

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

**Twelfth Tri-Annual Report of the
Federal Receiver's Turnaround Plan of Action**

September 30, 2009

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.

Table of Contents

		Page
1.	Executive Summary.....	1
2.	The Receiver’s Reporting Requirements.....	11
3.	Status and Progress Toward the Turnaround Plan Initiatives.....	12
	GOAL 1 Ensure Timely Access to Health Care Services.....	12
	<i>Objective 1.1</i> Screening and Assessment Processes.....	12
	<i>Objective 1.2</i> Access Staffing and Processes.....	13
	<i>Objective 1.3</i> Scheduling and Patient-Inmate Tracking System.....	14
	<i>Objective 1.4</i> Standardized Utilization Management System.....	15
	GOAL 2 Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services.....	17
	<i>Objective 2.1</i> Primary Care.....	17
	<i>Objective 2.2</i> Chronic Care.....	17
	<i>Objective 2.3</i> Emergency Response.....	18
	<i>Objective 2.4</i> Specialty Care and Hospitalization.....	19
	GOAL 3 Recruit, Train and Retain a Professional Quality Medical Care Workforce.....	28
	<i>Objective 3.1</i> Physicians and Nurses.....	28
	<i>Objective 3.2</i> Clinical Leadership and Management Structure.....	30
	<i>Objective 3.3</i> Professional Training Program.....	31
	GOAL 4 Implement a Quality Assurance and Continuous Improvement Program.....	33
	<i>Objective 4.1</i> Clinical Quality Measurement and Evaluation Program.....	33
	<i>Objective 4.2</i> Quality Improvement Programs.....	34
	<i>Objective 4.3</i> Medical Peer Review and Discipline Process.....	37

Objective 4.4	Medical Oversight Unit.....	39
Objective 4.5	Health Care Appeals Process.....	41
Objective 4.6	Out-of-State, Community Correctional Facilities and Re-entry Oversight.....	44
GOAL 5	Establish Medical Support / Allied Health Infrastructure.....	48
Objective 5.1	Pharmacy.....	48
Objective 5.2	Medical Records.....	53
Objective 5.3	Imaging/Radiology and Laboratory Services.....	55
Objective 5.4	Clinical Information Systems.....	57
Objective 5.5	Telemedicine.....	58
GOAL 6	Provide for Necessary Clinical, Administrative and Housing Facilities.....	60
Objective 6.1	Upgrade Administrative and Clinical Facilities.....	60
Objective 6.2	Expand Administrative, Clinical, and House Facilities.....	61
Objective 6.3	Finish Construction at San Quentin State Prison.....	62
4.	Additional Successes Achieved by the Receiver.....	63
A.	Focus on Cost Efficient Health Care.....	63
B.	Launch of CPHCS Intranet Site.....	63
5.	Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented By Institutions Or Individuals.....	65
6.	An Accounting of Expenditures for the Reporting Period.....	66
7.	Other Matters Deemed Appropriate for Judicial Review.....	67
A.	Coordination with Other Lawsuits.....	67
B.	Master Contract Waiver Reporting.....	67
8.	Conclusion.....	68

Section 1

Executive Summary

During this reporting period, progress has continued toward attaining constitutionally adequate medical care for patient-inmates of the CDCR. Highlights of progress include the following:

- The Receiver's Medical Classification Team identified and developed the Medical Classification Factors, Endorsement Process and the preliminary Continuum of Care process to correlate inmate medical needs with appropriate facility capabilities.
- All institutions have reported improvement in patient-inmate escorts to scheduled healthcare appointments. These reported improvements indicate that healthcare access custody teams, once fully implemented, will have the necessary resources to support all healthcare operations.
- Utilization Management (UM) – Implementation of the McKesson library of InterQual guidelines started in Fall 2008 and is now complete and all institutions are using the InterQual library of standardized evidence based guidelines. These guidelines assist in the clinical determination of specialty referrals, imaging and hospital admissions and continued stay and discharges. Training has been completed and routine monitoring of outcomes, compliance, backlogs and staffing is underway. Through the use of InterQual and ongoing monitoring of outcomes and compliance there has been a dramatic decrease in the number of medically unnecessary requests for services. On the average, the total number of referrals has decreased from the high of 25,000 per month (FY 08/09) to 15-16,000 per month.
- The Receiver continued to reduce the cost of hospital services, physician services and ambulance services for California's patient-inmates through the July 28, 2009 chaptering of SBX4 13 (Ch.22, Stats. 2009) which amended Penal Code section 5023.5 to establish the maximum reimbursement rates payable to a contract provider of hospital services, physician services and ambulance services (130 percent, 110 percent, and 120 percent of Medicare Fee Schedule, respectively). The estimated cost savings as a result of the reductions is \$50 million annually.
- The Office of Inspector General (OIG) completed five additional medical care inspections bringing the total inspections to date to ten. During this reporting period the OIG added a second inspection team that is currently receiving training on this process.
- The percentage of institutions passing pharmacy inspections has continued to increase during this reporting period. The number of pharmacies with an inspection rating score of passing has increased from 21 percent in March 2007 to 85 percent in July 2009.
- Centralized dictation and transcription was implemented at the three pilot institutions: Valley State Prison for Women, Central California Women's Facility and California State Prison, Los Angeles County in July 2009.

- The first round of site visits to all 33 institutions was completed by the Imaging/Radiology team to stabilize and standardize film filing of patient-inmate files to ensure access to health records is reliable and compliant with regulatory requirements. This effort included the implementation of local operating procedures to ensure current active patient films are returned from offsite Professional Service providers, are filed accurately for future reference and follow the patient-inmates between institutions at time of transfer.
- During this reporting period, a six-institution initiative to expand telemedicine services was launched. This initiative will engage with the healthcare management at six selected institutions (North Kern State Prison, Kern Valley State Prison, Richard J. Donovan Correctional Facility, Centinela State Prison, California State Prison at Corcoran and Substance Abuse Treatment Facility) to remove barriers to increase telemedicine services, expand the network of telemedicine providers and specialties and monitor the expansion of telemedicine services as well as the corresponding decrease in off-site specialty services.

While we continue to make progress in many important areas that bring us closer to the goal of providing a constitutional level of healthcare within California's correctional system, the momentum has clearly been affected by the State's budget and fiscal crisis, and resultant furlough days. The budget and fiscal crisis is likely to continue for the foreseeable future, and the Receivership is doing everything it can to reduce expenditures without cutting into core healthcare areas. However, productivity has been impacted throughout the organization, some staff turnover has occurred, and certain projects and initiatives have been delayed in their implementation. Due to these factors some of the objectives and action item goal dates have been extended.

Format of the Report

To assist the reader, this Report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific Turnaround Plan of Action initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions.

Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for May through August 2009 can be viewed at the CPHCS website (http://www.cprinc.org/receiver_mo.aspx).

2. *Appendices*: In addition to providing metrics, this report also references a number of documents that are provided to the reader in the included Appendices filed concurrently with this report.
3. *Website References*: Whenever possible website references are provided to the reader.

Dashboard Documents

A chart summarizing the status of each of the six Goals of the Turnaround Plan of Action is provided below. Objectives and Actions' status indicated with a "check mark" (✓) are currently on schedule to be completed by the specified completion date. Objectives and Actions' status with an "x" (✗) are delayed from the specified completion date. Objectives and Actions' status with a "boxed x" (☒) are not progressing. Objectives and Actions that have been accomplished are noted as being "complete." Summary progress on the action items is as follows:

Summary Progress - Action Items

	Current Reporting Period		Last Reporting Period	
Completed	19	40%	11	24%
On Schedule	8	17%	18	39%
Delayed	16	33%	11	24%
Not Progressing	5	10%	6	13%

A second chart is also provided below indicating the percent of completion for the Objectives and Actions of the Turnaround Plan of Action. Discussion and explanations regarding progress as well as delays are included in Section 4 with the narratives for the respective Objective or Action.

**Status of Turnaround Plan of Action
As of September 30, 2009**

9/30/09 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 3		Recruit, Train & Retain Medical Workforce																				
Obj. 3.1		Physician and Nurse Recruitment																				
complete	Act 3.1.1	Nursing and Nursing Executive Positions																				Extended to 01/2010
✘	Act 3.1.2	Physician and Physician Executive Positions																				Extended to 01/2010
Obj. 3.2		Management Structure																				
✘	Act 3.2.1	Establish and Staff Executive Leadership																				Extended to 01/2010
✘	Act 3.2.2	Establish and Staff Regional Leadership																				Extended to 03/2010
Obj. 3.3		Professional Training for Clinicians																				
✘	Act 3.3.1	Orientation and Preceptor / Proctoring																				Extended to 01/2010
complete	Act 3.3.2	CME Accreditation																				
GOAL 4		Quality Improvement Programs																				
Obj. 4.1		Quality Measurement and Evaluation Program																				
✓	Act 4.1.1	Measurement, Eval. and Patient Safety Programs																				
complete	Act 4.1.2	OIG Audit Program																				
Obj. 4.2		Quality Improvement Program																				
✘	Act 4.2.1	Train and Deploy QI Advisors to Develop Model																				Extended to 01/2010
complete	Act 4.2.2	Establish a Policy Unit																				
Obj. 4.3		Medical Peer Review Process																				
complete	Act 4.3.1	Establish Peer Review Process																				
Obj. 4.4		Medical Oversight Unit																				
complete	Act 4.4.1	Staff and Establish Medical Oversight Unit																				
Obj. 4.5		Health Care Appeals																				
complete	Act 4.5.1	Centralize Appeals, Correspondence & Habeas																				
complete	Act 4.5.2	Health Care Appeals Task Force & Report																				
Obj. 4.6		Out-of-State & Other Facilities																				
complete	Act 4.6.1	Administrative Unit for Oversight																				

