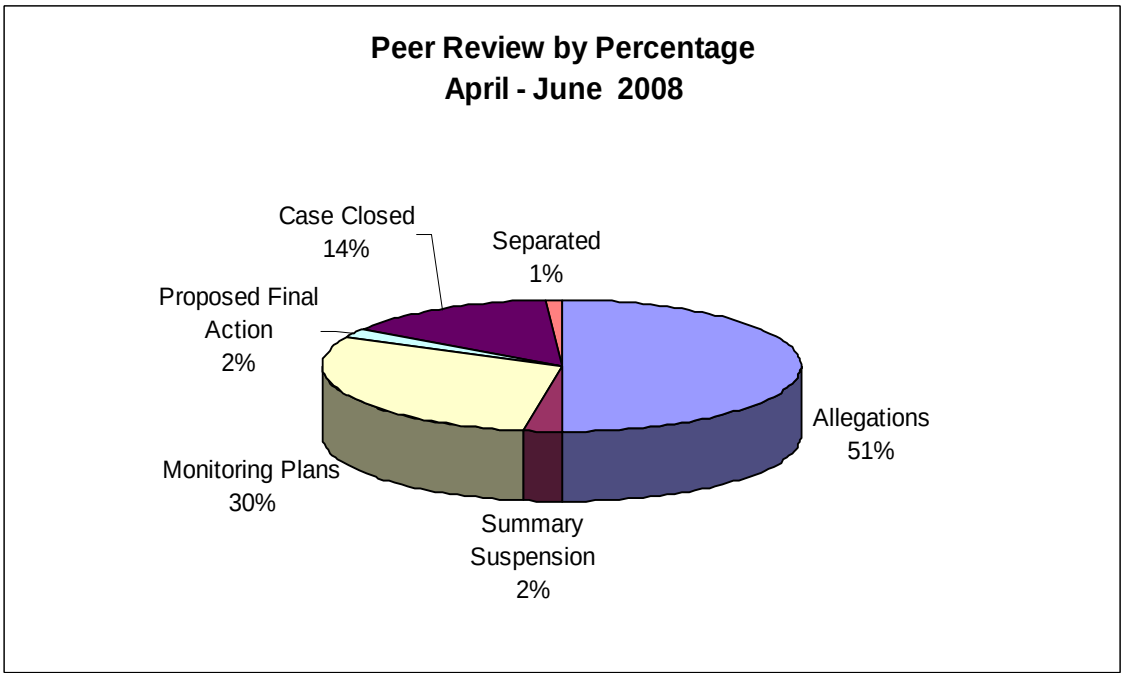


Table 9.



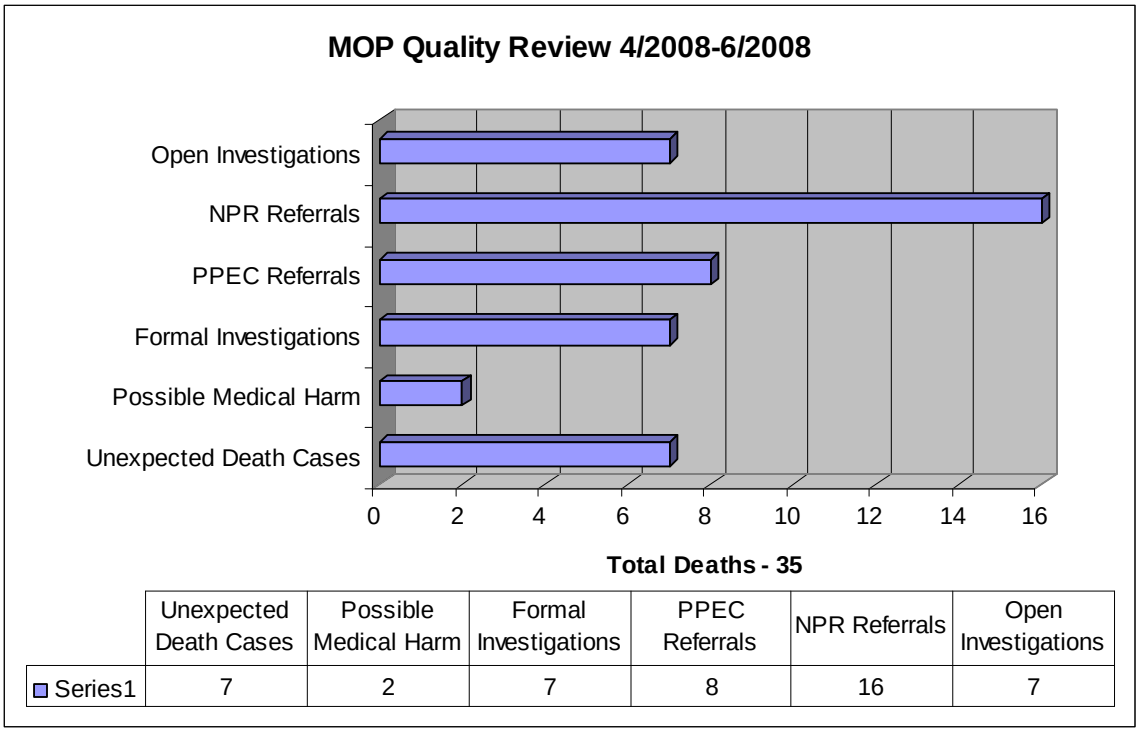
Objective 4.4. Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations

Action 4.4.1. By January 2009, fully staff and complete the implementation of a Medical Oversight Unit to control and monitor medical employee investigations

The Medical Oversight Program (MOP) is a collaborative pilot project to conduct clinical investigations consisting of staff from the CPHCS, CDCR Office of Internal Affairs (OIA), CDCR Employee Advocacy Prosecution Team (EAPT) and the OIG. The MOP has been conducting multi-disciplinary clinical investigations since January 1, 2008, and based on the initial staffing allocations, the MOP is fully staffed. During the reporting period, the MOP conducted reviews of six unexpected death cases and reviewed one case of possible medical harm that did not result in patient-inmate death. These reviews resulted in four cases being opened for formal investigation. Thirteen referrals were made to the Professional Practice Executive Committee (PPEC) and fourteen referrals were made to Nursing Practice Review (NPR) to address clinical practice concerns. As of August 31, 2008, there were fourteen open investigations. The MOP pilot is on schedule in developing and implementing an expedited process for conducting clinical employee investigations.

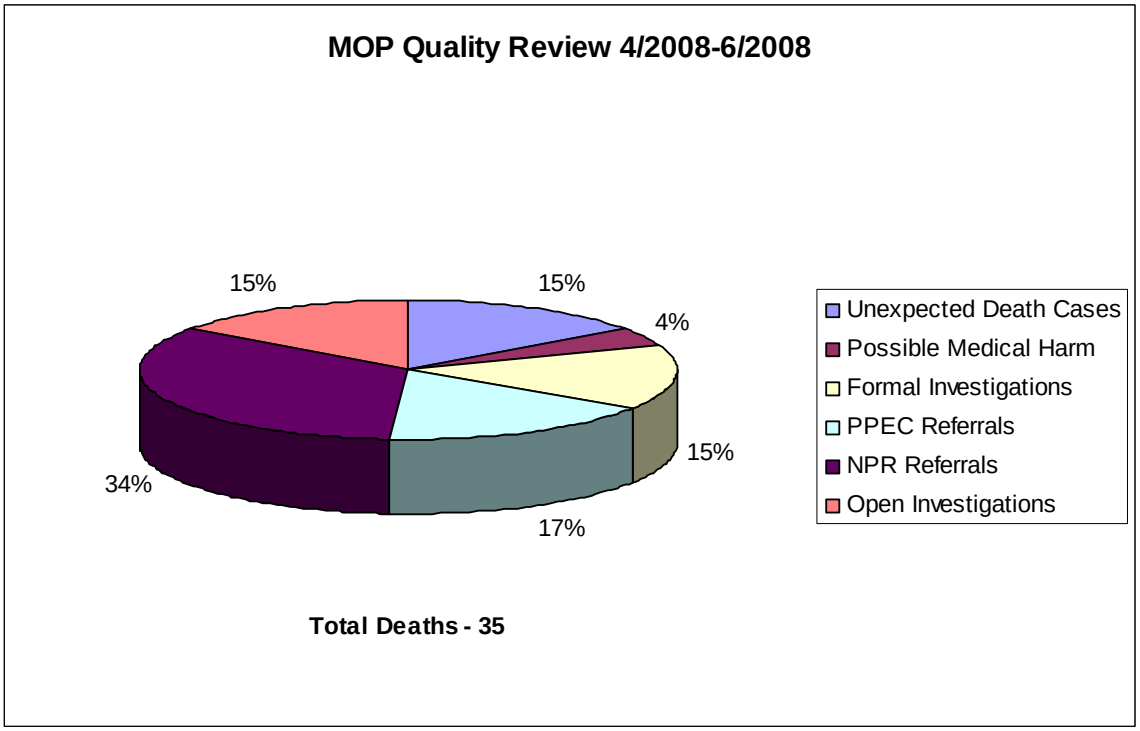
A graphical display of MOP outcomes for the second calendar quarter of 2008 is presented in Tables 10 and 11.

Table 10.



	Unexpected Death Cases	Possible Medical Harm	Formal Investigations	PPEC Referrals	NPR Referrals	Open Investigations
Series1	7	2	7	8	16	7

Table 11.



The program goals of MOP have broadened to include identification of serious systemic issues, as well as clinical employee misconduct. The MOP is defining specific types of incidents that require the investigative resources of the program, versus those warranting a referral to institutional, regional, and statewide clinical leadership, and/or the PPEC and NPR. The new peer-review policies outlined in the recent court decision have been incorporated into the decision-making process for MOP case review. The MOP has begun immediately referring possibly "dangerous" clinicians to medical and nursing leadership. These referrals have resulted in prompt actions including the limiting suspending the clinicians' privileges. Detailed information on PPEC outcomes are detailed in Tables 8 and 9, within Objective 4.3.

To meet one of the key program objectives, the MOP is in its final phase of revising the Employee Disciplinary Matrix to make it more clinically-relevant. A draft of the revision was developed through a collaboration of the following program stakeholders: CPHCS, EAPT, OIA, the OIG, CDCR Custody, Mental Health, and Dental. This modification has taken longer than anticipated; however, given the issues involved and the concerns of a wide variety of stakeholders, the extended period of review and discussion are warranted.

The MOP continues to collaborate with the California Out-of-State Correctional Facility program (COCF) on systemic issues identified at an out-of-state private prison. (Refer to Objective 4.6 for additional information regarding this incident.) Subsequent to the on-site investigation in Mississippi, MOP has been instrumental in the development of a Corrective

Action Plan (CAP) to address issues identified. The MOP also provided ongoing clinical resources and expertise to assist COCF in the development and implementation of the CAP with the out-of-state facility.

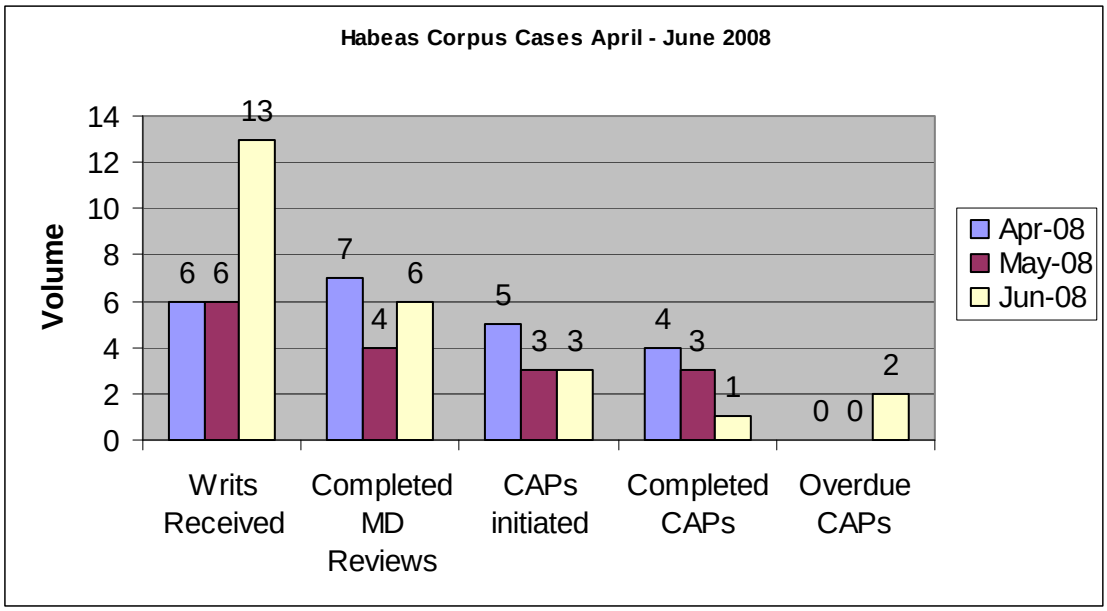
Objective 4.5. Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative

Action 4.5.1. By July 2008, centralize management over all health care patient-inmate appeals, correspondence and habeas corpus petitions

This action plan was divided into two phases. Phase I included the consolidation of all correspondence and habeas corpus petition responses under the Controlled Correspondence and Litigation Support Unit (CCLSU). Phase II included the separation of health care appeals from CDCR institution appeals and the establishment of the Office of Third Level Appeals – Health Care. Previously, institution appeals were routed through CDCR institution appeals which the Receiver deemed inefficient and unnecessary. Additionally, the third level appeals were responded to by CDCR custody staff who lacked the medical knowledge to appropriately respond to patient-inmates' health care issues.

Phase I, the consolidation of correspondence and Habeas corpus was completed in October 2007. As a result of this consolidation the work load for the CCLSU has increased nearly 200%. See Table 12 below regarding the tracking of correspondence and habeas corpus cases handled by the CCLSU for the second calendar quarter of 2008. The CCLSU Executive Summary Report for June through August 2008 is attached as Appendix 7.

Table 12.



Phase II, the centralized management of health care appeals, was completed and the objective was met on August 1, 2008, when all inmate health care appeals were completely centralized and consolidated under the Litigation Management Unit within the Plata Field Support Division.

Institutional Health Care Appeals

During this reporting period, the CCLSU staff drafted new policies and procedures and developed new forms for institutional Health Care Appeals functions. The revisions were necessary in order to separate health care appeals from other institution appeals. On July 22, 2008, a joint memorandum (from CDCR Division of Adult Institutions and Plata Field Support Division) was distributed to all institution staff and patient-inmates advising them about the new health care appeals process. These memoranda are attached as Appendices 8 and 9. A statewide conference for health care appeals staff was held on July 23 through July 25, 2008, to provide training on the new policies and procedures and to answer any questions and concerns from institution staff. Additionally, CCLSU staff developed a brochure for the patient-inmate population describing the new health care appeals process and how it would affect them and distributed copies of the brochure to all institutions. The brochure is attached as Appendix 10.

Health Care Appeals – Office of Third Level Appeals

CCLSU management staff completed the hiring process for 15 of the 17 newly established positions for the Office of Third Level Appeals (OTLA). The new OTLA health care staff includes one Physician, 2 Nurse Consultant Program Reviews and twelve support staff. New OTLA staff attended the statewide conference for health care appeals and received additional training on the Health Care Appeals tracking system and drafting appropriate responses to third level appeals. On August 1, 2008, OTLA began receiving all third level appeals regarding health care issues. As of August 28, 2008, OTLA has received 544 third level appeals.

Tables 13 – 16 below display data related to Health Care Appeals for the second calendar quarter of 2008.

Table 13.

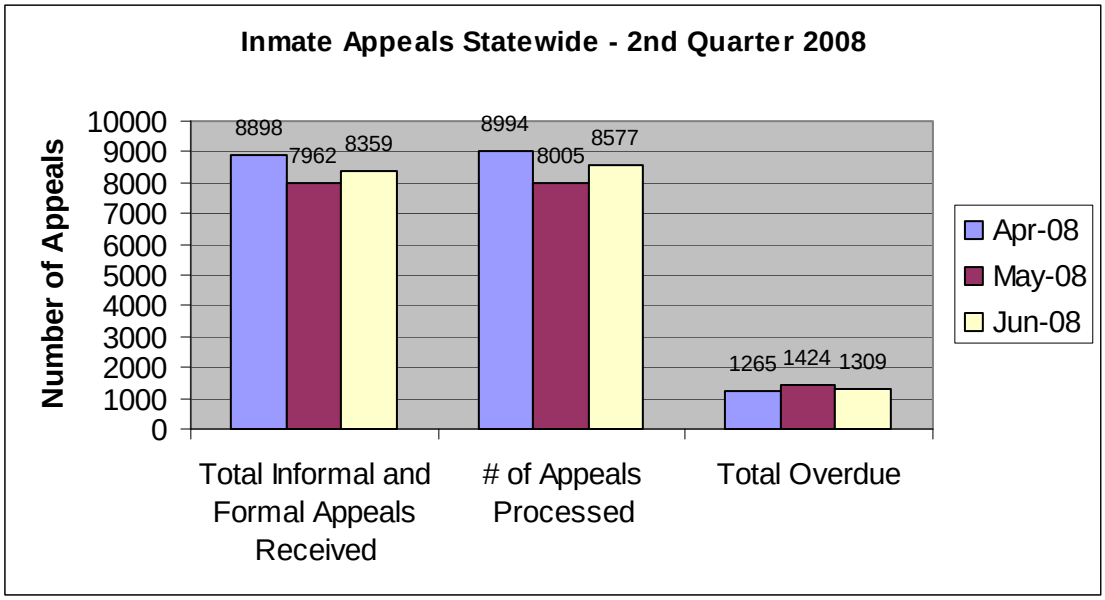


Table 14.

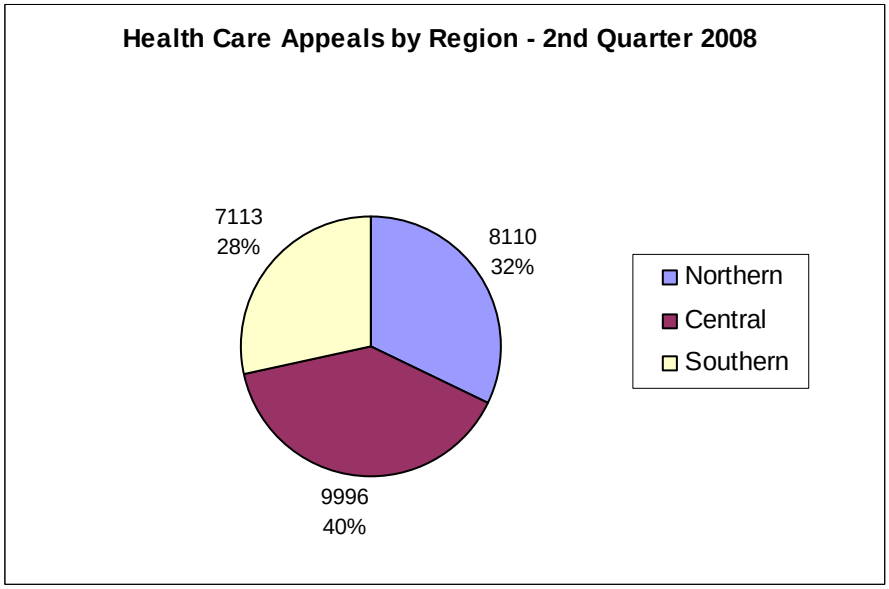


Table 15.

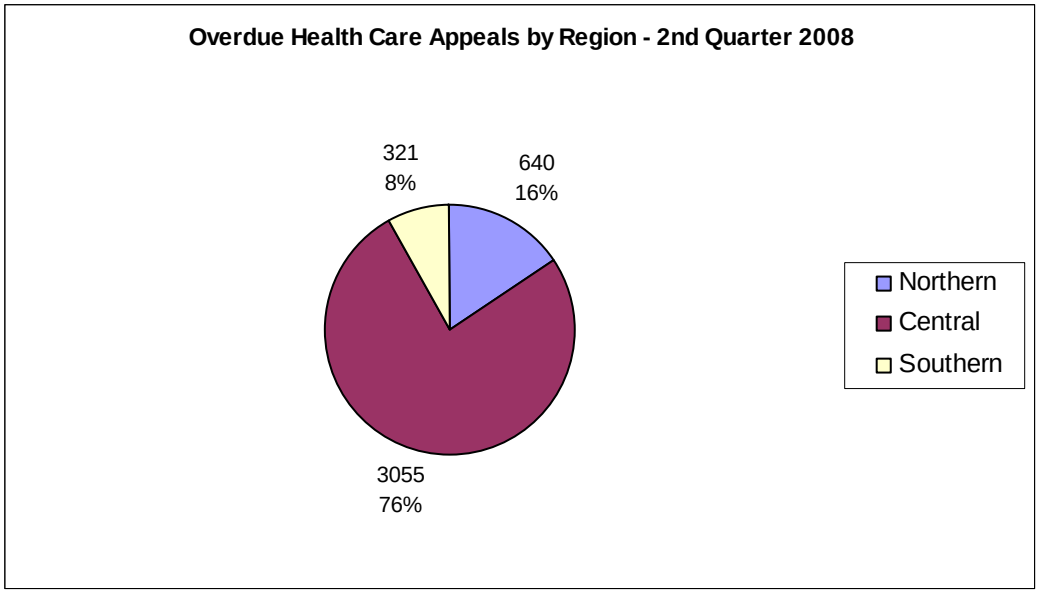
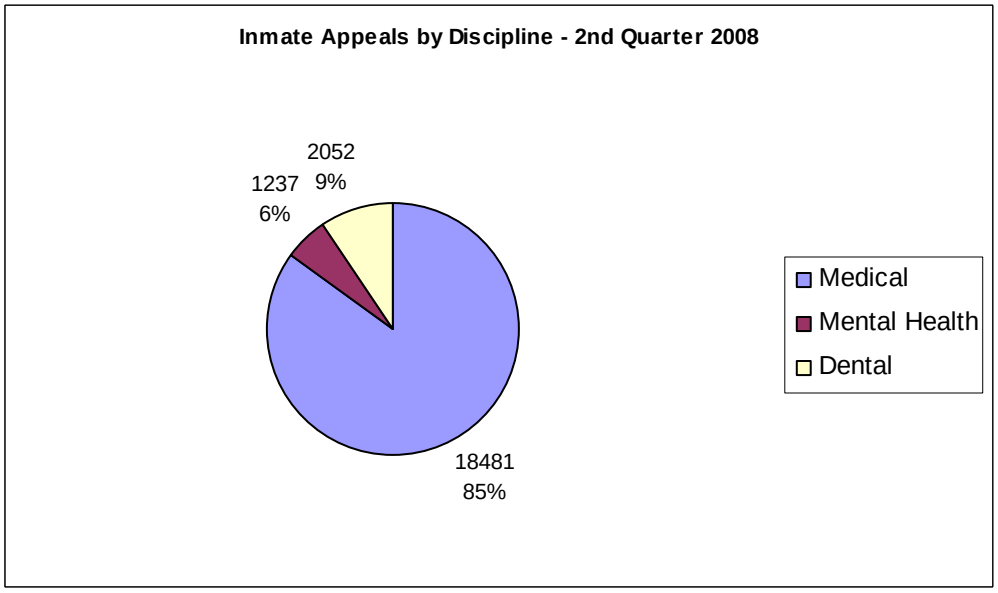


Table 16.



Action 4.5.2. By August 2008, a task force of stakeholders will have concluded a system-wide analysis of the statewide appeals process and will recommend improvements to the Receiver

To accomplish this action item, an action plan was created which included the coordination of the task force (including representatives from other class actions, other disciplines, and counsel); facilitating the task force meetings; identifying issues and recommendation; and forwarding the recommendations to the Receiver for review and approval. This action item is now complete.

During this reporting period, the task force of stakeholders concluded its system-wide analysis of the existing CDCR appeals process. Proposed improvements recommended to the Receiver included the following: (1) eliminating the informal level of appeals; (2) designating a Registered Nurse to triage each appeal for urgent or emergent health care issues; (3) establishing a Patient Advocate Liaison (PAL) position to precipitate face-to-face communication between patient-inmates and health care staff; and (4) establishing a correspondence program to resolve problematic patient-inmate health care issues that do not meet the appeal processing criteria, to address correspondence submitted form parties other than patient-inmates, and to informally resolve health care issues submitted by patient-inmates who do not have access to PAL (i.e. Administrative Segregation status, Out-to-Court status, etc.). It was also recommended that the proposed improvements be implemented on a pilot basis.

The recommendations and pilot program were approved by the Receiver's Chief of Staff on June 16, 2008 and is attached as Appendix 11. The pilot program will be implemented beginning November 1, 2008, at Central California Women's Facility, Mule Creek State Prison, Pelican Bay State Prison and California State Prison, San Quentin. New policies and procedures are in the process of completion, and will be submitted to representatives from the other class actions for review prior to submission to the Court.

Objective 4.6. Establish Out-of-State, Community Correctional Facilities and Re-entry Facility Oversight Program

Action 4.6.1. By July 2008, establish administrative unit responsible for oversight of medical care given to patient-inmates housed in out-of-state, community correctional or re-entry facilities

As previously reported, the COCF, Community Correctional Facilities (CCF) and Re-entry Program Oversight Unit (POU) has been in operation since November 2007. The Unit was originally staffed with one executive, 1 physician, 2 nurses and three support staff. As a result of the expanding COCF, CCF, and Re-Entry inmate population, the Unit has proposed a new organizational structure including additional staff resources which has been submitted to management for review and approval. Set forth below is a summary of specific actions accomplished during the reporting period.