**Status of Turnaround Plan of Action
As of September 30, 2009**

9/30/09 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 5		Medical Support / Allied Health Infrastructure																				
Obj. 5.1		Pharmacy Program																				
complete	Act 5.1.1	Drug Formulary																				
✘	Act 5.1.2	Pharmacy Policies and Practices & Guardian Rx																				
✘	Act 5.1.3	Central-Fill Pharmacy																				
Obj. 5.2		Health Records																				
✘	Act 5.2.1	Roadmap for Standardized Health Records																				
Obj. 5.3		Radiology and Lab Services																				
complete	Act 5.3.1	Determine Strategy for HR, Lab and Radiology																				
Obj. 5.4		Clinical Information Systems																				
✓	Act 5.4.1	Establish Clinical Data Repository																				
Obj. 5.5		Telemedicine Program																				
complete	Act 5.5.1	Secure Leadership for Upgrade																				
GOAL 6		Clinical, Administrative & Housing																				
Obj. 6.1		Upgrade Program																				
✘	Act 6.1.1	Assessment & Planning at 33 Institutions																				
✘	Act 6.1.2	Upgraded Administrative & Clinical Facilities																				
Obj. 6.2		10,000 Bed Expansion Program																				
✘	Act 6.2.1	Pre-Planning on All Sites																				
✘	Act 6.2.2	Construction at First Site																				
✘	Act 6.2.3	Phased Construction Program																				
Obj. 6.3		San Quentin Construction																				
✘	Act 6.3.1	All Construction excluding Central Health Services																				
✓	Act 6.3.2	Central Health Services																				

**Turnaround Plan of Action Goals
Percent Complete
As of September 30, 2009**

		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
GOAL 1	Ensure Timely Access to Care											
Obj. 1.1	Reception Center Screening and Assessment Processes											
Act 1.1.1	Develop Standardize Screening and Assessment	100%										
Act 1.1.2	New Processes at Reception Centers	5%										
Act 1.1.3	Medical Classification System at Reception Centers								75%			
Act 1.1.4	Medical Classification System Statewide	20%										
Obj. 1.2	Staffing and Processes for Health Access											
Act 1.2.1	Preliminary Assessment for Access Teams	100%										
Act 1.2.2	Fully Implement Health Care Access Teams	40%										
Obj. 1.3	Scheduling and Tracking System											
Act 1.3.1	Strategic Offender Management System						50%					
Obj. 1.4	Standardized UM System											
Act 1.4.1	Long-Term Care Pilot	20%										
Act 1.4.2	Implement Centralized UM System	100%										

**Turnaround Plan of Action Goals
Percent Complete
As of September 30, 2009**

		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
GOAL 2	Establish a Medical Services Program											
Obj. 2.1	Access and Processes for Primary Care											
Act 2.1.1	Redesign Episodic Care Processes						50%					
Act 2.1.2	Implement new Episodic Care System Statewide	20%										
Obj. 2.2	Chronic Care											
Act 2.2.1	Part 1 - Primary Care Model							75%				
Act 2.2.1	Part 2 - Chronic Disease	20%										
Obj. 2.3	Emergency Medical Response System											
Act 2.3.1	Emergency Medical Response Policy										100%	
Act 2.3.2	Certification and Training										100%	
Act 2.3.3	Standardize Emergency Equipment										100%	
Obj. 2.4	Specialty Care and Hospitalization											
Act 2.4.1	Utilization and Care Management Policies										100%	
Act 2.4.2	Statewide Specialty Care Contracts							70%				
Act 2.4.3	Specialty Care Invoice Payments	20%										
GOAL 3	Recruit, Train & Retain Medical Workforce											
Obj. 3.1	Physician and Nurse Recruitment											
Act 3.1.1	Nursing and Nursing Executive Positions										100%	
Act 3.1.2	Physician and Physician Executive Positions									90%		
Obj. 3.2	Management Structure											
Act 3.2.1	Establish and Staff Executive Leadership	20%										
Act 3.2.2	Establish and Staff Regional Leadership	20%										
Obj. 3.3	Professional Training for Clinicians											
Act 3.3.1	Orientation and Preceptor / Proctoring						40%					
Act 3.3.2	CME Accreditation										100%	

**Turnaround Plan of Action Goals
Percent Complete
As of September 30, 2009**

		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
GOAL 4	Quality Improvement Programs										
Obj. 4.1	Quality Measurement and Evaluation Program										
Act 4.1.1	Measurement, Eval. and Patient Safety Programs		20%								
Act 4.1.2	OIG Audit Program										100%
Obj. 4.2	Quality Improvement Program										
Act 4.2.1	Train and Deploy QI Advisors to Develop Model					50%					
Act 4.2.2	Establish a Policy Unit										100%
Obj. 4.3	Medical Peer Review Process										
Act 4.3.1	Establish Peer Review Process										100%
Obj. 4.4	Medical Oversight Unit										
Act 4.4.1	Staff and Establish Medical Oversight Unit										100%
Obj. 4.5	Health Care Appeals										
Act 4.5.1	Centralize Appeals, Correspondence & Habeas										100%
Act 4.5.2	Health Care Appeals Task Force & Report										100%
Obj. 4.6	Out-of-State & Other Facilities										
Act 4.6.1	Administrative Unit for Oversight										100%

**Turnaround Plan of Action Goals
Percent Complete
As of September 30, 2009**

		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
GOAL 5	Medical Support Infrastructure											
Obj. 5.1	Pharmacy Program											
Act 5.1.1	Drug Formulary	100%										
Act 5.1.2	Pharmacy Policies and Practices & Guardian Rx	70%										
Act 5.1.3	Central-Fill Pharmacy	40%										
Obj. 5.2	Health Records											
Act 5.2.1	Roadmap for Standardized Health Records	70%										
Obj. 5.3	Radiology and Lab Services											
Act 5.3.1	Determine Strategy for HR, Lab and Radiology	100%										
Obj. 5.4	Clinical Information Systems											
Act 5.4.1	Establish Clinical Data Repository	50%										
Obj. 5.5	Telemedicine Program											
Act 5.5.1	Secure Leadership for Upgrade	100%										
GOAL 6	Clinical, Administrative & Housing											
Obj. 6.1	Upgrade Program											
Act 6.1.1	Assessment & Planning at 33 Institutions	10%										
Act 6.1.2	Upgraded Administrative & Clinical Facilities	5%										
Obj. 6.2	10,000 Bed Expansion Program											
Act 6.2.1	Pre-Planning on All Sites	90%										
Act 6.2.2	Construction at First Site	0%										
Act 6.2.3	Phased Construction Program	0%										
Obj. 6.3	San Quentin Construction											
Act 6.3.1	All Construction excluding Central Health Services	90%										
Act 6.3.2	Central Health Services	87%										

Section 2

The Receiver's Reporting Requirements

This is the twelfth report filed by the Receivership, and the sixth 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 healthcare class actions pending against the CDCR, the Receiver now files Tri-Annual Reports in four different federal court class action cases. An overview of the Receiver's enhanced reporting responsibilities related to these cases and to other *Plata* orders filed after the Appointing Order can be found in the Receiver's Eleventh Tri-Annual Report (http://www.cphcs.ca.gov/receiver_tri.aspx) at pages 15-16.

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

This Action has been completed.

Action 1.1.2. By January 2011, implement new processes at each of the major reception centers.

During this reporting period, the Access to Care Integration Leadership Team re-evaluated the Reception Center implementation in coordination with the other Access to Care Initiatives: Primary Care, Episodic Care and Chronic Care. During the evaluation we found that it would be premature to implement the new reception center processes before the implementation of the foundational components of prison healthcare, including a team-based Primary Care Model, an Episodic Care Model and Medical Classification System (See the newly created Action 1.1.3 & 1.1.4). A key element in the Integrated Leadership Teams decision to delay the implementation of the reception center processes was the impending implementation of a medical classification system. The Reception Center redesign will now occur after completion of Action 1.1.3 in January 2010. Based on the new target dates, a re-evaluation of the reception center processes, established in Action 1.1.1, and statewide implementation of the new processes at each of the major reception centers is expected by January 2011.

Action 1.1.3. By January 2010, begin using the new medical classification system at each reception center prison

In May 2009, the Receiver initiated design of a Medical Classification System. The Medical Classification System is a foundational component that, once implemented, will support a more streamlined and efficient Reception Center process, and will allow the Department to more effectively match patient needs with institutional medical capabilities. The Medical Classification System will ensure that all inmates are assigned appropriate medical classification factors. Those factors will identify institutions with capabilities and staffing sufficient to meet the identified inmate medical needs, support efficient bed management statewide, eliminate redundant and unnecessary forms, screenings and evaluations and position the CDCR to support its overarching medical system.

Action 1.1.4. By January 2011, complete statewide implementation of the medical classification system throughout CDCR institutions

When fully implemented, it is expected that the Medical Classification System will ensure that all inmates are assigned comprehensive medical factors that allow matching of medical needs to institutions that will effectively support those needs. It is also expected that this system will reduce or prevent inefficiencies caused by disparity between inmate medical need and specialty care resources.

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 healthcare 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

This Action has been completed.

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

All institutions have reported improvement in patient-inmate access to scheduled healthcare appointments since the last Tri-Annual Report.¹ These reported improvements indicate that healthcare access programs, once fully implemented, will have the necessary resources to support healthcare operations at the current level of service. Because of these improvements, and barring any regression or inability to support the field, the data suggests that operational control of custody Health Care Access Units could be transferred back to CDCR and released from Receivership control by July 2011.

To facilitate this process, an accelerated schedule for conducting Institution Process Reviews has been developed. Currently, all institutions are scheduled to have process improvement reviews completed by June 2010. Although much work remains, overall healthcare access at the institution level is on track to meet this goal.

Operational Assessments

Working with CDCR this last reporting period, copies of all 33 Operational Assessments were provided to them for an independent review of allocated staffing resources at 33 adult institutions. The reviews were used to determine if existing custody staffing levels were sufficient at each individual institution. The reviews were conducted between April and June and did not assess medical guarding units at outside hospitals.

¹ These reports track the efficacy of custody escort and transportation to scheduled appointments—not whether all needed appointments are scheduled.

The CDCR reviews supported many of the areas of concern cited in the Preliminary Operational Reviews conducted by the Receiver. CDCR's proposed number of additional Health Care Access Unit staff necessary to satisfy the access to care issues at the 33 adult institutions is substantially lower than the staffing that was originally proposed in the Preliminary Operational Reviews. The Receiver is currently working with CDCR to reconcile these differences while ensuring that together, healthcare in prisons is safe, efficient, patient-centered, timely, efficient and equitable. It is anticipated that the results of these combined efforts will be included in the next reporting period.

Para-Transit Vans

During this reporting period, the Receivership received information from the field regarding security concerns with Para-Transit vans previously issued to the institutions. Specifically, the two person cells in the vans could be manipulated to open while padlocked, and the Lexan that covers the bars inside of the van had been substituted. All institutions affected were notified and all Para-Transit vans were taken out of operation and rotated through the retrofit process at an accelerated rate. At the completion of the retrofit process the vans were inspected and returned to their institution.

Monthly Health Care Access Quality Report - Data Collection Instrument

During this reporting period, the Quality Report data showed stabilization and a continued improvement in institutional coordination between clinical and custody staff (Refer to Appendices 1 - 3). The Quality Report for June indicates that 85 percent of all patient-inmates who received a ducat for a healthcare appointment were seen by a clinical provider. Specific to custody performance, the data element "Number of Inmates Not Seen Due to Custody" has leveled off at an average that falls between one and two percent of the total number of ducats, or ten to twelve percent of the total number of inmates not seen.

Additionally, much progress has been made in bringing automation to the Quality Report through the partnership with COMPSTAT. COMPSTAT data collection tools that mirror the Quality Report templates are complete and now in a testing phase. It is anticipated that Quality Report data for the 09/10 fiscal year should be available on COMPSTAT within the coming few months. During this reporting period, the Quality Report was posted on the Receivers Intranet site.

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

A centralized system for the scheduling and tracking of healthcare appointments, coordinated with all other appointments for patient-inmates, is an essential element of providing timely access to care. General offender scheduling and movement control within the 33 existing CDCR prisons and the planned new long-term healthcare facilities will be handled by the Strategic Offender Management System (SOMS). SOMS will include four informational components for

each offender that is critical to the success of the prison healthcare system: a unique lifetime identification number; demographic information; continuous real-time location; and a comprehensive master schedule and scheduling prioritization protocol.

In early summer 2009, the selected system integrator for SOMS, Electronic Data Systems (EDS), began the requirements definition phase of the SOMS project. EDS is leading a team that includes the development of a commercially available software product that is used, with necessary customizations, by several other State and local correctional agencies. A CDCR project team has been assembled, which includes a representative from CPHCS' Custody Support Services. Individual system functions will be implemented in the adult institutions in phases running through spring 2010, at which time all institutions are anticipated to have full functionality.

As a result of the increasingly difficult fiscal situation in the State, CPHCS decided in July 2009 to cancel the procurement for a Health Care Scheduling System. Instead, CPHCS has worked with CDCR and EDS to incorporate functionality for healthcare scheduling into the scope of SOMS. This approach will provide CPHCS with basic scheduling and tracking functionality at a lower cost and within a shorter timeframe. The SOMS Health Care Scheduling solution will have the capability to schedule medical, dental and mental healthcare appointments for offenders based on mandated healthcare requirements, offender requests, provider referrals and chronic care plans. SOMS Health Care Scheduling will integrate with CDCR Business Information System (BIS)² and CPHCS' forthcoming Clinical Data Repository. Providers will have access to appointment status and encounter history – including reason codes for cancellations or no-shows – through the clinical portal in the Clinical Data Repository.

The SOMS Health Care Scheduling project was kicked off by CPHCS on August 5, 2009 and a team of healthcare subject matter experts has been participating in the requirements definition workshops with CDCR and EDS. After the completion of the requirements by the end of September 2009, EDS will begin system development. Activities for system and user acceptance testing are planned for spring 2009. An implementation of SOMS Health Care Scheduling to selected pilot sites is planned for summer 2010 with a subsequent phased rollout to the remaining CDCR institutions. The rollout schedule is currently being developed and will be included in the next Tri-Annual Report.

Objective 1.4. Establish A Standardized Utilization Management System

Action 1.4.1. By May 2010, open long-term care unit at one facility as a pilot project to assist in developing plans for the long-term chronic care facilities

The California Medical Facility was identified as the pilot site for this project and planning was initiated on May 20, 2008. A project was developed to convert the "H" wing in California Medical Facility to a 109 bed Outpatient Housing Unit with related clinical spaces and other

² BIS will standardize, automate and integrate CPHCS's financial, procurement and human resources business processes for the headquarters and all 33 institutions.

renovations at a total project cost of \$6.65 million. As previously reported, this project was put on hold due to a lack of funding.

However, during this reporting period a less expensive alternative was identified to provide interim cost savings. This alternative is expected to convert an existing E-Dorm at the California Medical Facility into an open long-term care unit. The conversion will require minor renovation of fire sprinklers, fire alarms, air conditioning, lighting and the custody station. The total estimated cost of construction is \$580,000 and the estimated cost of equipment is \$145,000. Construction is tentatively scheduled to begin in March 2010 with an anticipated completion date of May 2010. This conversion will operate as a 72-bed Outpatient Housing Unit (OHU) and help to alleviate the number of aberrant bed days caused by the lack of bed space.

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

This Action has been completed.

At this time the UM department physician and nurse team is field based, rather than centralized, so that efficient oversight, monitoring and mentoring of institutional and regional medical and nursing management can be accomplished. UM focuses on implementing, teaching and supporting standardized processes to facilitate medically necessary clinical decisions that will improve access to care and reduce medically unnecessary costs.

Activities that are emphasized include:

- Oversight of specialty referral management
- Oversight of institutional infirmary bed availability
- Oversight and co-management of high volume community hospital census
- Development of Telemedicine referral policies and processes
- Co-management of high cost, high risk patients with institutional staff
- Education and outcomes reporting to Headquarters and Regional Leadership
- Implementation of institutional and Headquarters UM Committees and Workgroups
- Development of guidelines and assessment of new technology.

Additional activities that involve key UM participation include:

- Implementation of the Claims Third Party Administrator Payment System
- Development of a Claims Based Electronic Medical Outcomes Reporting Library
- Network Initiatives to Improve Specialist, Ancillary and Hospital Coverage and Rates
- Contract Initiatives to Improve Specialty Coverage in key areas and specialties.

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 December 2009, complete the redesign of episodic care processes, forms, and staffing models

The implementation of the inter-disciplinary Primary Care Model is the foundation of effective sick call processes (refer to Action 2.2.1 below). The Integrated Leadership Team determined that sick call could not effectively be redesigned until the Primary Care Model was in the implementation phase.

During July 2009, the redesign of sick call processes resumed with approval of a detailed charter for the initiative. The team determined that the term “Episodic Care” more accurately described the target processes. The essential features of the process and its information flow were defined. The team began design of the proposed solution and definition of the critical policy elements.

Completion of the redesign of Episodic Care processes, forms and staffing is expected to be completed by December 31, 2009.

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

The Eleventh Tri-Annual Report proposed accelerated statewide implementation of new Sick Call processes, forms and staffing model by December 31, 2009, which was six months earlier than originally planned.

The Integrated Leadership Team has created a standardized implementation plan for clinical initiatives that incorporates methods that emphasize and ensure rapid and sustainable change (refer to Action 2.2.1 below). The revisions discussed in Action 2.1.1, above, result in a return of the date of implementation to its original July 31, 2010 date.

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

Action 2.2.1. Implement an inter-disciplinary team-based Primary Care Model in all institutions by December 2009. Implement a Chronic Disease program within the framework of the Primary Care Model by December 2010.

The Chronic Care Initiative was scheduled for completion by December 2009.

In April 2009, the Access to Care team, in collaboration with the Regional Leadership Team and the six pilot institutions, identified barriers to system wide implementation of the Chronic Disease Program. Key among these barriers was the absence of a clearly formulated team based Primary Care Model of care, which includes delineation of roles & responsibility for managing populations (panels) of patients. Establishment of a Primary Care system would provide the

infrastructure for the improvement of other processes related to all components of care, including timely accessed sick call, planned care of chronic disease, guidelines based specialty care and cost effective hospital care.

The Access to Care team was reorganized to include the Regional Leadership Team and was renamed The Integrated Leadership Team. This team re-evaluated the Access to Care Initiatives, which resulted in consolidation of some initiatives, adjustment of timelines and priorities and inclusion of additional initiatives. A Clinical Initiative Model provides the structure for interdisciplinary policy development, creation of sample local operating procedures, implementation of training templates, review and approval of institution local operating procedures, defined metrics, ongoing monitoring activities to measure facility compliance and reporting requirements and a process for certification of facilities upon successful implementation. This model was used to design and implement the Primary Care Initiative.

During this reporting period, a Primary Care Policy was written, approved and distributed. Facility leadership received training on the policy, a sample local operating procedure was written, approved and distributed, all institutions created their customized local operating procedure, which was reviewed and approved by the Regional Leadership Team. Ten institutions have reported full compliance and on site evaluation of institution compliance is proceeding.

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

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

This Action has been completed.

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

This Action has been completed.

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

This Action has been completed.

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

This Action has been completed.

The following are charts that contrast the total referrals for specialty services (RFS) generated vs. the total RFSs run through the InterQual system for the northern, central and southern regions during the April 2009 through July 2009 timeframe. (See Table 1, 2 & 3)

Table 1.

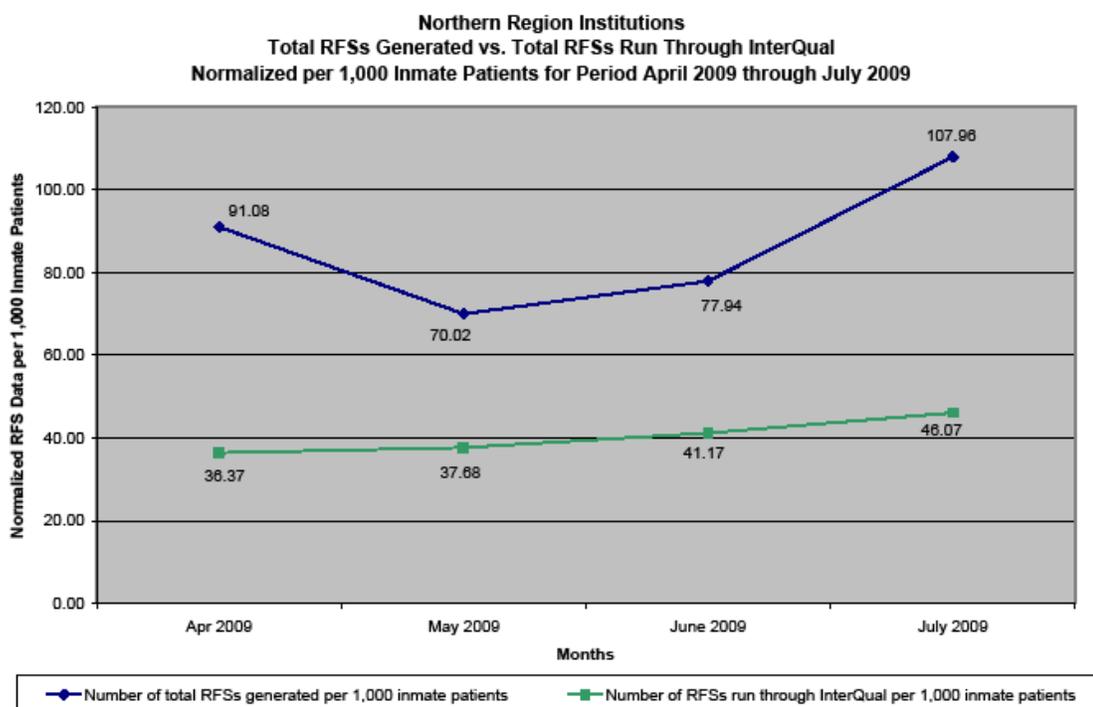


Table 2.