Investigation at the Tallahatchie County Correctional Facility (TCCF) in Mississippi
As a result of the death of a California patient-inmate at the Tallahatchie County Correctional Facility (TCCF) in Mississippi, staff from the COCF Unit and the MOP conducted an on-site investigation. On June 3, 2008, after returning from TCCF in Mississippi operated by the Corrections Corporation of America (CCA), staff from the COCF and MOP briefed Receiver's staff regarding the preliminary findings of an investigation.

In June 2008, staff from the CDCR's COCF, MOP, and the Plata Field Support Division's POU, which has responsibility for the medical programs within the out-of-state facilities, met several times to develop a draft TCCF Remedial Plan. During the week of June 23, 2008, the aforementioned staff met with CCA representatives to finalize the Remedial Plan. As a result of

this meeting, a final TCCF Remedial Plan was presented to Receiver's staff. On July 1, 2008, the Office of the Receiver conducted an executive level meeting with all parties, including CCA, informing CCA and CDCR that a CAP was required to address the clinical and access to care findings of the on-site investigation.

During July and August 2008, the POU, CDCR, COCF, and MOP worked extensively with CCA to develop and finalize a CAP. The CCA CAP is available for viewing on the CPHCS website (www.cphcs.ca.gov). To summarize, CCA has agreed to implement the following remedial measures:

1. Implement the CAP in a timely manner at Tallahatchie.
2. Increase clinical staffing at Tallahatchie.
3. Seek approval by the Receiver's clinical team concerning all future physician hires that will treat California prisoners.
4. Establish a special CCA oversight organization to monitor and manage the health care provided to California prisoners at all CCA facilities which house California prisoners.
5. Over time, roll out the Tallahatchie remedial plan to all CCA facilities which house California prisoners, creating an internal CCA structure which will provide consistent medical care to California prisoners.

After some confusion during the initiation of the development of the CAP, CCA has worked diligently to address the concerns raised, and cooperation and coordination between the Receiver's staff, CDCR personnel, and CCA staff has been good. Furthermore, CCA has endeavored to commence implementation of the CAP in a timely fashion and has demonstrated a willingness to work closely with CDCR and Receiver's staff to address problems. Despite the timely development of CAP, however, five points require emphasis:

1. When the plan for out of state transfers was presented to the Receiver by CDCR and State officials, no one anticipated the level of monitoring of health care functions that would prove necessary.
2. The timely correction of problems at Tallahatchie has had a serious negative impact on the Office of the Receiver, drawing critical clinical personnel away form other important projects and delaying "in-state" remedial efforts. In essence, thousands of dollars of valuable clinical hours have been devoted to helping a private prison organization rework its medical delivery system (at the request of CDCR and State officials) in order to keep the out of state transfer process from collapsing. In fact, the in state remedial process has suffered as a result.
3. The Receiver's clinical executives have determined that medical screening standards for out-of-state transfers must be tightened, a program that will be implemented within 30 days.
4. The Receiver's clinical executives have also determined that certain "at risk" California prisoners in CCA facilities should be returned to California. The number of such patients appears to be small.
5. Given the need to oversee the implementation of the CCA CAP, the fact that CDCR does not have the clinical staff to evaluate CCA medical care, the number of prisoners the

State anticipates sending to CCA facilities, the geographical diversity of the locations of CCA facilities, and the need for enhanced levels of monitoring, the Receiver will be submitting, within 30 days, a request to the CDCR and State for very significant increases in clinical staff to effectuate the necessary clinical oversight of CCA facilities. Unless and until that staffing is provided, the Receiver's ability to approve out-of-state transfer and monitor out-of-state inmates will be limited.

Community Correctional Facilities

The POU staff, on a limited basis, continue to monitor the Community Correctional Facilities (CCF) and provide direction and oversight. Program staff is working with CDCR's CCF staff to modify the CCF Handbook, which is anticipated to be released during the upcoming reporting period. Additionally, staff has been working on developing a proposal to modify the current method of staffing the CCFs with health care professionals to ensure quality care is being provided to the patient-inmate population. It is anticipated that the proposal will be submitted to the Receiver during the next reporting period.

As explained above, however, the Receiver's ability to properly monitor CCFs has been limited due to the reallocation of resources required for the Tallahatchie remedial plan. The request for increased staffing described above will address this problem.

Re-entry Facilities Update

The CDCR continues performing pre-activation activity for the Northern California Re-Entry Facility, which is scheduled to open in approximately July 2009. Receiver's staff have worked collaboratively with CDCR in every step of the pre-activation efforts. Appendix 12 is the most recent letter from the Office of the Receiver regarding the approval of the planned physical plant and health care staffing for the NCRF.

Goal 5. Establish Medical Support Infrastructure

Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program

Implementation of the *Road Map to Excellence* continues to move forward in a deliberate and timely manner. The collective efforts of the pharmacy improvement program guided by the *Road Map* give priority to achieving improved patient safety and health outcomes, developing an evidence-based pharmacy practice and increasing cost-efficiency. Progress continues to be made in addressing each of these priorities. During this reporting period, activities have been focused upon extending implementation of the GuardianRx® pharmacy operating system to additional facilities; moving forward to build, equip and bring into operation a central fill pharmacy; updating staffing assessments, addressing pharmacy staffing needs and continuing the development of improved staff competencies; actively working with the ongoing CDCR Pharmacy & Therapeutics (P&T) Committee processes to maintain positive momentum; and, maintaining an active and aggressive purchasing and contracting program.

Action 5.1.1. Continue developing the drug formulary for the most commonly prescribed medications

Development and improvement of the Formulary continues. The P&T Committee has continued its monthly meetings to address formulary issues, discuss and approve Disease Medication Management Guidelines (DMMG), and review and approve pharmacy policies and procedures. The P&T Committee also realized an important milestone in June. The CDCR (CPR Edition) Formulary reached its one year milestone. The CDCR Formulary plays an important role in the Pharmacy *Road Map to Excellence* as adopted by the *Plata* Federal Court. Primarily, it is a key health care management tool oriented to the specific needs of the CDCR patient-inmate population, and reflects the goals of standardization of a contemporary, evidence-based, efficient, safe and cost effective correctional healthcare system.

During this reporting period, a formal request for a representative from the Department of Mental Health (DMH) to serve on the P&T Committee was approved, with participation beginning in August 2008. DMMGs for Schizophrenia, Major Depressive Disorder and Bipolar disease were prepared and reviewed. The Schizophrenia and Major Depressive Disorder DMMGs has been approved for implementation and the remaining one is pending final approval. Formulary additions were reviewed and approved for a number of additional medications. A therapeutic interchange program to facilitate appropriate dosing of Abilify (a formulary antipsychotic medication included in the Schizophrenia DMMG) was also approved.

During this reporting period, the Clinical Pharmacy Specialists conducted multiple in-service training sessions for health care providers, nursing and pharmacy staff on pharmacy policies and procedures, formulary changes and the non-formulary process.

As noted in earlier reports, the establishment of a viable, active and engaged P&T Committee process, the implementation of a CDCR-specific formulary that is managed on an ongoing basis, and the development of treatment medication guidelines that are evidence-based and focused on

patient safety are critical components of achieving improved cost-effectiveness in the system. This integrated approach provides a firm foundation for more effective pharmaceutical contracting. These responsive contract strategies and management continue to provide opportunities for cost avoidance. As displayed in Table 17, in the first seven months of 2008, Maxor has documented cost avoidance of $8,466,155 from the use of targeted contracting strategies resulting from P&T Committee decisions.

Table 17.

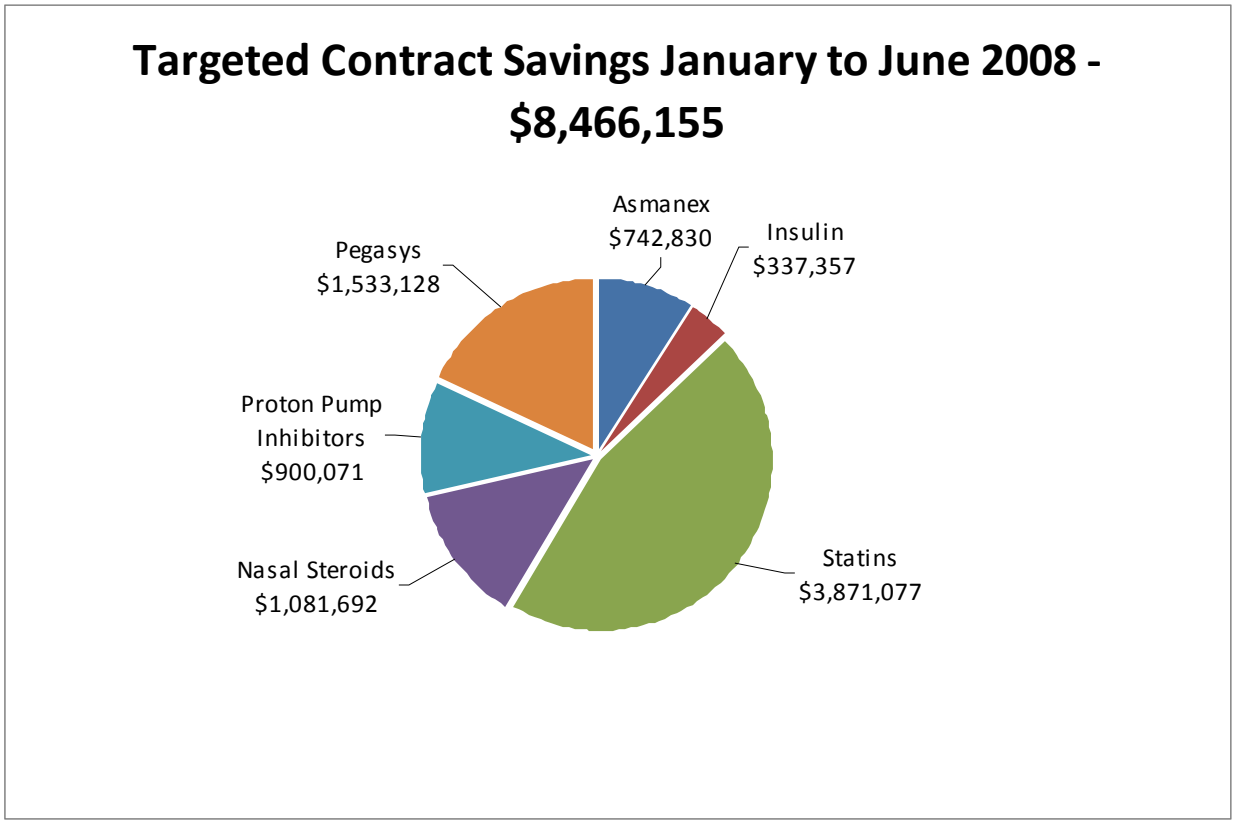


Table 17 Results Explanation*: These categories represent specific P&T Committee initiatives targeting particular drugs or drug classes. Savings calculated by comparing purchases using the actual targeted contract rate to the pre-targeted contract rate.*

Contract, purchase, and inventory monitoring efforts also continue to yield results by avoiding unnecessary costs due to out-of-stock orders and ensuring that the correct contracted items are purchased. Targeted contracts, order management activities, and the implementation of a new wholesaler agreement tailored specifically to address the pharmaceutical needs of the CDCR health care system have contributed to cost avoidance. As displayed in Tables 18 and 19, total cost avoidance when compared to the prior purchase trend is more than $16.8 million.

Table 18.

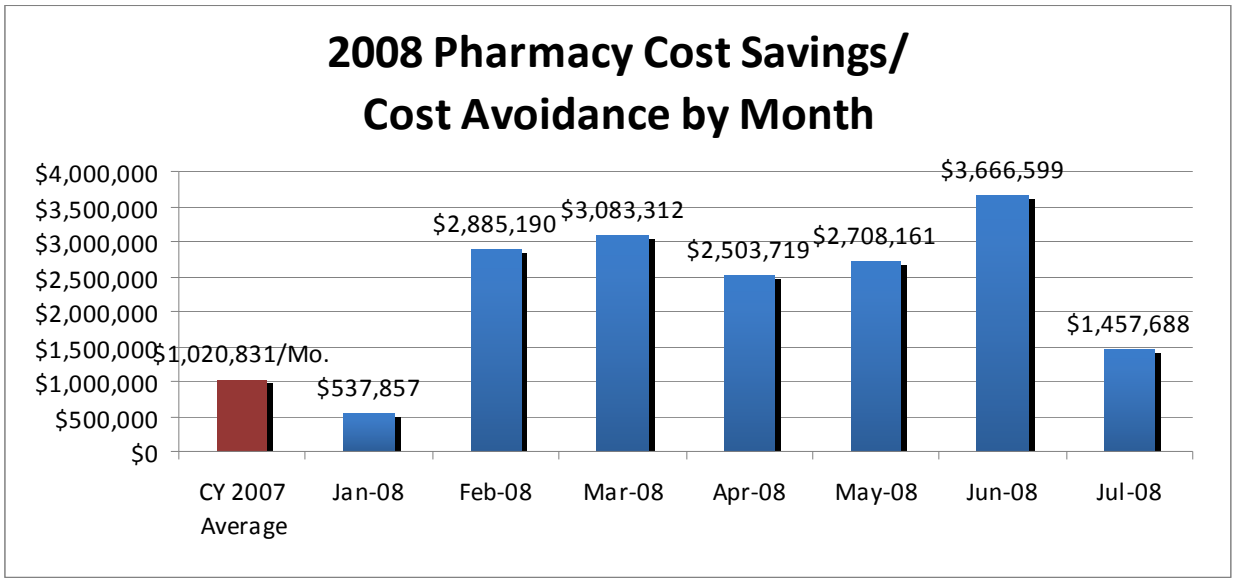


***Table 18 Results Explanation**: Cost savings/cost avoidance calculated based on comparing actual wholesaler purchases to prior historical trendline (also based on wholesaler purchases). Data pulled monthly from Wholesaler Purchase data. Maxor began managing pharmacy purchasing in April-May 2007.*

Table 19.