**Southern Region Institutions
Total RFSs Generated vs. Total RFSs Run Through InterQual
Normalized per 1,000 Inmate Patients for Period Mar 2009 through July 2009**

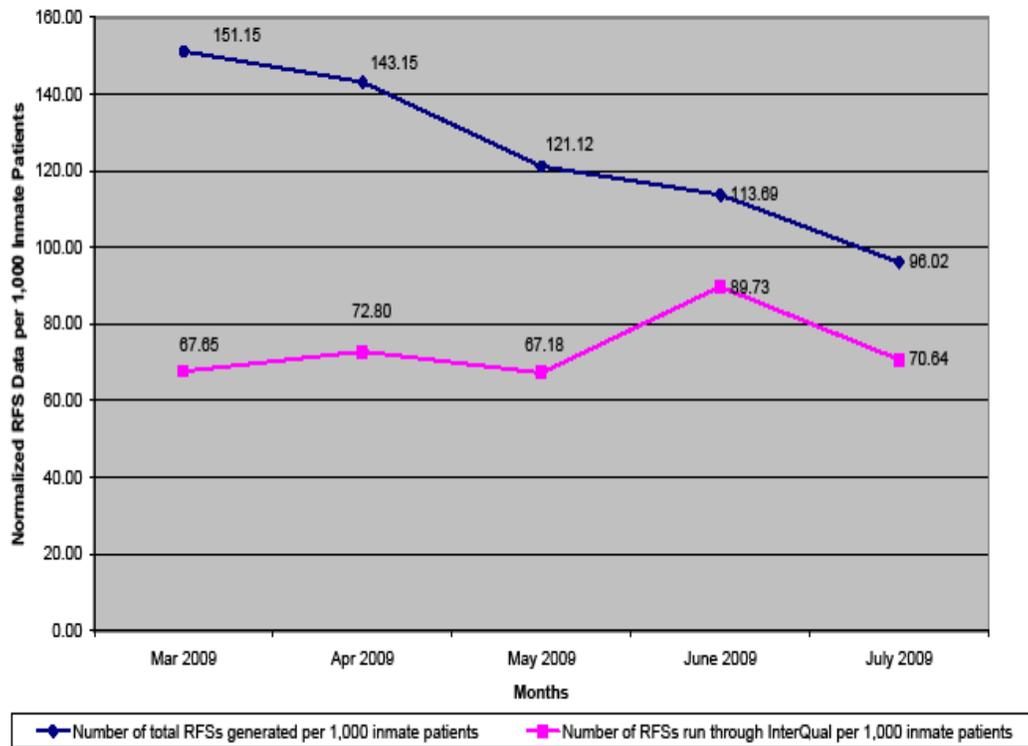
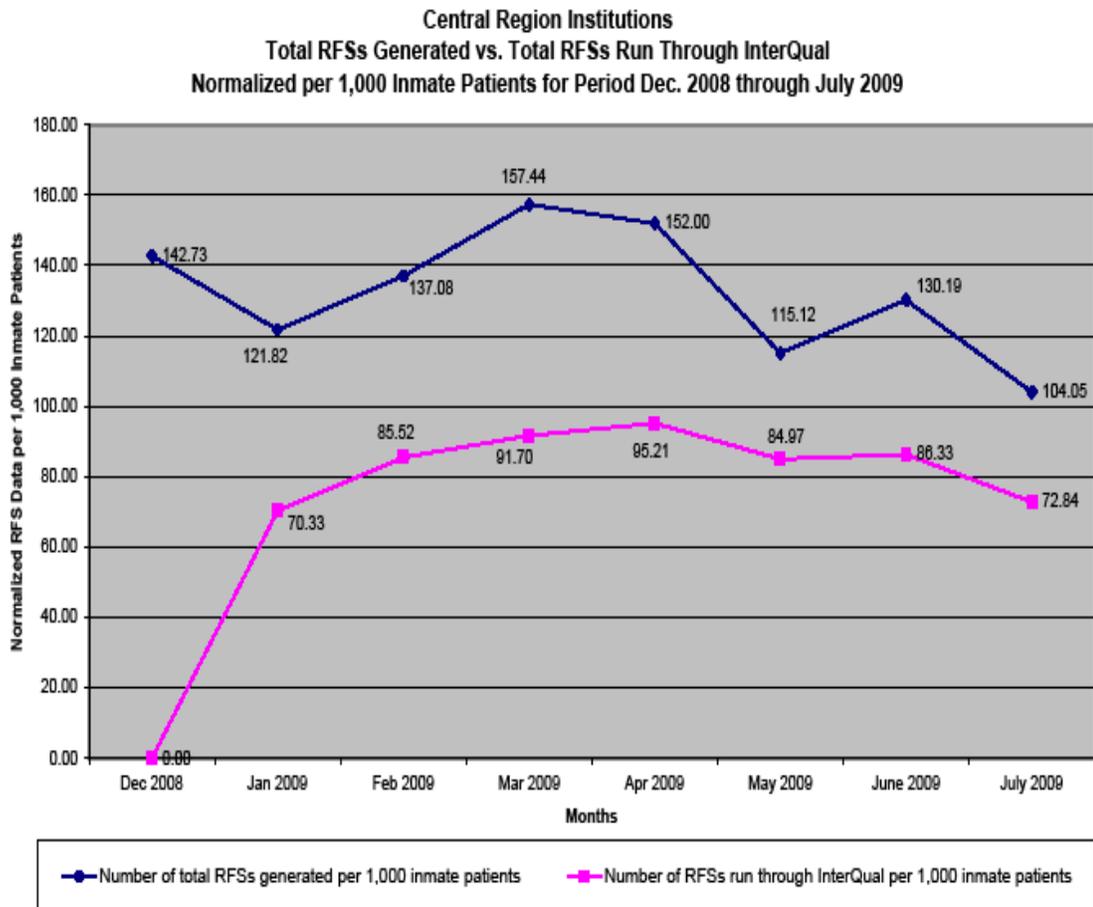


Table 3.



Ongoing Assessment

There has been a dramatic decrease in the number of medically unnecessary requests for services. On the average, the total number of referrals has decreased from the high of 25,000 per month (FY 08/09) to 15-16,000 per month. (See Table 4 below)

Table 4.

RFS Total	North	South	Central	Statewide
Baseline FY 08/09				25,000
April 2009	4,525	6,674	10,023	21,222
May 2009	3,479	5,647	7,482	16,608
June 2009	3,578	4,978	8,124	16,680
July 2009	4,905	4,245	6,600	15,750

Ongoing on-site audits are regularly performed to ensure that denials are not “overdone” and that decreasing utilization is medically safe and appropriate.

Challenges and Threats

Personal, direct and continuous UM physician advisor and nursing support continues to be essential to sustain the improvements achieved. These processes are new to CPHCS, and, while embraced by Headquarters leadership, have not yet become embedded into the institutions’ culture.

Threats to the success of the referral management program exist. Institutional cultural acceptance of careful resource management is not universally accepted, although an increasing number of institutions have positively adapted to recent changes. Organizational familiarity with the concepts of integrated healthcare (data driven healthcare management and closely integrated clinical and management functions) is weak.

Infirmiry/Community Hospital Bed Access

Regular clinical rounds on patients in institutional infirmiry beds and community hospital beds are required and monitored. Census review will be facilitated with the completion of a web-based, Microsoft SQL server supported electronic census report (CADDIS), which the UM team has designed in conjunction with the Project Management Office and Information Technology Services. For the first time, a statewide institutional community hospital and infirmiry bed census that is accurate will be available daily. Implementation of the system was completed on August 31, 2009.

While improvements in patient transfers and bed vacancies have resulted, significant challenges continue. Hospital aberrant bed days (patients who have no clinical reason to stay in the

hospital, but have no suitable, safe destination to return to) remain in the hundreds per month, despite significant attempts by management to reduce this number. Weekly surveillance of all infirmary beds in the Central Region reveals that a large percentage of patient beds are occupied by patients who are long-term and who will need alternative placement options before they can be discharged. The beds these patients occupy will not become available for hospital discharges until solutions are found. Predictable mental health overflow into medical beds continues to decrease bed availability on a regular basis and prevent hospital discharges. Even with maximum efficiency, given the lack of treatment beds within the organization, healthcare staff will have no option but to continue to use outside hospital and providers at a significant cost. The Receiver's office is aggressively pursuing alternative construction and patient transfer strategies to mitigate this problem, and they are described in other sections of this report.

Acute Community Hospital Bed Oversight

To enhance institutional surveillance and management of community hospital beds, the UM team has focused its efforts on the top 10 high volume hospitals, statewide. Daily census review and cooperative discharge planning efforts with hospital case management are ongoing.

Case Management

While awaiting organizational solutions to Case Management, UM processes have been implemented to identify highest cost patients, statewide, who generally represent the highest acuity medical patients, at risk for frequent hospitalizations and multiple specialty referrals.

Telemedicine

Standardized referral review processes, similar to off-site specialty requests have been implemented for all institutional telemedicine requests. Working with the Telemedicine team, additional analysis to determine which specialty areas would benefit from additional telemedicine referrals is planned. (See Objective 5.6 for more information)

Action 2.4.2. By October 2010, establish on a statewide basis approved contracts with specialty care providers and hospitals

ProdÁgio Contract Processing System

Implementation of an upgrade to the ProdÁgio system is in process. The upgrade will enhance reporting, security, and processing features for more efficient direct medical contract processing. However, while this system was implemented quickly to provide critical contract processing functionality, the system does not provide the full functionality required to meet program needs (i.e. encumbrance tracking, tracking of contract expirations, processing and approval workflows, expanded reporting). This and additional functionality is required for a fully functional contracting system and is expected to be provided by the CDCR's BIS as discussed below.

Streamlining Medical Contracting and Aligning Resources to Achieve Performance Goals

To the greatest extent feasible, medical contracts are now entered into as a statewide master, regional or joint contracts, rather than on an institution-by-institution basis. This contracting methodology significantly streamlined CPHCS' ability to provide greater patient-inmate access

to care. During this reporting period, 96 exempt from bid contracts and 15 exempt from bid contract amendments were executed. In addition, bid efforts initiated in the previous reporting period resulted in 93 bid contracts and 58 bid contract amendments executed for Respiratory Therapy Services, Temporary Relief Occupational Therapy, Mobile Ultrasound, Temporary Relief Radiology Technicians, Temporary Relief Clinical Laboratory Scientist, Temporary Relief Dietician and Temporary Relief Physical Therapists.

Effective July 28, 2009, SBX4 13 (Ch.22, Stats. 2009) amended Penal Code section 5023.5 to establish the maximum reimbursement rates payable to a contract provider of hospital services, physician services and ambulance services (130 percent, 110 percent, and 120 percent of Medicare Fee schedule, respectively) to California's patient-inmates. The Receiver's staff acted quickly to develop policies and procedures, as well as regulations to ensure that access to care remains available if unable to contract with a provider(s) at the legislatively-mandated reimbursement rates. The maximum reimbursement rates do not apply to services provided pursuant to competitively bid contracts, contracts executed prior to September 1, 2009, and contracts entered into through a CPHCS-designated healthcare network provider.

The Request for Proposal to obtain a medical services network from a Preferred Provider Organization (PPO), as allowed under the new legislation, will be released during the next reporting period. The use of a PPO will greatly enhance the availability of consistent healthcare services throughout the State for our patient-inmate populations.

Emergency Medical Services Committee

During the current reporting period, CPHCS Medical Contracts staff evaluated the CDCR ground and air transportation for healthcare needs and developed a comprehensive plan to provide these services to the institutions and conservation camps. The plan coordinates the need for emergency ground, non-emergency ground and air transportation with local government and current CPHCS contracts already in place. Implementation of the plan has begun, with thirty contract requests in process from the institutions.

Status of Chancellor Group Hospital and Associated Physicians Contract Negotiations

During this reporting period, the CPHCS contract with the Chancellor Consulting Group (CCG) was terminated, and hospital negotiation responsibilities were transferred to the CPHCS Medical Contracts Branch. The Branch is aggressively pursuing hospital and physician panel contracts, both previously negotiated by CCG and others, at rates consistent with the newly-implemented legislation discussed above.

CDCR's Business Information System Integration

CPHCS is continuing its participation in work groups and training sessions organized by the CDCR BIS Team. It is expected that the CDCR BIS system will include the current ProdÁgio system functionality as well as address the functionality currently lacking in that system as discussed above (see ProdÁgio Contract Processing System).

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

Medical Invoice Processing Days

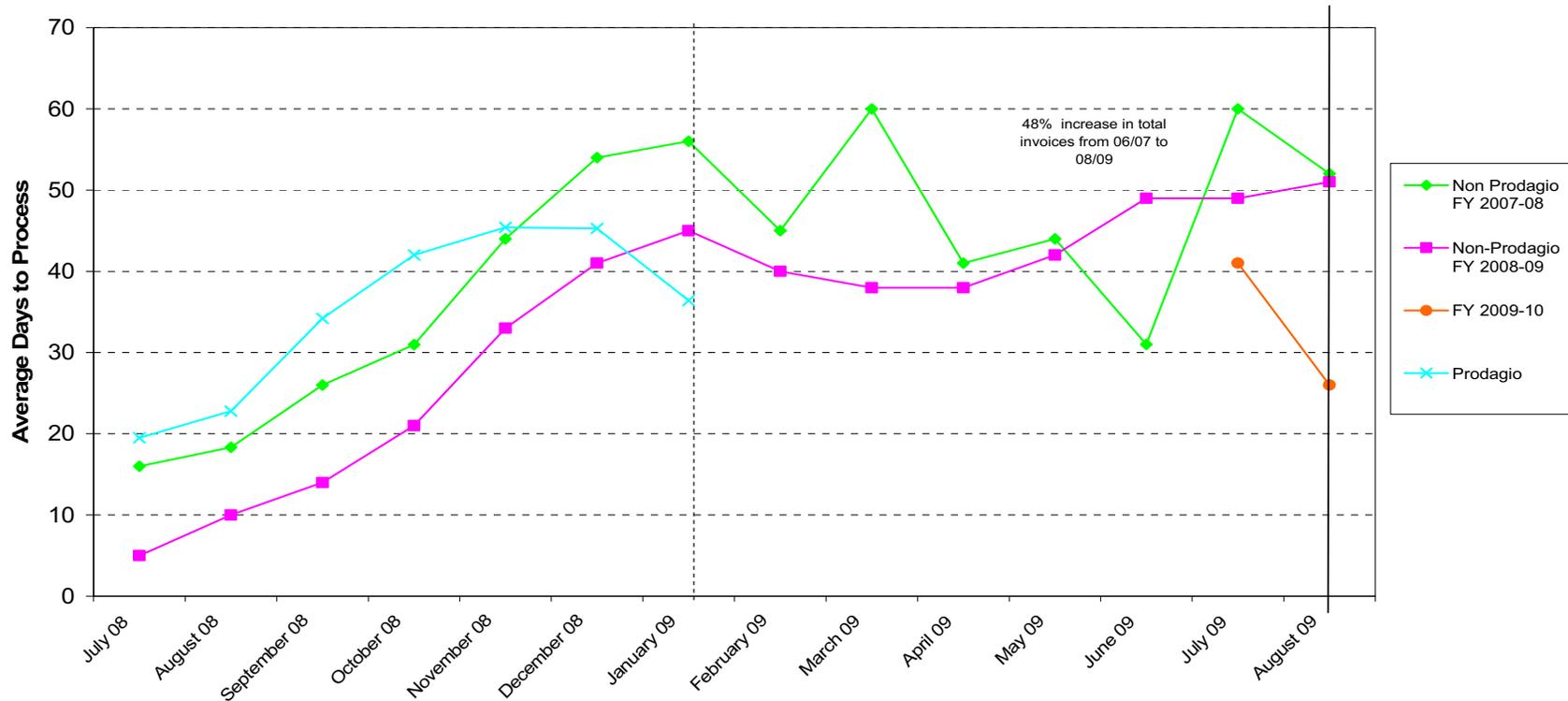
Due to the State's fiscal crisis and the resulting furlough program, the initial success of reducing the backlog has diminished. An initiative is underway to mitigate the impact of the furloughs and will be addressed in the next report.

Between February and April, calls from providers about aged accounts receivables diminished significantly. However, since May of this year calls from many of our largest physician and hospital providers have increased. These calls indicate a growing concern regarding outstanding payments due. The untimely payments have also contributed to continuing hardship on providers some of which may be small businesses.

As of June 2009, the average number of invoices processed per day is decreased from the last reporting period. Remedies are under development to address the growing backlog of invoices. However, as explained further below, the full implementation of the Third Party Administrator will likely reverse this trend in the late fall. See Table 5 below for a display of the Statewide Invoice Processing Days trends.

Table 5.

**Statewide Invoice Processing Days
July 1, 2008 through September 8, 2009**



*Date range: 7/1/08 - 9/8/09

*FY 07/08 - Total # of Invoices for Non-Prodagio **236,709**, Prodagio **51,744**.

*FY 08/09 - Total # of Invoices Non-Prodagio **293,328**, Prodagio **19,254**.

*FY 09/10 - Total # of Invoices **8,723**.

*Total number of invoices is under-stated due to data entry inconsistencies with invoice numbering.

*Prodagio numbers for 07/08 reflect all invoices for CCWF, CMF, PBSP, SQ, FSP, and SOL through 11/17/08. CCC, COR, HDSP, and SATF to Prodagio in August 2008 through 11/17/08.

*In order to eliminate duplicate counting of invoices, any institution's invoice sent to accounting on or after 11/18/08 is considered "Non-Prodagio".

*Institutions no longer use Prodagio to process invoices. There are no production averages beyond January 2009. (Indicated by dashed line on graph)

Contract with the Third Party Administrator (TPA)

In order to assist with the growing backlog, the TPA began to manually process all hospital claims on July 1, 2009. While the TPA never intended to manually process these claims, it has helped to identify bottlenecks in the process, which will ultimately have a positive effect in building the electronic claims processing system. Although this manual process slows progress, the TPA will continue to process claims manually in a phased approach adding physicians and other providers until all of the systems are in place to begin the electronic claims processing system.

Staff, working with consultants, is developing several technical interfaces to support the electronic claims processing system. One interface will assist the TPA in identifying eligibility of the inmate through access to Offender Based Information System and another allows transmission of utilization and expenditure data back into the contract medical database. Additionally, the payment and reporting interfaces between the TPA, CPHCS BIS system and the State Controller's Office are being designed. The completion of these interfaces has extended beyond the initial timeframes. However, the entire project remains on schedule and full implementation is expected by fall 2009.

The contractor who was selected to perform the two-year post audit and go forward audit, Viant, has received copies of the contract medical database and begun the initial identification of duplicate payments to vendors. The first recovery letters will be sent out in the next few weeks. Several hospitals have been selected to identify the feasibility of obtaining two-years worth of electronic claims data necessary for comprehensive audit. Outcomes of these initial recovery letters audits will be reported in the next Tri-Annual Report.

Status of Contract Medical Database System Upgrades

The redesigned web-based Contract Medical Database (CMD) has been developed and deployed. The web-based CMD combines the 33 institutions' databases into a single centralized database providing real-time access to information and streamlining the maintenance of contracts and vendor data. The web-based CMD allows medical contract and fiscal staff access to contract medical utilization and expenditure data to aid them in preparing reports for contract negotiations and budget documents.

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 2010, fill 90% of nursing positions

As of July 31, 2009, which is the most recent reporting period available, approximately 90 percent of the nursing positions have been filled statewide (this percentage is an average of six State nursing classifications)¹.

More specifically, the goal of filling 90 percent of the RN positions has been achieved at 21 institutions (63.6 percent of all prisons). Ten institutions (30 percent) have filled 80 to 89 percent of their RN positions. The goal of filling 90 percent of the LVN positions has been achieved at 16 institutions (48.5 percent) and 16 institutions (48.5 percent) have filled 80 to 89 percent of their LVN positions. Seventeen institutions (51.5 percent) have achieved the goal of filling 90 percent of their Psych Tech positions. Nine institutions (27.3 percent) have filled 80 to 89 percent of their Psych Tech positions.

A growing concern is the increase in the number of nurses leaving state service during this reporting period. From February 2009 through April 2009, 53 nurses separated from state service. From May 2009 through July 2009, 62 nurses separated from state service. Then in just the month of August, after the third furlough day was implemented, 59 nurses separated from state service. These separations include service retirements and voluntary resignations. Based on reports from staff, many of the separations are due to the furlough days and the resulting cut in pay.