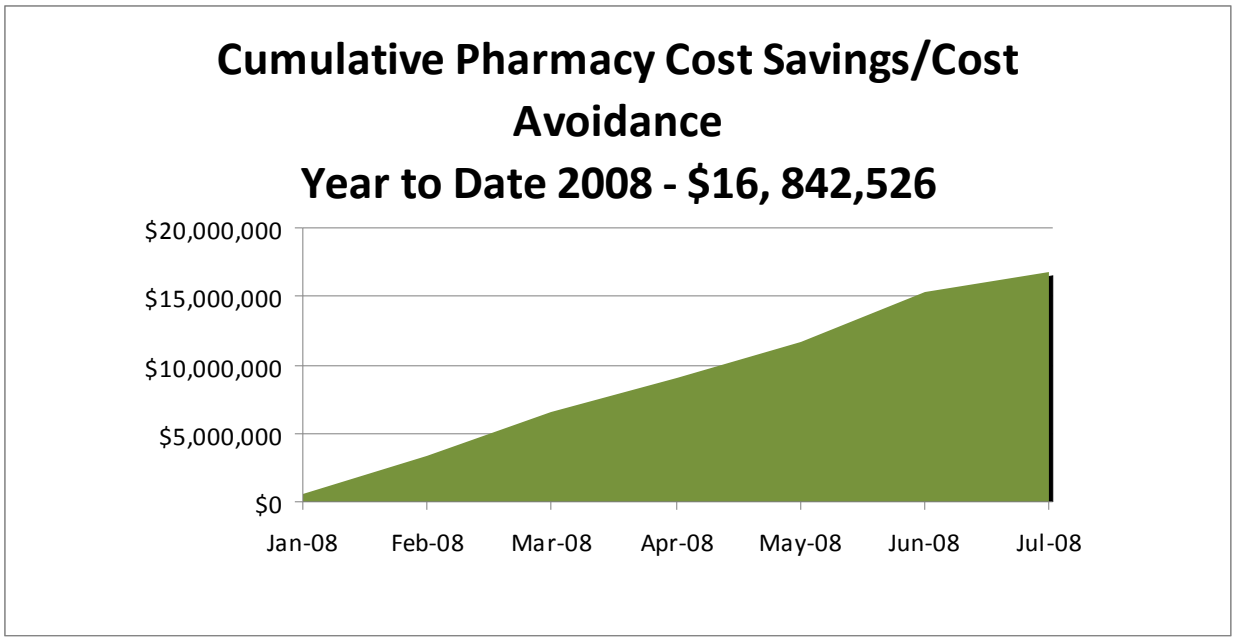


***Table 19 Results Explanation**: Savings/Cost Avoidance is calculated by comparing actual wholesaler purchases to prior wholesaler purchase trend line. Maxor began managing pharmacy purchasing in April-May 2007.*

***Action 5.1.2. By June 2009**, improve pharmacy policies and practices at each institution and complete the rollout of the GuardianRx® system*

Pharmacy Policies and Practices

The CDCR P&T Committee has continued its work on a complete revision of the Pharmacy Policies and Procedures, reviewing and updating them to reflect improved practice standards, implement quality control measures and standardize pharmacy processes. The P&T Committee approved revisions to Chapter 7 (After Hours Pharmacy Services); Chapter 23 (Repackaging and Compounding of Non-Sterile Medications); Chapter 28 (Parole & Discharge); Chapter 29 (Impaired Pharmacy Personnel) and approved new procedures in Chapter 37 (Pharmacy Staff Scheduling and Position Appointments); Chapter 38 (Prescription turn-Around Time); and Chapter 16-Appendix I (Guidelines for Handling Pharmaceutical Waste). Additionally, Chapter 30 (Drug Regimen Review) was deleted and replaced with a new "Guidelines for Profile and Drug Regimen Review" including a chart abstraction form. Chapters 15 (Directly Observed Therapy and 31 (Pharmacy Terms) were deleted because the items were determined to be adequately addressed in other policies.

Maxor continues to provide support for policy implementation as well as monitoring for adherence to pharmacy policy and procedure. Clinical Pharmacy Specialists provide in-service and implementation support to facility staff as new procedures are released. A statewide Pharmacist-In-Charge (PIC) meeting was held on July 10, 2008 and was well attended. Training included Chapter 21 (Reporting theft or loss of medications); Chapter 16, (Handling of Pharmaceutical Waste); Diabetes Disease Medication Management Guideline (DMMG); and pharmaceutical contract compliance. Additionally, an update on the status of the *Road Map* goals and objectives was provided.

Also during this reporting period, a transition to a process of centralized hiring for Pharmacist I and Pharmacist II positions was implemented. This effort, initiated by the Office of the Receiver and involving both Maxor and CDCR, is intended to assist in filling critical vacancies for pharmacists and includes updated processes for credentialing, coordination of interviews and making final selections. Standardized duty statements for both Pharmacist positions have been developed and are currently under review. Reference check questionnaires and scored interview questionnaires have been developed. Interviewing for vacancies using the revised hiring process commenced in July 2008. Three candidates have been recommended for hire and offers are pending approval of standardized duty statements.

The pharmacy inspection process has been well established with documented movement towards compliance across the state. The number of pharmacies with an inspection rating score of pass/problem (not failed) has increased from 21 percent in March 2007 to 64 percent in July 2008. The Maxor team is also continuing its efforts to objectively validate the improvements for any facility moving from non-passing to passing status in their monthly inspection reports. To date, inspection status has been validated for 12 facilities (Chuckawalla Valley State Prison, Ironwood State Prison, Richard J. Donovan Correctional Facility, Calipatria State Prison, Centinela State Prison, California State Prison Los Angeles County, California Rehabilitation

Center, California Institution for Women, California Institution for Men, Wasco State Prison, North Kern State Prison, and California Correctional Institution). Pharmacy inspection status data is displayed in Table 20.

Table 20.

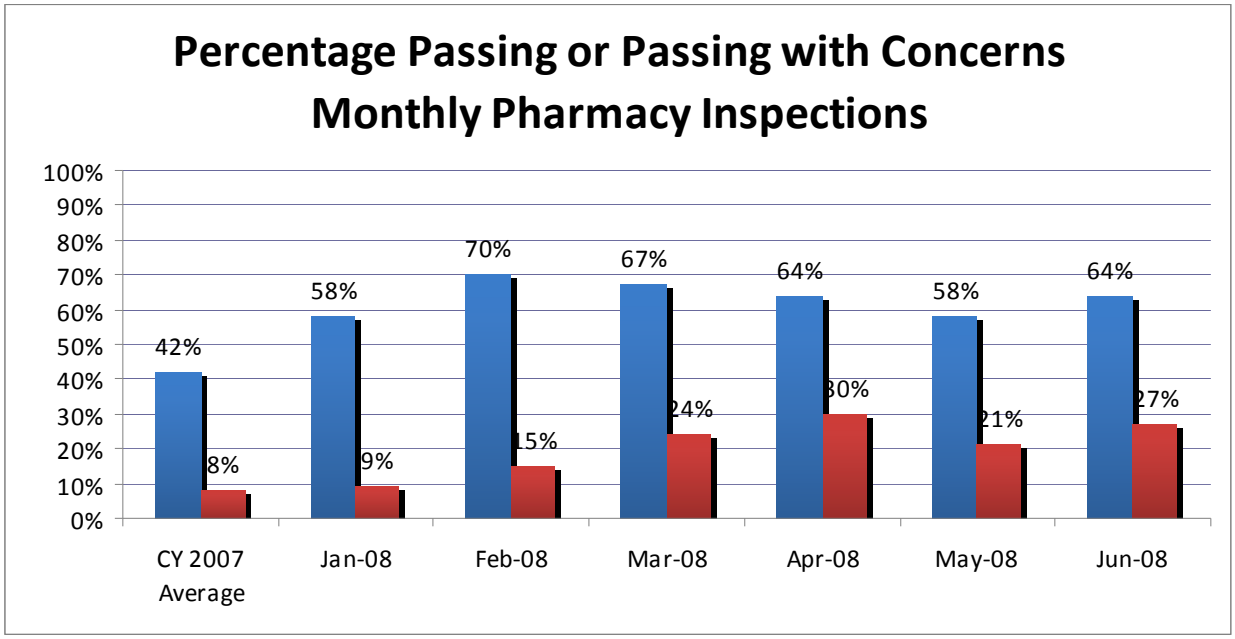


Table 20 Results Explanation *Pharmacy areas are denoted in blue, and non-pharmacy locations (medication administration locations) are denoted in red: Independent Maxor Validation of Monthly Inspection Data began in Feb 2008.*

Rollout of the GuardianRx® System

The GuardianRx® pharmacy operating system has been successfully implemented in 14 sites (California Correctional Center, High Desert State Prison, Folsom State Prison, Mule Creek State Prison, California State Prison San Quentin, California State Prison Sacramento, California Men's Colony, Chuckawalla Valley State Prison, Ironwood State Prison, California State Prison Corcoran, Substance Abuse Treatment Facility, Central California Women's Facility, Valley State Prison for Women, and California Institution for Women). Group training for PICs on the GuardianRx® system and the implementation process has continued as scheduled.

During July 2008, a review of the GuardianRx® implementation schedule was initiated to assess progress following conversion of the first third of the state's facilities. A decision was jointly reached and approved by members of the steering committee to revise the GuardianRx® rollout schedule in order to allow time for more training, to improve efficient use of limited rollout team resources and to allow facilities with significant infrastructure issues additional time to address those challenges. A revised schedule is under review and will be issued upon approval by the Receiver's staff.

Additionally, as the initial GuardianRx® implementation and deployment proceeds, work has begun on the next phase of the project intended to extend automation efforts out from the pharmacies to the actual medication management process. Maxor leadership met with Receiver's staff in July 2008 to discuss aspects of this critical next step.

Maxor is on schedule to improve pharmacy policies and practices at each institution by June 2009. The roll out of the GuardianRx® system has been delayed, as described above, and is not on schedule to complete implementation statewide by June 2009. A revised schedule is under review and will be included in the next Quarterly Report.

Action 5.1.3. By February 2009, establish a central-fill pharmacy

Work continues related to the establishment of a Central Fill Pharmacy Facility for the CDCR. The pre-centralization ambulatory model is being defined and implemented as processes are standardized and validated as part of the GuardianRx® implementation work plan.

During this reporting period, two key recommendations related to the Central Fill Pharmacy Facility were finalized: selection of a site location for the facility and selection of an automation vendor to design and equip the facility.

A site recommendation was prepared for consideration by the Office of the Receiver. A meeting to review the final recommendation was held on July 23, 208 and a final selection decision letter was approved on July 30, 2008. With the final recommendation approved, representatives of the Department of General Services, CDCR and Maxor are working to negotiate final lease and/or purchase terms with the property owner.

Concurrently, work was finalized on the related recommendation to address automation needs for the Central Fill Pharmacy facility. The RFP for automation needs was issued on May 8, 2008 with responses due June 20, 2008. A mandatory bidder's conference was held on June 3, 2008, with a number of potential bidders in attendance. Four detailed proposals were received in response to the RFP and were evaluated by an evaluation team including representatives of Maxor, CDCR and the Office of the Receiver. On July 9, 2008, two firms were selected to make oral presentations and to address follow-up questions. A finalized recommendation for selection of an automation vendor was prepared and presented to the Office of the Receiver on July 23, 2008. Additional internal coordination at the request of the Receiver's Chief of Staff was conducted and a final selection approved in mid-August. Negotiation of a final contract for the automation has been initiated and work on the Central Fill Facility is anticipated to begin immediately upon contract approval.

Establishment of the Central Fill Pharmacy is proceeding; however there was a delay in the site selection and site acquisition which has offset the overall completion timeframe. A revised schedule will be included in the next Quarterly Report.

Maxor's monthly reports for June and July 2008 are provided as Appendices 13 and 14 respectively.