The following hiring-related initiatives continued during the reporting period: (1) focused recruitment continues statewide for LVNs and Psych Techs; (2) presentations at nursing schools statewide; (3) online advertisements; and (4) mass mailers targeting LVN classifications. 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. We hope to alleviate future issues with lack of LVN and Psych Tech candidates by initiating our own training programs through adult education and community college offerings, subject to the availability of funds.

As displayed in the Nursing Filled Percentage and Turnover Rate map in the July Human Resources Recruitment and Retention Report, Nursing has experienced moderate turnover (11 to 19 percent) and moderate vacancies (70 to 89 percent filled) at Richard J. Donovan Correctional Facility and California State Prison Solano. They are also experiencing moderate vacancies (70 to 89 percent filled) at Ironwood State Prison, Chuckawalla Valley State Prison, California Correctional Institution, California Men's Colony, Kern Valley State Prison, North Kern State

¹ The percent filled is based on the current number of established positions.

Prison, Pleasant Valley State Prison, Correctional Training Facility, California State Prison Corcoran, Substance Abuse Treatment Facility, Valley State Prison for Women and Sierra Conservation Center. Moderate turnover (11 to 19 percent) is being experienced at Salinas Valley State Prison and Wasco State Prison. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for May, June, July and August 2009. These reports are included as Appendices 4 - 7. Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the follow information by institution: (1) Physicians Filled Percentage and Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate. Also included as Appendices 8 and 9 are the Human Resources Monthly Reports for May and June 2009.

Action 3.1.2. By January 2010, fill 90% of physician positions

Physician recruitment efforts continued to focus on “hard-to-fill” institutions during the reporting period. Most urban institutions have now hired their full complement of primary care providers.

As of July 31, 2009, approximately 88 percent of physician positions are filled (this percentage is an average of all three State physician classifications).⁴ More specifically, 89 percent of the CMO positions are filled; 79 percent of the Chief P&S positions are filled; and 89 percent of the P&S positions are filled. Eighteen institutions (54.5 percent) have achieved the goal of filling 90 percent of their P&S positions; all of these institutions have filled at least 95 percent of their P&S positions. Five institutions (15.2 percent) have filled 80 – 89 percent of their P&S positions. The Central Valley region, along with High Desert State Prison, Pelican Bay State Prison, and Chuckawalla Valley State Prison continue to be “hard-to-fill.”

The goal of this Action is to obtain a 90 percent fill rate for physician positions by January 2010. The current filled rate for physicians is 89 percent. Recruitment efforts have been redesigned due to a significant reduction in budget allotted for recruitment activities; however, job postings continue to be placed online at the Department’s recruitment website, and recruiters continue to visit residency programs and other recruitment events.

As displayed in the Physicians Filled Percentage and Turnover Rate map in the July Human Resources Recruitment and Retention Report, Physicians have experienced high (69 percent or less filled) vacancy rates and high (20 percent or more) turnover rates at Pelican Bay State Prison, High Desert State Prison, Correctional Training Facility, Avenal State Prison, California Correctional Institution, and Chuckawalla Valley State Prison. They have also experienced high (20 percent or more) turnover at Salinas Valley State Prison, Central California Women’s Facility, California State Prison Los Angeles County, and Ironwood State Prison. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for May, June, and July 2009. These reports are included as Appendices 4 - 6. Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the follow information by institution: (1) Physicians Filled Percentage and Turnover

⁴ The percent filled is based on the current number of established positions.

Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

Objective 3.2 Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2010, establish and staff new executive leadership positions

Action 3.2.2. By March 2010, establish and staff regional leadership structure

The Chief Executive Officer (CEO) examination was launched on December 24, 2008. Since the exam commenced, 313 CEO eligible applicants have been added to the certification list and two hires have been completed. Due to the severity of the State's fiscal crisis, the salary structure for the CEOs has been reduced to more closely approximate that of the institutional wardens; however, a differential for hard to recruit or high cost areas and the performance incentive features were retained as additional means of compensation. The new salary range has been approved and the Department of Personnel Administration (DPA) is issuing a pay letter. Current list eligible applicants have been informed of the new salary structure.

Strategically, the CEO positions will be filled first at each institution and this individual will then play a pivotal role in establishing the remainder of the clinical structure. Efforts are underway to proceed with the hiring of all CEOs.

The Receiver's Nurse Executive examination was launched in September 2008. Since the examination commenced, 218 Nurse Executive eligible applicants have been added to the certification list and eight Nurse Executives have been hired. Of these eight total hires in this classification, three Nurse Executives began work in May 2009. However, three other Nurse Executives declined job offers during this reporting period due to higher salary expectations.

The Receiver's Medical Executive examination was launched in December 2008. Since the examination commenced, 74 Medical Executive eligible applicants have been added to the certification list and nine Medical Executives have been hired. These employees commenced work in March, April, and June 2009.

The State Personnel Board (SPB) approved a fourth Receiver's Career Executive Assignment (RCEA) classification, entitled Clinical Executive on September 3, 2008. This classification is intended for the chief and assistant chief responsible for all allied health disciplines (rehabilitation, pharmacy, laboratory, radiology, optometry, podiatry, respiratory and dietary services). The civil service examination for this classification is nearing completion and should be finalized by the time DPA issues the pay letter. An organizational structure has been approved by CPHCS executive management and plans are being formulated to recruit for five of the listed specialties during the coming months.

A fifth and final RCEA, Health Care Administrator, was submitted to DPA and SPB for consideration on January 4, 2009. This RCEA classification will be responsible for all medical administration subject areas that are not clinical in nature. This classification would complete the RCEA executive management structure for healthcare. This classification item remains under submission at SPB.

CPHCS has received delegation for the establishment of CEA positions, thus relieving some of SPB's workload. To handle the numerous items requiring DPA assistance, CPHCS is funding one position at DPA that will be dedicated solely to the CPHCS workload.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2010, establish statewide organizational orientation for all new healthcare hires and institution-specific clinical orientation through a nursing preceptor or proctoring program

Status of New Employee Orientation and Training

Due to State-imposed restrictions on travel, the Health Care New Employee Orientation (HCNEO) program was placed on hold effective February 9, 2009. The HCNEO program has resumed for those staff located in the greater Sacramento area where no travel is required; however, CPHCS new hires in the field continue to attend local CDCR New Employee Orientation via the institution In-Service Training Office until an alternate delivery method using a blended learning approach, such as satellite and e-learning can be developed and implemented. Portions of the orientation are now being conducted for our out-of-state patient-inmate providers using WebX meetings through the Internet. An updated plan for delivering statewide organizational orientation will be provided in the next Tri-Annual Report.

Status of the Proctoring/Mentoring Program

CPHCS is committed to providing qualified proctors and mentors for the purpose of orienting new staff to correctional nursing, improving job satisfaction and reducing employee turnover. The proctor and mentor program is designed for all new RNs and LVNs assigned to perform patient care functions. The proctor and mentor program consists of a four-week program for RNs and a three-week program for LVNs in addition to the four-day HCNEO.

Full implementation of a proctoring/mentoring program was put on hold at the end of February 2009 and will be discussed in more detail in the next Tri-Annual report.

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

The Action has been completed.

During this reporting period, the following six Continuing Medical Education courses have been provided to a total of 389 MDs and 478 non-MD participants.

- Primary Care Introduction to Hepatitis C
- Primary Care Introduction to Chronic Pain Management
- Coccidioidomycosis – Review of 2 Atypical Cases
- Principles of Just Culture – Application to Critical Care
- Crash Course in Asthma Classification and Management
- 2009 Program Guide Training (Mental Health)

In addition, the following six courses are pending approval or implementation.

- Summary of the above Mental Health Program Guide (for medical providers)
- Differential Diagnosis of Acute Joint Pain
- Primary Care Evaluation of Low Back Pain
- Tuberculosis (TB) 202: Focus on Corrections
- Diabetes activity
- New Chronic Pain Policy Pain Management (new policy)

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, RAND continued its work under a contract with CPHCS to assess current measurement activities; collect information about other correctional and health system approaches to quality measurement; and recommend strategies for the CPHCS to routinely measure and evaluate performance. RAND assembled a list of over 1,200 possible performance indicators obtained from other healthcare systems and over 50 CDCR key informant interviews. The indicators were tested against criteria for true performance measurement resulting in approximately 90 key performance indicators identified to reflect quality of medical, mental and public healthcare. In July 2009, these indicators were evaluated by a nine-member expert panel that ranked them based on importance and feasibility. Final recommendations by RAND and the expert panel will be issued in October of 2009.

In addition to collaboration with RAND, the Measurement and Evaluation Unit staff continued to assist clinical staff in implementing and evaluating the implementation of the primary care model at all 33 institutions. Additionally, based on the expert panel recommendations, we are refining a work plan to collect, validate and evaluate a few key healthcare outcome measures within the next few months. The budget reductions to the unit have necessitated exploring alternate methods for collecting and analyzing performance measurement and patient safety data. Lack of staff and travel resources to validate data from paper medical charts have limited staff's ability to monitor certain quality improvement interventions but alternative methods of accessing and incorporating medical chart data into the quality measurement system by July 2011 are being considered.

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 is divided into two phases. Phase I included program development and pilot implementation, and Phase II included statewide rollout and implementation. Phase I is complete and Phase II is well underway.

As of the close of this reporting period, the OIG has completed five additional inspections at Central California Women's Facility, California Men's Colony, Sierra Conservation Center, California State Prison, Los Angeles County, and Pleasant Valley State Prison respectively. The first year inspection results will establish a baseline that will provide an objective, clinically appropriate method to evaluate and monitor the progress of medical care delivery to patient-inmates within each institution. Once final inspection reports are issued, the inspection results for each institution are available to be viewed on the OIG website at <http://www.oig.ca.gov/pages/reports/medical-inspections.php> and the CPHCS website at <http://www.cphcs.ca.gov/audits.aspx>.

During this reporting period, the Program Compliance Section performed its first follow-up review at California State Prison, Sacramento as a result of the OIG medical inspections. The follow-up review focused on those areas where the institution stated corrective action of the OIG findings had been fully implemented. These follow-up reviews will provide the necessary monitoring to ensure progress continues towards a system of adequate medical delivery for patient-inmates.