Objective 5.2. Establish Standardized Health Records Practice

Action 5.2.1. By February 2009, create a roadmap for achieving an effective management system that ensures standardized health records practice in all institutions

To create a standardized health records practice that supports constitutionally-adequate healthcare system, we need to assess CDCR's current operations, create a roadmap for transformation of the system to support health records best practices, build a plan based on the road map, and implement the plan. The Receivership is on schedule with its vision for remediation of health records management.

In the most recent reporting period, the Office of the Receiver selected Sourcecorp, Inc. from a bidder's pool that included 12 highly competitive proposals, to provide health information management (HIM) professional services. Sourcecorp, Inc. initiated their work on September 1, 2008. The contract goal is to transition the current paper-based HIM operation to one based on industry best practices and standards applicable to the correctional environment. The major objectives of this initiative are to remediate health information management within CDCR to enable cost-effective, constitutionally adequate, cost-effective healthcare for all patient-inmates and to standardize records processes as a preparatory step for the eventual implementation of an electronic health record (EHR). Specifically, Sourcecorp's scope of work includes establishment of effective leadership and management oversight over CDCR's health record services; preservation of the integrity and continuity of the health record; updated policy and procedures regarding the security and confidentiality of the health record; updated policies and procedures; development of the structure of the HIM organization at the local and Headquarters levels; evaluation and, as necessary, remediation of the physical infrastructure of, the 33 prison health record departments; evaluation of the HIM automation infrastructure of all prison medical record departments; and establishment of management controls over HIM processes.

The Sourcecorp engagement will be divided into two phases. Phase I deliverables, due in January, include an overall assessment of CDCR's health records management and a road map for remediation. Upon the Receiver's approval, Sourcecorp will proceed to Phase II, which includes implementation of the Phase I recommendations and creation of a management structure that can eventually be transitioned back to the State over the course of 19 months. Sourcecorp has also been asked to help plan for a document imaging and scanning project, and to help with planning for construction of the Receiver's new healthcare prison facilities as it relates to HIM and health record issues.

Objective 5.3. Establish Effective Radiology and Laboratory Services

Action 5.3.1. By August 2008, decide upon strategy to improve medical records, radiology and laboratory services after receiving recommendations from consultants

Medical Records

A strategy for improving medical records has been achieved and is detailed above in Goal 5, Objective 5.2.

Radiology Services

A strategy for improving radiology services has been achieved. In late July, the Receiver's radiology consultants, McKenzie-Stephenson, Inc. presented CPHCS with a comprehensive assessment of CDCR's medical imaging services and a road map for future improvement. Areas covered included operations, technology, professional services, physical infrastructure, and financial impact across the entire domain of imaging, including radiology, CT, MRI, and ultrasound. The cover sheet and Executive Summary of the McKenzie-Stephenson, Inc. report is included as Appendix 15, and the complete report is available for viewing on the on the CPHCS website (www.cphcs.ca.gov).

McKenzie-Stephenson, Inc.'s assessment found that "the diagnostic imaging care continuum...currently 'functions' in a state of disrepair throughout each operational, technical, and professional level of service…If urgent action is not taken to remediate numerous problematic areas, the current mixture of deficient work processes, lack of leadership, poor technology decisions, violations of regulatory mandates, nonsensical goods and services contracts, and a profound absence of industry standards may actively cause harm to inmate-patients and staff." As part of their assessment, McKenzie-Stephenson, Inc. created a medical imaging road map for planning and stabilization; building and integration of an imaging program; operational deployment and adoption; and monitoring and measurement. Major recommendations included transition to a fully digital imaging system; expanding in-house services to include distributed radiology, CT, ultrasound, and mobile MRI; and creation of a core professional radiology reading environment. McKenzie-Stephenson, Inc. presented evidence that implementation of their recommendations could result in annual savings to the state of $67 million after two years.

The Receiver has retained McKenzie-Stephenson, Inc. to provide strategic planning advice for the 10,000 bed construction project. We are currently preparing an RFP for professional services for outsourced management of our Enterprise Imaging Program (similar to the Maxor model) to implement the McKenzie-Stephenson, Inc. recommendations.

Laboratory Services

Consultants from Navigant presented the Receiver with an assessment, road map, and recommendations for remediation of laboratory services in April 2008. The cover sheet and Executive Summary of the Navigant report are included as Appendix 16, and the complete Navigant report is available for viewing on the CPHCS website (www.cphcs.ca.gov). The Receiver adopted these recommendations, and thus has achieved the objective of forming a strategy for improving laboratory services.

Due to delays created by SPB concerning the establishment of certain clinical executive RCEA positions, the Receiver has been unable to secure administrative leadership for the laboratory program to implement the strategy. The Receivership currently has an open candidate search for the position of Chief Medical Officer, Laboratory Services.

Objective 5.4. Establish Clinical Information Systems

Action 5.4.1. By July 2009, establish a clinical data repository available to all institutions as the foundation for all other health information technology systems

In October 2007, the Receivership issued a RFP for a clinical data repository and portal solution. The goal of the project is to store key patient health information, such as current medications, allergies, lab results, encounters, problems, etc., in a standardized manner and make this information available to providers at the point-of-care to support clinical decision making. In the end, 20 vendors submitted proposals in response to the request. The proposals were reviewed over a three week span by a proposal review committee that consisted of members of the Receiver's IT team, a representative from the *Coleman* case, CDCR healthcare services staff, and a nationally-recognized expert in health information technology retained by the Receivership to assist it during the selection process.

The proposal review committee subsequently selected six proposals to evaluate further and invited the respective vendors to interview with the Receivership. The vendors selected were: 3M Health Information Solutions, Accenture, Allscripts Healthcare Solutions, Emergis, IBM, and Medicity. The Receivership conducted in-person interviews from December 12 through December 17, 2007 in the former San Jose office. The interviews involved meetings with three separate evaluation committees: a) executive committee consisting of senior management from both the Receivership and CDCR healthcare services, as well as representatives from the *Coleman* and *Perez* cases; b) clinical user committee consisting of CDCR clinical staff (e.g., physicians, dentists, nurses, psychiatrists, etc.) from a variety of institutions throughout the state; and c) technical committee consisting of members of the Receivership IT team, a representative from the *Coleman* case, CDCR healthcare services staff, and a nationally-recognized expert in health information technology retained by the Receivership.

After the interviews, each of the committees submitted their respective recommendations to the Receivership IT team. The solution stack proposed by both Accenture and IBM was the first choice of all three committees, followed by 3M and Allscripts. The team subsequently conducted due diligence activities in January and February 2008 – meeting with vendor product teams, performing site visits, interviewing current and former product managers, etc. On February 28, 2008, the Receivership issued a notification of award to IBM, indicating that it had been selected to deliver the clinical data repository and portal solution, pending the successful completion of contract negotiations.

In June 2008, the Receivership successfully concluded contract negotiations with IBM, Initiate Systems, and Orion Health for a clinical data repository and portal solution and began formal implementation efforts in July 2008. During the week of July 7, 2008, IBM in conjunction with Receiver's staff conducted a week long work session to orient the subcontractors (Initiate, Oracle, and Orion Health) and initiate project planning efforts. Subsequently on July 15, 2008, the Receiver's staff held a project kick-off meeting in Sacramento to provide key stakeholders with an overview of the solution as well as key project information. Among those in attendance

were representatives from CDCR, the *Coleman* and *Perez* courts, DMH, OIG, as well as senior members of the Receiver's staff.

As previously reported, IBM is the lead system integrator on the project. The Receivership expects to pilot the initial release of the system at select institutions beginning in April 2009. Currently, IBM and its subcontractors (Initiate Systems, Oracle and Orion Health) are in the first of the six phases of the project. During this phase of the project ("Solution Outline"), the IBM project team is establishing an overall project management methodology, completing staffing of the project team, establishing the overall technical architecture of the solution, developing detailed system functional and non-functional requirements, creating design documentation, and building out the development environment. The project team has also initiated discussions with Maxor to plan for the exchange of medication-related patient-inmate information and similar discussions with Quest Diagnostics, Foundation Laboratory, and the microbial disease laboratory of the California Department of Public Health for the exchange of laboratory results.

On August 4 and August 5, 2008 the Receivership and the IBM project team conducted a two-day session to design the clinical portal through which CDCR clinical staff will be able to access patient-inmate health information as well as future clinical information systems. In order to ensure that the clinical portal solution would meet the needs of its target user audience, the Receivership convened a clinical user advisory group. The clinical user advisory group was composed of clinical staff from a variety of disciplines (dental, medical, mental health and nursing) and included representatives from institutions from throughout the state. It had been established initially in December 2007 to assist the Receivership in its selection efforts related to the clinical data repository. During the two-day session, led by the Receivership's Chief Medical Information Officer, the group assisted the IBM project team in developing specific requirements around the functionality scheduled to be rolled out as part of the initial release of the solution and provided valuable insight into current clinical workflows and processes. The group's feedback regarding the design session was very positive, as were their comments about the project as a whole. The Receivership will be subsequently utilizing the members of the group as project "champions" at their respective institutions to build further support.

The solution outline phase of the project is approximately two and a half months in duration and is scheduled to be completed by the end of September, 2008. At the conclusion of this phase, IBM will produce the first of the project's deliverables, which will include a finalized project plan, system requirements documentation, technical architecture specifications, and solution strategy documentation. Upon acceptance of these deliverables by the Receiver, the project will then move into the second phase ("Solution Design").

The Clinical Data Repository project is on schedule.

Objective 5.5. Expand and Improve Telemedicine Capabilities

Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure

This action item is not on schedule due to delays created by SPB concerning the establishment of certain clinical executive RCEA positions. As a result of SPB's inaction, the Receiver has been unable to recruit an executive leader for the telemedicine program in a timely manner. Additionally, a majority of the recommendations contained in the University of Texas Medical Branch's (UTMB) assessment and telemedicine roadmap report still cannot be implemented until a new and robust Health Care Information Network has been rolled out to all 33 institutions.

In the interim, the Office of Telemedicine Services (OTS) continues to focus on issues which can be addressed at this time. For instance, in an effort to improve efficiency and increase services to the patient-inmate population, CPHCS management has completed an analysis of the current processes within the OTS and has implemented changes to improve the efficiency of staff. In June 2008, the OTS increased its number of patient encounters by 34.5 percent over the same period last year, and in July 2008, the number of encounters increased by 38 percent over the same period last. The OTS is also working collaboratively with the Supervising Psychiatrist and Mental Health staff to increase services to a number of institutions.

On June 2, 2008, the OTS met with the Contracts Branch and the Healthcare Invoice, Data and Provider Services Branch to discuss issues with current contact language and the development of additional contracts to increase the network of telemedicine providers. Additionally, a project manager has been brought on board and is currently working on developing and implementing a new process for on-boarding medical facilities and specialty providers to expand the off-site specialty provider network. The new process will include clear guidelines, processes and responsibilities, in addition to measurable outcomes, and will be tested through a series of pilots. On August 29, 2008, the project manager met with various stakeholders to discuss the development of the project charter and the next meeting is scheduled for September 2008.

Goal 6. Provide for Necessary Clinical, Administrative and Housing Facilities

<u>Objective 6.1.</u> Upgrade administrative and clinical facilities at each of CDCR's 33 prison locations to provide patient-inmates with appropriate access to care

Action 6.1.1. By January 2010, complete assessment and planning for upgraded administrative and clinical facilities at each of CDCR's 33 institutions.

The assessments and planning to renovate or build new clinical space at each of the 33 prisons continues. The Facility Master Plans for the Correctional Training Facility, California Rehabilitation Center and Mule Creek State Prison (the second, third, and fourth prison respectively to undergo the planning process) have proceeded into implementation of the design and construction phase. The Receiver filed and received in July 2008 Waivers of State Law from the Court. Implementation subsequently began on August 8, 2008 for Mule Creek State Prison and will continue with a staggered kick-off of Correctional Training Facility and California Rehabilitation Center incrementally in three week intervals.

Facility Master Plans for California Institution for Women, California Institution for Men, Richard J. Donavon Correctional Facility and Folsom State Prison (the firth, sixth, seventh, and eighth prisons respectively to undergo the planning process) have been completed and approved by the respective Warden; Associate Warden, Health Care Services; Chief Medical Officer; and Director of Nursing as well as a member of CDCR's Facility Management. The Master Plans have been reviewed by an architectural consultant and are awaiting approval by the Receiver. Additionally, the Planning for California State Prison, Sacramento; California Correctional Center; and High Desert State Prison have been completed with final reports prepared. Similar to the previous assessments, an analysis of existing facility space was completed at these prisons and multiple coordination meetings (inclusive of court designated representatives from the *Coleman* and *Perez* litigation as well as the CDCR's Facilities Management) were held to review concepts and coordinate needs specific to each prison.

Final approval of these Master Plans has been suspended as a result of recent considerations to integrate mental health and possibly dental space needs into the Master Plans. This effort is intended to specifically determine standards for the mental health space needs in light of the 5,000 new mental health beds being planned by the Receiver in new health care facilities. As these new beds come on-line over the next three to five years, mental health program space needs in the existing prisons will change. Plans must take into account all these factors.

Consistent with the established master schedule, planning was initiated at Sierra Conservation Center on August 12, 2008 and two progress meetings were held. This effort has also been suspended pending determination of impacts from the possible integration of future mental health space needs into the program scope.

At this time, efforts are underway to define a strategy for gathering mental health and dental program data and information and to allow the team to adjust the budget model to determine the

impacts to the program budget. In order to complete this effort, the progress of the planning teams has been suspended and the teams will be dispatched to some of the remaining 23 prisons that have not been visited for planning purposes and to gather baseline information that will allow the budget model to be accurately developed. Upon completion of the updated budget model in the next 30 to 45 days, it is anticipated that the Office of the Receiver together with CDCR will agree upon the planning scope to be included to meet the program budget. This exercise is anticipated to delay the Master Planning Schedule by possibly 60 to 90 days and could possibly result in a delay to the overall Implementation completion as well.

Looking ahead, the Master Schedule for planning and assessments of the remaining prisons will undergo further revision to adjust for the time needed to assess the impact of the expanded scope to include mental health and possibly dental programs, as well as the possible expansion of the approval process to facilitate these departments. Upon completion of the updating of the budget modeling and the impact analysis in the next 30 to 60 days, the Office of the Receiver will then be able to determine the final scope of the program components and make adjustments to the Master Schedule accordingly in order to determine the impact and possible delay in completing a Master Plan for each prison by January 2010.

The special planning project to address inadequate treatment space at the Salinas Valley Psychiatric Program (Intermediate Care Facility) has been completed and submitted to the Receiver for consideration and approval. It appears that neither the CDCR nor the DMH have funding for this project; therefore, how and when it will be implemented has yet to be determined.

Action 6.1.2. By January 2012, complete construction of upgraded administrative and clinical facilities at each of CDCR's 33 institutions

Presently, San Quentin State Prison, Avenal State Prison and Mule Creek State Prison are the only prisons in the implementation phase of design *and* construction.

As a result of the Receiver's recent tour of the prison, additional projects were added to the Avenal State Prison Facility Master Plan. An Addendum was completed, agreed to by the Institution as well as CDCR Facilities Management and approved by the Receiver. The Addendum includes the following: (1) adds shade canopies to the central core mobile clinics location and at the pill distribution areas on each of the six facilities, (2) revises the Administrative Segregation clinic from an interior renovation to a new modular clinic building adjacent to the housing block, (3) provides additional space for the Custody Access Team within the modular Health Services Administration building, (4) expands the existing Medical Records building, and (5) adds an additional area to Building 390, the Central Health Services building, for inmate waiting. The Addendum increases the previously approved Master Plan budget of $27,500,000 to $33,429,830. The Vanir Master Plan Addendum for Avenal State Prison is included as Appendix 17, and Vanir's June and July monthly reports for Avenal State Prison are included as Appendices 18 and 19.

Despite the modifications to the design, the implementation phase of construction at Avenal State Prison has continued. Based on the recommendations of the County Department of Public Health, an occupational health and safety consultant was hired to assist with finalizing the Valley Fever mitigation plan. The report is in final stages and will be incorporated into the bid documents for construction as well as processes and training of staff. The design-build documents for the modular health services clinics, Administration, and Administrative Segregation buildings were completed and advertised. A pre-bid meeting is scheduled for early September with bids scheduled to be received at the end of September 2008. Bid documents for the medical supply warehouse are being finalized and the projects added as a result of the Addendum are being initiated in order that they may duly be issued for bids as well. All six additional mobile clinics as required in Project One have been delivered and are fully operational and in use by health care staff to see patients. The Infirmary and Pharmacy renovation is in progress and furnishings for the Pharmacy are in the process of being scheduled for bidding to allow installation in advance of Guardian Rx® implementation in October 2008. Upon completion of the Pharmacy (Building 395) the renovation of Building 390 will begin. The final construction completion date is on schedule as planned.

While upgrade planning is proceeding in a timely manner, even if somewhat behind, the actual upgrade construction program for all prisons is not on schedule because defendants have failed to fund the prison upgrade construction program. Thus, Action 6.1.2 is behind schedule. As a result, the Receiver has filed a motion re contempt as described in Section 5.

Objective 6.2. Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs

Action 6.2.1. Complete pre-planning activities on all sites as quickly as possible

Site evaluations are continuing at eight existing CDCR locations. The Environmental Impact Report (EIR) process is being implemented in compliance with the California Environmental Quality Act (CEQA) at each site.

Community Outreach materials are being prepared to assist the communities in understanding why these facilities are being built, what will happen in these facilities, and what impact these facilities will have on the communities. These materials will help to communicate to the public more effectively and make getting information out more efficient.

Action 6.2.2. By February 2009, begin construction at first site

Plans for the seven new facilities have been refined and described in documents published to serve as the basis for the detailed facilities design. The draft Facilities Program Statement, (FPS), a 900 page document, was completed July 22, 2008, describing initial thoughts and considerations concerning possible facility requirements. Initial programs have been developed for three facility types to serve as the basis for planning and design for construction. The initial programs will evolve significantly as planning and design phases continue.

An agreement was executed with each of the selected Integrated Project Delivery (IPD) teams on July 1, 2008 for participation in a six-month Co-Opetition phase of work. The firms selected are: Project Production Systems Laboratory; Lean Project Consulting; and Strategic Project Solutions, Inc. The IPD process has been adapted to the specific needs of the 10,000 bed program. This preliminary design and validation phase, calling for both collaboration and competition, is referred to as Co-Opetition. This Co-Opetition phase is a process in which the three IPD teams work collaboratively and competitively to develop two prototypical facility designs. At the completion of the Co-Opetition, each IPD team will submit separate and competing design-build proposals, which will serve as the basis for selecting the team to negotiate a contract to design and construct the "first fastest" facility.

It is anticipated that the first site will be located in Stockton. Engineering evaluation of infrastructure systems is underway. The administrative draft EIR (ADEIR) is scheduled to be released to agencies in September 2008 and released to the public in October 2008. The EIR is scheduled for certification in February 2009 which will enable the start of construction.

Meanwhile, however, defendants have failed to take the steps necessary to ensure funding for this project. As a result, the Receiver has filed a motion re contempt as described in Section 5.

Action 6.2.3. By July 2013, complete execution of phased construction program

A project manager has been retained to track the activation projects, tasks and resources necessary to have the first building fully operational by the time it is scheduled to open in 2011. The project manager is building a master project schedule that will track all items. A transition team is in the process of being staffed, and will include representatives from medical, mental health, dental and custody, and inmate programs. This team will report on the progress and consult with the Office of the Receiver and URS Bovis Lend Lease (URS/BLL). Additionally, the Office of the Receiver has embedded staff at URS/BLL working as part of the Core Planning Team and Integrated Project Delivery Teams to identify and drill down on operational and space requirements.

The necessary planning and programming is taking place to ensure the implementation of a timely and fiscally responsible phased construction program by July 2013; however, until an adequate funding stream is established, this schedule is in jeopardy.

Objective 6.3. Complete Construction at San Quentin State Prison

Action 6.3.1. By December 2008, complete all construction except for the Central Health Services Facility

Four of the eight projects in Construction Package One are complete. The completed projects are: Project Two, Replacement Parking Spaces; Project Three, Relocate Exercise Yard; Project Five, the Triage and Treatment Area Renovation; and Project Eight, Addition of Re-locatable Office Space Trailer.

The following is an update on each of the four remaining projects in Construction Package One. Project One, the Personnel Offices, was authorized by the Office of the Receiver on March 24, 2008 and the builder's contract was subsequently signed. The builder was given a Notice to Proceed with construction on March 26, 2008. At the time of this report, construction is approximately 50 percent complete. Rough framing is complete. The roofing is complete; window and door frames installed, and installation of the exterior plaster and interior sheetrock are in progress. The soil contamination issue, where the soil was discovered to have nickel content that was slightly above hazardous level, is resolved as well as the issue of over saturated soil. Both events were encountered during the early earthwork activity and resulted in a combined delay of 23 calendar days. Since then, there have been no other owner caused delays. Overall, the contractor is approximately 20 days behind schedule but gradually recovering the lost time. The completion date is late October 2008.

Project Four, Medical Supply Warehouse, is currently in the design phase. Bids were received on March 31, 2008 and a Selection Panel chose W. E. Lyons as the design/build entity. A Notice to Proceed was issued on June 26, 2008; the project duration is 240 calendar days and the contract completion date is February 25, 2009. The contractor completed his onsite geotechnical investigation and is incorporating his findings into the construction documents. Onsite mobilization for demolition began in late August 2008. Construction of the foundation system will start in mid September 2008 after approval of the foundation plans.

Project Six, East and West Block Rotunda Clinics, commenced construction on March 17, 2008 and is currently running approximately 60 days behind schedule. The delay is due to the late procurement of the new electrical panels which must be installed prior to building the structures. The existing electrical transformers were relocated, which required two prison wide power shutdowns. The foundation piers are complete as is installation of the temporary construction barriers in each rotunda. Due to the electrical procurement delay, the project will not meet the original November 12, 2008 completion date. The contractor is finalizing revisions to the project schedule with assistance from the construction manager. Many sequencing scenarios were analyzed to recover as much lost time as possible, but the best realistic completion date at this time is mid-January 2009.

Project Seven, Clinic Heat Projects, consists of installing space heating in the Adjustment Center Clinic, North Segregation Clinic, TTA and installation of an electrical panel at the medical staff modular office for emergency power. The project was competitively bid to three general contactors and the Receiver's Office approved the award to Hitchcock Builders. A pre-construction kick-off meeting was held August 14, 2008. Construction began the week of August 25, 2008 with installation of the emergency power panel. Total construction duration is approximately 40 days.

In reference to Construction Package Two, two of the three projects are complete. The remaining project is the Upper Yard Medical Modular. Construction is essentially complete. Furniture equipment and telecommunications are installed. The State Fire Marshal has granted occupancy to the administration side. Last minute changes directed by the Fire Marshall have

delayed occupancy of the clinic side, but the changes are almost complete. San Quentin medical staff are now occupying the Upper Yard Medical Modular.

Action 6.3.2. By April 2010, complete construction of the Central Health Services Facility

Construction Package Three, the Central Health Services Facility, is progressing well and is on schedule. Steel erection is complete. The current critical activity is placing concrete on the metal floor decks. Installation of the pre-cast exterior wall panels is scheduled to start September 15, 2008. The contractor is attempting to complete the pre-cast panels by mid-December and have the interior weatherized through the winter. This project remains on schedule to complete by April 2010.

Vanir's June and July monthly reports for San Quentin State Prison are included as Appendices 20 and 21 respectively.

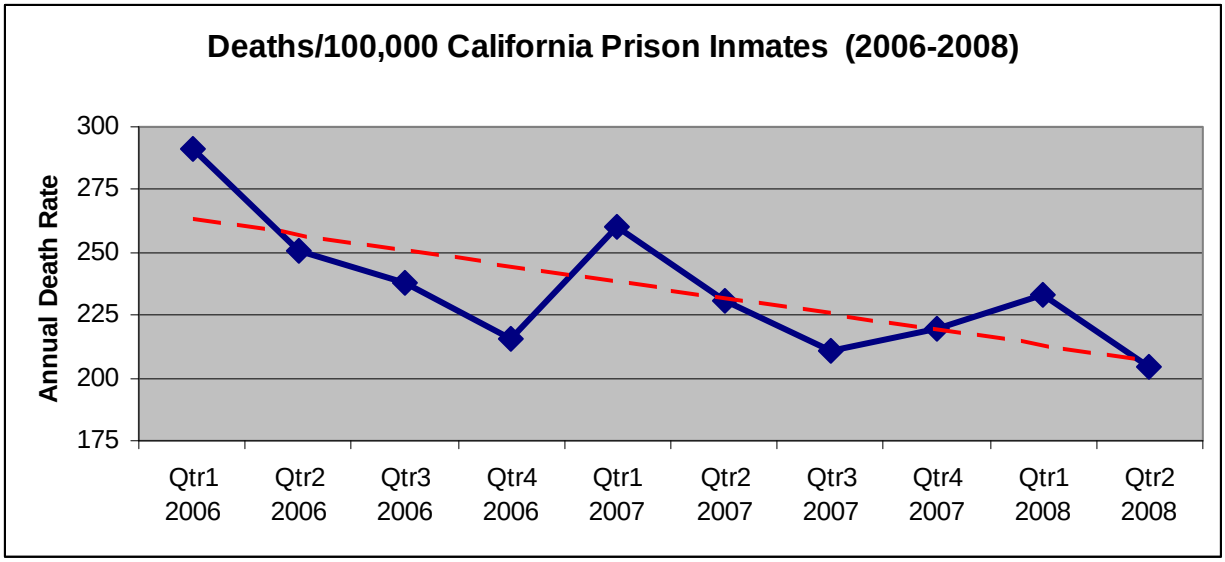
Section 4
Additional Successes Achieved by the Receiver

A. Reducing Prisoner Deaths

In the October 3, 2005 Findings of Fact and Conclusions of Law re Appointment of Receiver (hereinafter "Findings"), the Court held that "the California prison medical system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action." (Findings at 1:21-24). One finding supporting this conclusion involved the "…uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six or seven days due to unconstitutional deficiencies in the CDCR's medical delivery system. This statistic, awful as it is, barely provides a window into the waste of human life occurring behind California's prison walls due to the gross failures of the medical delivery system." (Findings at 1:26-2:2).