Objective 4.2. Establish a Quality Improvement Program

Part of the Quality Improvement Program has been the implementation of a Credentialing and Privileging Program. The Program contains both a formal committee and a support unit to process all initial and reappointment medical staff applications, while ensuring all providers have adequate and current credentials.

Credentials Committee

During this reporting period, the Committee reviewed 44 individual practitioner cases. Of those cases, 23 were approved, 8 denied and 13 are pending a final determination. An activity report is presented to the Professional Practices Executive Committee and the Governing Body on a monthly basis. This activity report lists the specific files and decisions made on all credential applications received for the CPHCS, CDCR, specific Department of Mental Health employees, specific Community Correctional Facilities and Telemedicine providers. Within this reporting period, the Unit processed 393 initial application credential requests. Of these, 278 were approved, 18 denied, 14 were closed due to incomplete and/or untimely requests and 83 files are pending completion.

Two-Year Reappointment Compliance

During this reporting period, the *CredentialSmart* on-line reappointment process was initiated. Since May 2009, 764 practitioners have been advised that it is time for their two-year reappointment. Of this total, 534 reappointments have been completed and 230 files are pending completion either by the practitioner or by the Unit. The two-year reappointment process is a requirement of all civil service and contract providers during their duration of employment and/or providing services to the Department.

Tracking of License and Board Certification Expirations

During this reporting period, 102 Notice of Licensure Expirations were processed and renewed. To date all practitioner licenses are current. In addition, eleven board certification expiration notices were provided to the human resources department for processing. The tracking of expiring license and certifications is an on-going process with notifications being sent out regularly to ensure that the practitioners have active, current credentials and/or licenses at all times.

Backlog and Delays in Processing

The number of pending files is higher than any previous reporting periods, which is due in part to the resource impact of the furloughs. Not only is there a delay in the processing of files but in the

review of files by the Chief Clinicians. With the furlough affecting the clinical leaders, their ability to review files in a timely manner has also diminished. In addition, the Credentials Committee is now meeting on a biweekly basis to make final decisions regarding providers credential files. These delays will continue to cause a delay in the hiring of civil service practitioners as well as contract practitioners and specialists, and steps are underway to mitigate these delays.

Action 4.2.1.(merged Action 4.2.1 and 4.2.3): By January 2010, train and deploy existing staff--who work directly with institutional leadership--to serve as quality advisors and develop model quality improvement programs at selected institutions; identify clinical champions at the institutional level to implement continuous quality improvement locally; and develop a team to implement a statewide/systems-focused quality monitoring/measurement and improvement system under the guidance of an interdisciplinary Quality Management Committee

During this reporting period, the Quality Improvement Section was reorganized and the objective actions have been revised. The new plan for the Quality Management Improvement program will include a small headquarters team of clinicians supported by analytical staff dedicated full-time to state-level oversight, monitoring and training functions. They will coordinate and evaluate statewide and systems-focused quality improvement activities under the guidance of an interdisciplinary Quality Management Committee (QMC).

Regional QMI leadership will be coordinated by existing nursing and physician staff who travel to the institutions on a regular basis to monitor and address a variety of issues and who maintain ongoing relationships with institutional healthcare leaders. These staff will work closely with quality improvement teams and clinical champions at each institution. To achieve this action, state-level, regional and institutional staff from throughout CPHCS will be trained by January 2010 with the goal of full deployment and statewide implementation by June 2010.

In addition, during this reporting period a joint interdisciplinary QMC (encompassing medical, mental health and dental issues) has begun to meet on a regular basis. The QMC has met a total of five times to provide direction to the QMI work plan, with an initial focus on measurement of healthcare quality processes and outcomes. The interdisciplinary Clinical Guidelines Committee which reports to the QMC has continues to meet and has made adjustments to and adopted national guidelines on diabetes care. The best practices that are identified and guidelines that are approved will be used as a basis for development of training and medical education programs and tools to support quality improvement at the institutions.

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

This Action has been completed.

During this reporting period a policy tracking system was procured and user training on the new system is in progress. Planning is also underway to expand the system statewide. The Policy

Unit staff have identified the most current versions of medical policies and uploaded them into the new policy tracking system. Staff has also begun the process of updating existing policies and procedures, centralizing the policy development process, and standardizing the development of new policies and procedures.

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

This Action has been combined with Action 4.2.1.

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 has been completed.

Graphical displays of Professional Practice Executive Committee outcomes for the period May through August 19, 2009 are presented in the Tables 6 and 7 below.

Table 6.

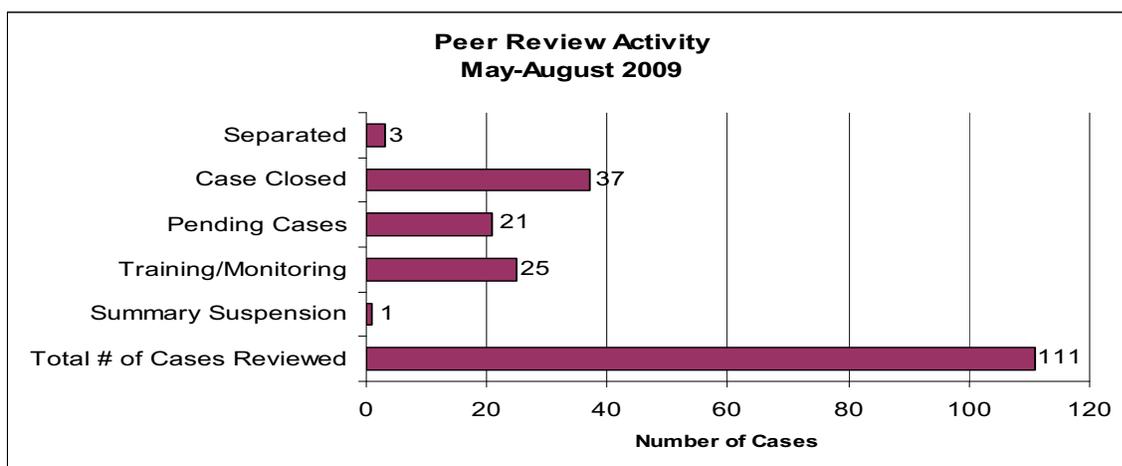
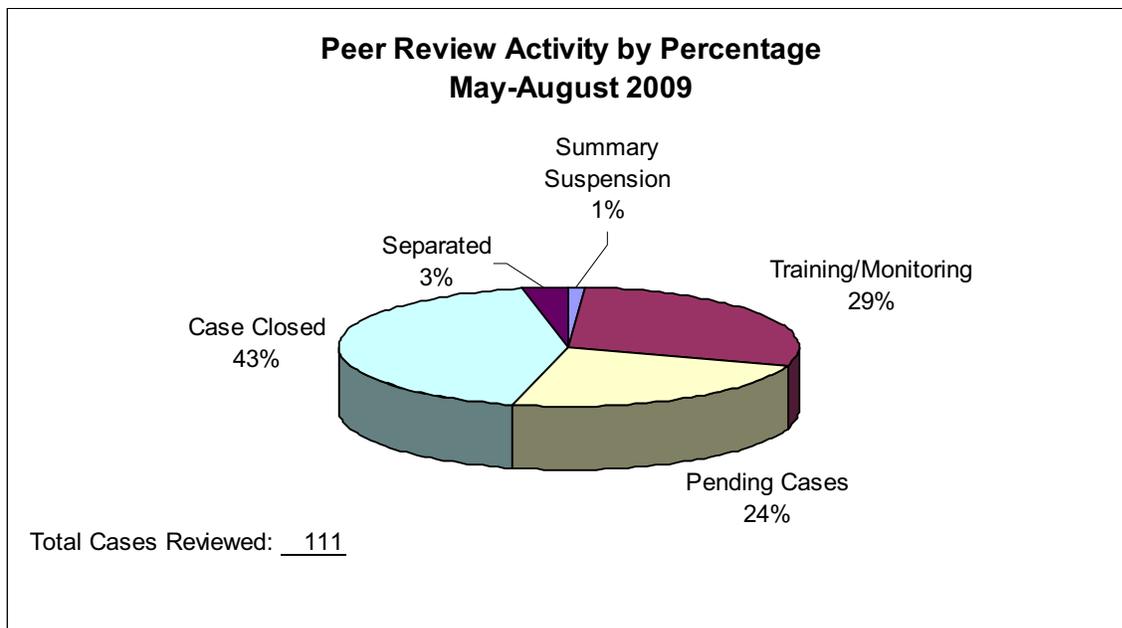


Table 7.



Tables 6 and 7 Results Explanation:

The data represented pertains to physicians and surgeons and mid-level providers.

“Separated” status refers to employees that separate from State service after a peer review investigation is initiated by PPEC.

“Case closed” is defined as physicians or mid-level providers that are deemed to be practicing at an appropriate standard of care after conclusion of training/monitoring or a peer review investigation.

“Pending cases” are referrals that are not yet closed due to training /monitoring or further information needed.

“Training/Monitoring” is the manner in which provider’s are supported in the development of clinical competency through training/monitoring.

“Summary Suspension” is defined as a suspension of some or all of a practitioner’s clinical privileges by a peer review body based on the determination that allowing the practitioner to continue without such limitation would put patients at risk.

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

This Action has been completed.

A graphical display of Medical Oversight Program outcomes for May through August 2009 is presented in Tables 8 and 9.

Table 8.