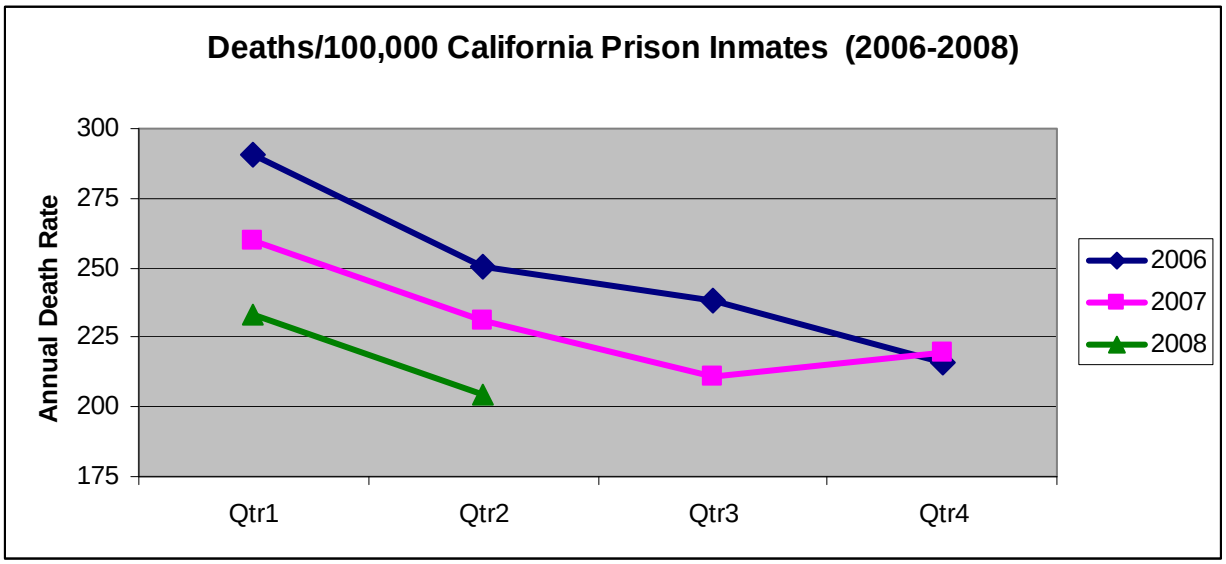
While many gross problems of the California prison medical delivery system continue, and more remedial work (including the dire need for adequate treatment space for chronically ill prisoners) is needed, there is, for the first time, indications that elements of the Turnaround Plan of Action, including the addition of clinical staff, is having a positive impact on prisoner deaths. The prisoner death rate in California's prisons has trended downward for the last 10 quarters. Table 21 below reflects the aggregate death rate, including homicides and suicides.

Table 21.



While future variations are expected, the downward slope of the dashed regression line is heartening. Displaying the same data in lines one year long in Table 22 demonstrates the seasonal variation pattern, correlating with circulation of winter viruses, that is usually seen in population-based mortality studies:

Table 22.



A number of factors contribute to this favorable trend. Most prominently, an influx of new physicians and nurses has bolstered the physicians and nurses already providing services. CPHCS hired 172 new physicians between August 1, 2007 and July 31, 2008; every one of them is board-certified in internal medicine or family medicine as required by the new credentialing criteria. This figure represents 47 percent of the 366 authorized positions in the physician pool. During this same period (August 1, 2007 through July 31, 2008), CPHCS added 488 Registered Nurses and 533 Licensed Vocational Nurse to the prison medical delivery system.

In addition, the death review and peer review processes have benefited from multiple revisions and new resources. The death reviews are intended to identify significant systemic lapses in care and to identify potentially unsafe practitioners. The peer review process has resulted in 65 physician practitioners separating from CPHCS employment from June 2005 through August 2008. Another 33 physician practitioners currently have some restriction of privileges, at least until completion of ongoing investigation.

No doubt the same California officials who allowed horrific prison conditions to fester to a degree that lead to the Receivership, and those California officials who continue to attempt to impose bureaucratic barriers to thwart the Receiver's efforts, will be among the first to cry out that an initial reduction of prisoner deaths warrants an end to the Receivership or significant modification of the Turnaround Plan of Action. Nothing could be further from the truth. This initial reduction in deaths, and the many positive reports of progress set forth above, demonstrate only that the Receivership is started its work and is achieving preliminary results, not that the work is complete. The Receiver's objectives and metrics for success are defined by the Turnaround Plan of Action - a three to five year project approved by the Court after extensive discussion with both the State and plaintiffs. A constitutionally adequate and sustainable prison medical system will not be established until the Turnaround Plan of Action is fully implemented, including the construction of new facilities for the thousands of California prisoners with long-

term, chronic illnesses. The Receivership cannot sustain its preliminary improvements unless facilities, working conditions and medical systems are improved.

Nevertheless, this news is very encouraging. A comprehensive analysis of all the year 2007 deaths will be forthcoming on November 1, 2008.

B. Establishing the CPHCS Project Management Office

Establishing a Program Management Office (PMO) is the first step to improving the project, program and portfolio management within the CPHCS. In April 2008 the Office of the Receiver retained a consultant to serve as the project manager for building and deploying the PMO. The responsibility of the consultant is to develop the PMO processes and library of templates, deploy an appropriate electronic Project and Portfolio Management (ePPM) system, and help identify project management needs throughout the organization and staff for those needs.

During this reporting period, CPHCS hired a Director of the PMO and is currently recruiting for a Deputy Director. Two existing program staff have been transferred into the PMO and a Administrative Assistant position will soon be filled. Additionally, a Request for Offer (RFO) has been issued for a contract Technical Architect to work with all projects sponsored by the Office of the Receiver. The PMO has also, during the reporting period, developed and deployed a library of PMO materials and templates (e.g. project plan templates, project charter templates and workflow diagrams) for all project managers to utilize. To date, a total of 16 master templates have been prepared; four other lower priority templates are still to be prepared. All of these templates are stored in a master repository available to all project managers.

Additionally, during this reporting period, the PMO has purchased and implemented an ePPM system, Clarity, produced and marketed by Computer Associates. The ePPM is currently being used by project managers to help deliver projects within scope, schedule and budget. The system will help the PMO to manage its procedures and controls for collecting information, performing data analysis, optimize decision making and strengthen controls. The system will also give the Office of the Receiver the ability to track and report on all projects and align them with the goals and objectives laid out in the strategic plan.

The PMO is working to hire needed project managers for all CPHCS projects. Currently the PMO employs 20 full time project managers and is working to add at least 11 more project managers by the end of September 2008. Additionally, the PMO, in cooperation with Plata Human Resources, has developed the duty statements for a new project management classification within the California State civil service. During the upcoming reporting period, PMO staff will conduct exams, create permanent civil service positions and recruit for those newly established positions.

C. *Turnaround LifeLine* Newsletter Published

Good communication is essential to changing the work culture of any organization. On August 5, 2007, the Receivership launched one of its prime tools for fostering communication, delivering timely information, and boosting morale among staff. The *Turnaround Lifeline*, is a

four-page monthly newsletter designed to inform the staff of the improvements in the delivery of health care in California's prisons. The *Lifeline* features profiles of successful staff members and best practices stories in a section entitled "Above and Beyond." It also includes a message penned directly from the Receiver called "The Receiver's Corner." The newsletter provides facts and short articles about workplace and career issues.

The Communications team requested a dedicated e-mail address to facilitate communication between the writers in the Communications Department and the readers. The first newsletter drew widespread compliments from the field staff.

> Cheryl Almquist, a Health Program Specialist, for example, wrote: "I am so pleased to read the Turnaround Lifeline Newsletter; I have been with CDCR for approximately two years and I am ecstatic to see Mr. Kelso's commitment to communication."
>
> Programmer Analyst Robert Cummings wrote: "This is a big milestone in CPHCS history! Congratulations! I've been here about eight months. About an hour before we were told of the appointment of a new receiver I told my team members during a team meeting that "If internal communications doesn't improve around here soon, I'm leaving!" I'm glad I stayed!"

E-mail replies from the field staff led to the two new "Above and Beyond" feature stories in the second edition which was published September 8, 2007.

In total, 15,000 copies of the newsletter are printed by the Reproduction Unit at CDCR Headquarters and mailed to the Plata Analysts at the 33 institutions for distribution to all Medical, Mental and Dental Health Employees. The Warden's offices also receive copies for the custody staff who are most involved with health-related issues. In an ongoing effort to save taxpayers money and contribute to a "greener" environment, the staff at the Sacramento Headquarters location receive copies electronically.

The goal is to foster two-way communication through the newsletter so that field staff will know that their efforts are appreciated, their concerns are taken into account, and that help is on the way. The August and September editions of the *Turnaround Lifeline* are attached as Appendices 22 and 23.

Section 5
Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals

The Receiver encountered two problems during the reporting period, both presenting significant obstacles to the timely and complete implementation of the Turnaround Plan of Action. The first, defendants' failure to fund an absolutely critical element of the plan - prison upgrade construction and the construction of new healthcare facilities is the very heart of the Plan. Without adequate treatment facilities, adequate care for most serious CDCR patients will be impossible to provide. Forced by months of State inaction, the Receiver has filed a motion re contempt to be heard on October 6, 2008. Because this motion is pending, further discussion will not be provided in this Quarterly Report. The pleadings filed are available for review on the Receivers website (www.cphcs.ca.gov). .

The second serious problem encountered this reporting period involves a California agency which, throughout the Receivership, has repeatedly attempted to present obstacles to the timely and cost-effective implementation of remedial efforts: the State Personnel Board (SPB). This reporting period, however, the SPB's obstacles are not legal in nature; they have been created by the ineffective and wasteful operation of SPB itself. The three operational failures of SPB, each of which has had an adverse impact on remedial programs, are explained as follows:

A. SPB Is Not Automating CPHCS Examinations Timely

As explained in this and prior Quarterly Reports, the creation of the Receiver's Nurse Executive, Medical Executive, and Chief Executive Officer classifications and examinations is one of the Receiver's key staffing initiatives. This was discussed with the SPB Executive Officer and Assistant Executive Officer directly on September 6, 2007 and July 9, 2008. Examination material is created by CPHCS staff, but it is web-enabled by SPB staff. To process such exams in a timely manner, SPB requested and subsequently received two positions in fiscal year 2006/2007 to work on examinations related to CDCR lawsuits.

CPHCS provided SPB with adequate notice of the importance of web-enabling of the exams. For example, a phone call to the SPB Examination Services Manager in early June 2008 stressed the importance of these examinations and that the pilot program was scheduled to debut on July 1, 2008. SPB staff agreed that the three examinations could be completed by July 1, 2008 if the material for the first two examinations was submitted to SPB by June 6, 2008, and completion was guaranteed within two weeks of submission of material for the third examination. CPHCS staff provided the materials for the first two examinations on June 9 and June 10. SPB indicates that each examination takes approximately 40 hours to program for the web, dependent upon the condition of the examination materials and how much additional work SPB staff needs to perform to complete automation. The development of these examinations was managed by a CPHCS staff member who was formerly the Examination Services Manager of SPB, and the materials submitted were complete and in the proper format. The Nurse Executive examination

was not completed by July 1; indeed, *it was seven weeks late* and recently delivered in final form on August 25, 2008. The Medical Executive examination was delivered to CPHCS on September 8, 2008 but had serious discrepancies in the exam format and was returned on the same date for revisions. Nothing has been heard from SPB concerning the completion of this exam, despite repeated requests. The Chief Executive Officer exam materials were submitted to SPB on July 11, 2008; however, as of the date of this report nothing has been heard from SPB concerning when it will be completed. For example, no responses have been received to numerous e-mails and phone calls requesting status updates and commitments for final products. At the same time, despite instructions to the contrary, several other examinations that were not high priority have been completed. Absent formal legal action it is difficult to determine, given an ongoing failure to meet objectives, whether this SPB conduct represents only mismanagement or whether it is deliberate thwarting. Given the repeated failures to communicate, however, there are indications that at some level of the SPB operation, the delays encountered represent efforts to thwart a critical element of the Receiver's remedial program. The Receiver has discussed these problems directly with SPB's Executive Director, but problems at a staff level have persisted.

B. CEA Requests Are Not Being Processed Timely

Procedural and staffing changes during this past year, coupled with SPB workload issues have created significant delays in establishing positions resulting in delays for CPHCS in appointing individuals to these positions. To make matters worse, CPHCS staff has been held accountable by SPB for new scheduling requirements that were discussed at task force meetings where we were not present, and that have not yet been publicized to State departments. In addition, lower level SPB staff have created self-imposed procedures that require that proposed CEAs be posted on the SPB agenda, and not acted upon until after each board meeting. This creates at least a month, and sometimes longer, delay from the submission of the proposal to its approval, which, in turn, delays the appointment of key executives.

C. Board Items Are Not Being Processed Timely

To facilitate the process of establishing classifications, SPB issues a calendar of board meetings and due dates for submission of materials. Traditionally, items that are submitted by the date all materials are due to Secretariat are placed on the next board meeting agenda. In at least two instances, critical board items have not been calendared according to the published schedule, even though the board items were prepared by staff that have years of experience managing SPB's board item program, many more years preparing and reviewing board items, and are following a template for previously adopted board items (thus requiring minimal review). Again, SPB delays created delays in appointing key executives at CPHCS.

For example, on January 18, 2008, the class specification and board item for Receiver's Chief Executive Officer, Health Care (Safety) were submitted to SPB. According to the published schedule, this item could have been placed on the February 4, 2008 calendar; however, CPHCS staff agreed to its placement on the February 19, 2008 calendar. It was not calendared until March 4, 2008. On June 27, 2008, the class specification and board item for Receiver's Clinical

Executive (Safety) were submitted to SPB. According to the published schedule, this item could have been placed on the July 22, 2008 calendar or the August 8, 2008 calendar; however, it was not calendared until September 3, 2008. Even worse, on April 14, 2008 a class specification and board item for Receiver's Project Manager was submitted to SPB and DPA. Despite both organizations' agreement in concept to the item and repeated attempts by CPHCS staff, the control agencies did not review and schedule the item until September 3, 2008. With more than fifty key projects awaiting a Project Manager, this delay has been costly to the Receiver in terms of time and necessitated hiring contractors to manage the most pressing projects.

The Receiver is contemplating a range of options to correct these problems, including taking responsibility for the management of web-enabling, obtaining delegation for selected tasks, seeking waiver of State law given SPB's failure, and an Order to Show Cause re contempt. Prior to seeking Court involvement, however, the Receiver has delegated certain members of his staff to made one final attempt to resolve each of the problems above.

Section 6
An Accounting of Expenditure For the Reporting Period

Expenses

The total net operating and capital expenses of the Office of the Receiver for the year ended June 2008 were $22,921,817 and $28,732,703 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 24.

For the two months ending August 31, 2008 the net operating and capital expenses were $4,641,376 and $7,185,333 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 25.

Revenues

On June 30, 2008 and on July 7, 2008 the Receiver requested a transfer of $34,147,258 and $20,000,000 respectively from the state to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the office of the receiver for the first quarter of the Fiscal Year 2008-2009. All funds were received in a timely manner.

Section 7
Other Matters Deemed Appropriate for Judicial Review

A. Coordination with Other Lawsuits

During the reporting period, regular meetings between the Receiver and the monitors of the *Coleman*, *Perez*, and *Armstrong* (Coordination Group) class actions have continued. Coordination Group meetings were held on June 24, 2008 and August 12, 2008. Steady progress continued during the reporting period. For example, the coordination group has agreed that the Receiver in coordination with DCHCS and subject to the oversight of the monitors in the health care class action cases will assume responsibility for all non-institutional office space statewide for the medical, mental health and dental programs. As a result, a space planning coordination agreement was submitted to the Courts for approval.

Currently, coordination agreements are being prepared in the areas of health care appeals and the transition, activation, and management of the Receiver's 10,000 bed project. Once completed and approved by the coordination group, these agreements will be submitted to the Courts for approval.

B. Master Contract Waiver Reporting

On June 4, 2007, the Court approved the Receiver's Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders issued since that date. The approved project areas, the substitute bidding procedures and the Receiver's corresponding reporting obligations are summarized in the Receiver's Seventh Quarterly Report and are fully articulated in the Court's orders, and therefore, the Receiver will not reiterate those details here.

As ordered by the Court, attached as Appendix 26 is a summary of each contract the Receiver has awarded during this reporting period, including the following: (1) a brief description of each contract, (2) which project the contract pertains to, and (3) the method the Receiver utilized to award the contract (*i.e.*, expedited formal bid, urgent informal bid, sole source.) Vendors were also engaged by the Receiver during this reporting period to assist in the operation of the Receiver's non-profit corporation, the California Prison Health Care Receivership Corporation. While such contracts are not governed by the Master Contract Waiver, a list of contracts is provided to the Court for its information.

C. Additional Steps Taken During the Reporting Period to Ensure A Fiscally Responsible Receivership

As summarized above, a number elements of the Turnaround Plan of Action call for initiatives that will save taxpayer dollars. In some cases, as with Chancellor Group hospital negotiations, the saving will be millions of dollars. In other projects, such as contract and invoice processing, savings will result from more efficient and timely processing and more effective negotiations. The effective implementation of several clinical support projects (projects that are delayed because of SPB failures), should also result in the more fiscally responsible use of diagnostic imaging and laboratory functions. For example:

> *McKenzie-Stephenson, Inc. - Radiology*: As mentioned in the Status of Goal 5, Objective 5.3, Action 5.3.1, McKenzie-Stephenson, Inc., presented CPHCS with a comprehensive assessment of CDCR's medical imaging services and a road map for future improvement. Areas covered included operations, technology, professional services, physical infrastructure, and financial impact across the entire domain of imaging, including radiology, CT, MRI, and ultrasound. McKenzie-Stephenson, Inc. presented evidence that implementation of their recommendations *could result in annual annuity savings to the state of $67 million after two years*.
>
> *University of Texas Medical Branch - Telemedicine*: The consultants from the University of Texas Medical Branch estimate that an improved telemedicine program could avoid inmate transport costs *totaling nearly $60 million annually*.
>
> *Navigant – Lab Services*: Navigant guarantees its high-quality lab services will yield *five-year cumulative savings of approximately $5 million*. Navigant believes this model has the potential to additionally reduce operating costs by 10 to 15 percent over 5 years through reduction of waste, inefficiency, and unnecessary duplicated testing.

The major clinical support function which has been implemented, the Maxor pharmacy project, continues to provide California taxpayers with significant savings. For example, based on a review of the first 8 months of wholesaler pharmacy costs and assuming a continuation of current trends, Maxor, *projects a cost avoidance of approximately $33 million in 2008 compared to prior drug cost trends*. These cost avoidances are being achieved through more effective formulary management, implementation of disease medication management guidelines, targeted pharmaceutical contracting strategies and increased pharmacy services accountability and oversight.

During the reporting period, the Receiver initiated three additional fiscal responsibility projects which focus on the following: (a) establishing a unique and transparent construction oversight process, (b) initiating an independent audit concerning contract processing, and (c) providing accurate information about the true cost of correctional health care, specifically, what portion of correctional health care is clinically-driven, and what portion of expenses are generated because health care is provided in prisons which have been designed in a manner which precludes the efficient delivery of medical services.

The Construction Oversight and Advisory Board

The Receiver established and conveyed the first meeting of his Construction Oversight and Advisory Board (COAB) during the reporting period. The purpose of the COAB governing body is to provide advice, expert recommendations, and transparency regarding the construction of the 10,000 bed health care facilities. The eleven-member COAB includes representatives from public and private sectors with expertise in the fields of governmental accountability, facility planning, and construction in order to obtain the highest quality of advice and to be able to ensure optimum quality and accountability for project scope, schedule, and budgets, including a representative from the United States Justice Department's National Institute of Corrections, California's State Auditor, and California's Inspector General. Specific details regarding the Board members are attached as Appendix 27, and the draft Board Charter is attached as Appendix 28.

The COAB met for the first time on September 3, 2008, and was presented an overview of the following: Receivership and Organization, Court Orders, Board and Charter, Turnaround Plan of Action, Health Care Expansion Program, Health Care Improvement Program, and Management and Transition Plan. The next meeting is scheduled for November 2008.

Request for Contract Investigation and Audit by the Bureau of State Audits

On a regular basis, key executives who report to the Receiver make decisions concerning a wide range of contracts as to whether to utilize State processes, or to request a formal waiver of State Law and initiate an appeal under the authority of the Court's order of June 4, 2007. In mid-2007 the number of staff reporting to the Receiver was far less than today, and the informal controls and processes in use to effectuate this decision making process may no longer be adequate given the scope of the Turnaround Plan of Action and the number and pace of remedial projects. For example, perhaps a practice of verbal discussion between among a small group of project leaders should now, given the growth of projects, be better defined by written policy and procedures and more formal documentation requirements. Given the growth of the number of projects, and the execution of a contract which appears to have met neither State or Court protocols, the Receiver has asked the Bureau of State Audits (BSA) to conduct whatever investigations and/or audits it deems appropriate in order to provide the Receiver and his staff findings and advice to ensure, as the Turnaround Plan of Action progresses, that timely contract processing is effectuated consistent with the appropriate fiscal controls. Audit findings are, at this time, anticipated to be available in November 2008.

The Cost of Prison Health Care

As the Receivership begins implementation of the Turnaround Plan of Action (and the Receiver moves forward with plans to construct new healthcare facilities for 10,000 chronically ill patient-inmates), questions and concerns have been raised about the cost of health care in California's prisons. Some concerns are legitimate. For example, California's unconstitutional prison medical delivery system not only delivered poor care, but also, because it was so dysfunctional, at the same time wasted millions of dollars of taxpayer resources. As explained above, the Receiver and his staff continue to devote significant efforts to implement medical delivery

programs that will function in a far more cost effective manner that those in place when the Receivership began.

Putting aside for the moment the dysfunctional and wasteful nature of the system, it is necessary to emphasize that correctional health care is inherently expensive. Like it or not, California's prisons were designed to *prevent* the human movement, the communication, the transportation, and the timely observation of medical conditions that is necessary to provide adequate and cost effective health care. Because of this, caring for prisoners *inside* California's prisons cannot be compared to clinics in the free world, facilities which provide care to veterans, rest homes for the retired, or County hospitals. Like it or not, California's prisons are different.

Because all patients in the correctional environment are prisoners, men and women confined and subject to security restrictions entirely different to patients in the free world, correctional health care is ultimately far more expensive than healthcare services provided to the public – even when the level of actual *clinical* services is less than that provided through MediCare or MediCal or private insurance.

For example, approximately 19% of medical care budget involves custody related medical delivery functions, as explained below:

Total Medical Budget for 2008-09:	$1,515,548,330
Total Custody Budget for Medical 2008-09:	$285,921,589
Total Custody Transportation Budget 08-09:	$73,818,000
Overall Custody Budget 2008-09:	$359,739,589
Total Medical/Custody Budget for 2008-09:	$1,875,287,919
Total Percentage for Custody:	19 percent

The cost of the custody component, however, *is only the beginning.* Given prison structures, lock downs, and legitimate security related concerns, delivering clinical care in prison is inherently more expensive that providing similar levels of care in the free world. To explain this difference, and to provide real life illustrations of the staff intensive nature of correctional care, the Office of the Receiver has prepared a report entitled Understanding the Cost of Prison Health Care. This document is attached as Exhibit 29.

Section 8
Conclusion

As the Court forecast in its Order Appointing New Receiver, filed January 23, 2008, the Receivership has now decidedly entered "an implementation phase, during which the Receivership must translate the conceptualized reforms into reality" (Order Appointing New Receiver at p. 4). In order to understand and organize the complex reforms which are necessary, the Receiver worked with stakeholders and the Courts to produce the Turnaround Plan of Action which now guides all of our initiatives. With the Turnaround Plan of Action in place and a strong focus on project management, concrete, measurable progress is now plainly evident. We know where we need to go, and we are aggressively moving in that direction. The Receiver's message of planning, project management and progress is paying off.

The steady reduction in the prison population's death rate per 100,000 is one of the strongest indicators of our progress. We are confident that this reduction is largely attributable to the Receiver's efforts over the last 30 months. For the first time in many, many years, there is genuine reason for some hope that CDCR's health care system can be fixed, and that the Receiver is the right instrument for completing the fix in a reasonable period of time and at reasonable cost.

The most serious obstacle to continued progress is the State's failure to provide funding for the Receiver's facilities improvement and expansion program. The progress which has been made to date will be for naught unless we are able to make permanent improvements to CDCR's facilities. Right now, the facilities are simply inadequate, given CDCR's population, to sustain for the long-term the improvements we are seeing. The Turnaround Plan of Action recognized that a long-term solution requires improvements at each adult institution and construction of new facilities to care for CDCR's most seriously and chronically ill patient-inmates. The Receiver fervently hopes the State will, even at this late date in the budget process, recognize its federal constitutional obligations and provide the necessary funding for the Receiver to move forward with his construction program.