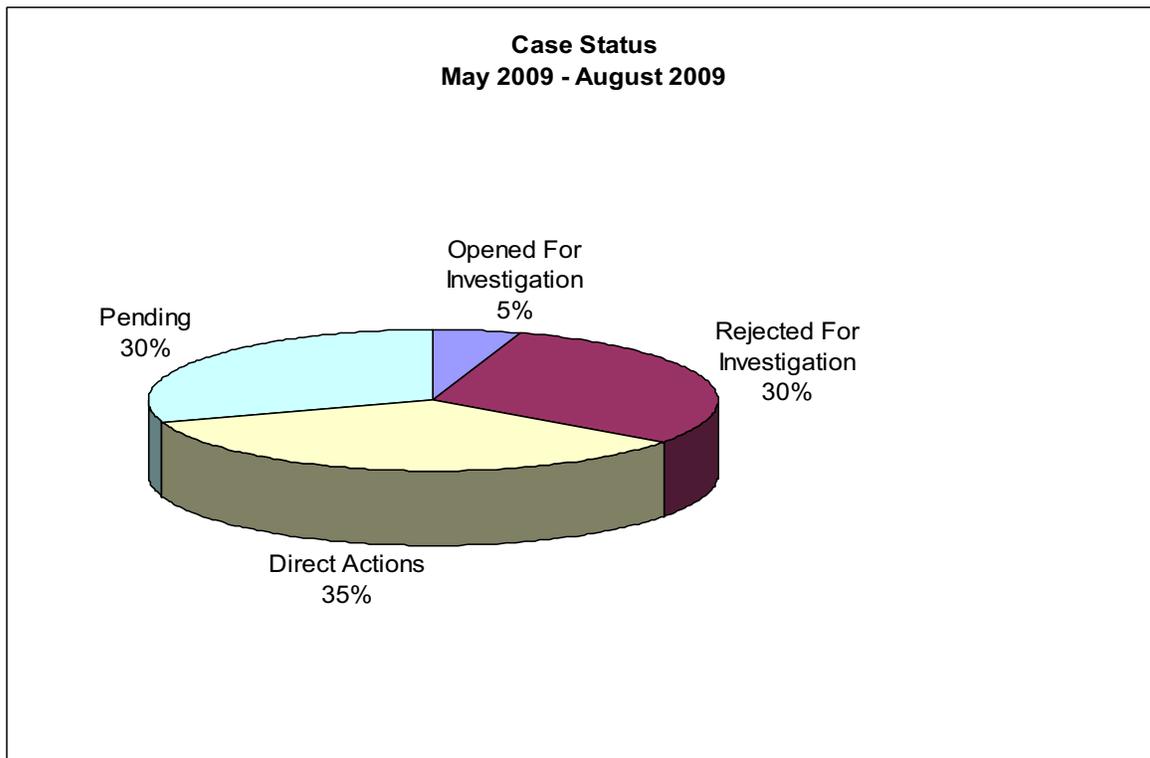


Table 8 Results Explanation:

“Opened for Investigation” is a formal investigation conducted by MOP.

“Rejected for Investigation” is when a MOP inquiry does not result in a formal investigation being opened (e.g. due to insufficient facts to support an investigation).

“Direct Actions” are when a request for investigation is referred back to the hiring authority (healthcare manager) for employee remedial training, counseling, a letter of instruction, or adverse action for general administrative corrective purposes (e.g. attendance).

“Pending” is when a case is awaiting an investigatory assignment prior to Medical Inquiry Panel review.

Table 9.

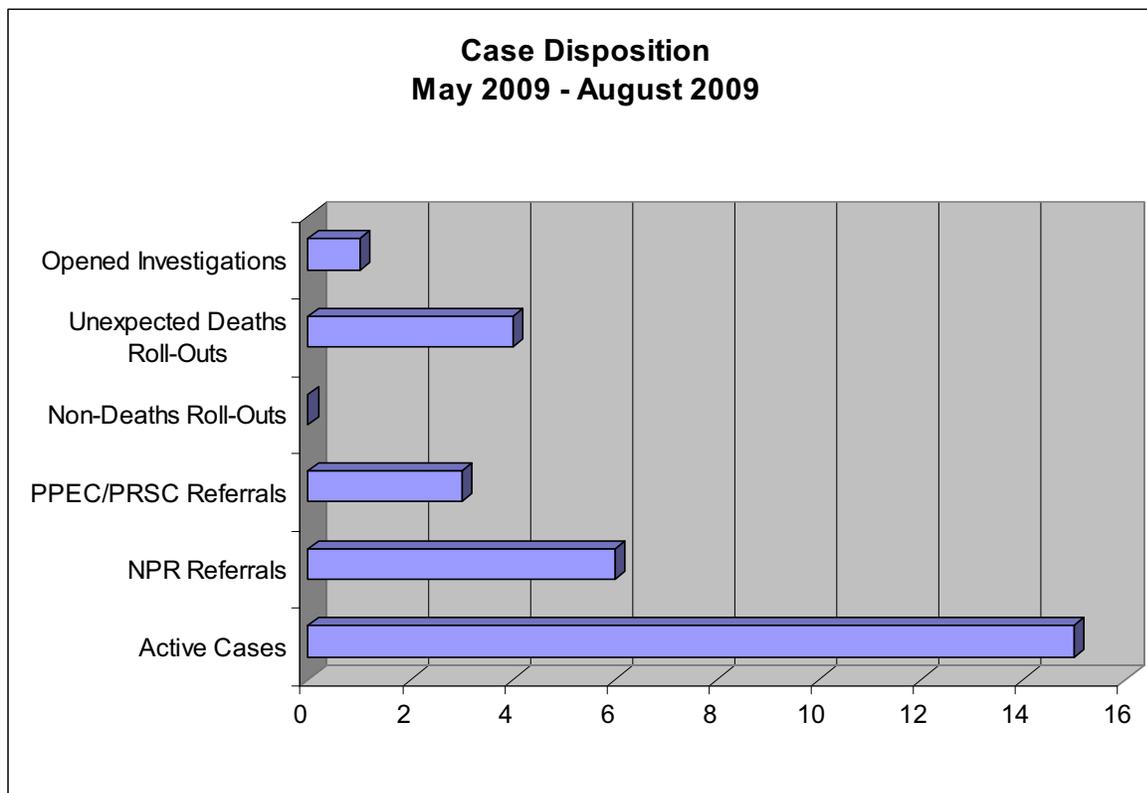


Table 9 Results Explanation:

“Active Case” is any case currently under inquiry by the MOP (i.e. under preparation for Medical Intake or in the investigative process).

“NPR Referral” is made when the Medical Intake Unit suspects substandard clinical practices by a nurse and refers the case to the Nursing Practice Review Program.

“PPEC Referral” is made when the Medical Intake Unit suspects substandard clinical practices or clinical misconduct by a physician or mid-level provider and refers the case to the PPEC.

“Non-death Roll-Outs” are defined as any act that may cause imminent danger to the patient-inmate (e.g. disruptive conduct, unethical conduct, substandard competencies, fail to perform standards of care).

“Unexpected Death Roll-Outs” are cases when a patient-inmate is one of the following: 40-years old or less and has had no history of a chronic medical condition; was seen two or more times in the TTA within the last week of life, submitted two or more request for services in the last week of life. “Unexpected death cases” also include cases where possible inappropriate, absent or untimely care is suspected; death is directly attributed to asthma or a seizure condition; the patient-inmate returned from an off-site emergency room visit or acute care inpatient stay within 14 days prior to death; or a medication error is suspected.

“Opened for Investigation” are formal investigations conducted by MOP.

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 healthcare patient-inmate appeals, correspondence and habeas corpus petitions

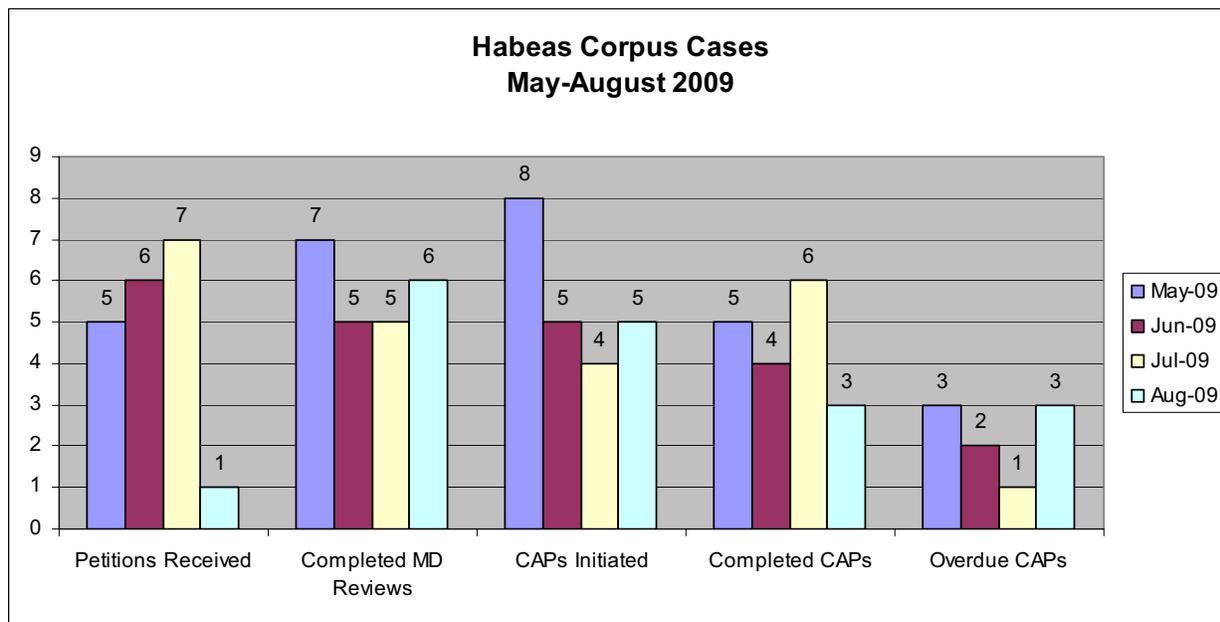
This Action has been completed.

Habeas Corpus Petitions

The volume of Habeas Corpus petitions received remains inconsistent from month to month (e.g. in March 2009, eleven were received and in May 2009, five were received). However, an average of seven petitions was received each month since late 2008. During this reporting period, an average of six habeas corpus petitions were received; an average of six Corrective Action Plan (CAP)s were initiated; an average of five CAPs were completed; and an average of two CAPs were overdue.

Refer to Table 10 below regarding habeas corpus petitions for May through August 2009.

Table 10.



Institutional Health Care Appeals

During this reporting period, the monthly average of healthcare appeals received at institution healthcare appeals offices increased from 12,169 during the prior reporting period to 12,369. The monthly average of all healthcare appeals processed at institutions increased from 12,018 during

the prior reporting period to 13,183. However, the monthly average of overdue appeals statewide declined from 1,751 during the last reporting period to 1,467.

Office of Third Level Appeals- Health Care

On August 1, 2008, the Office of Third Level Appeals began receiving all third level appeals regarding healthcare issues that were previously processed by CDCR. Due to the higher than anticipated volume and a necessary clinical review there continues to be a significant and growing number of overdue appeals. In an effort to address this, a re-engineering analysis has recently been completed to streamline the Office of Third Level Appeals processes. Additionally, some staff has been redirected from other departments within CPHCS and overtime has been approved to assist in alleviating the backlog of overdue appeals. The fruits of the re-engineering process began to materialize during the month of August 2009, with the percentage of completed appeals increasing substantially.

Table 11 below displays data related to Inmate Appeals Statewide for May through August 2009 and Table 12 below displays data related to the Office of Third Level Appeals for May through August 2009.

Table 11.

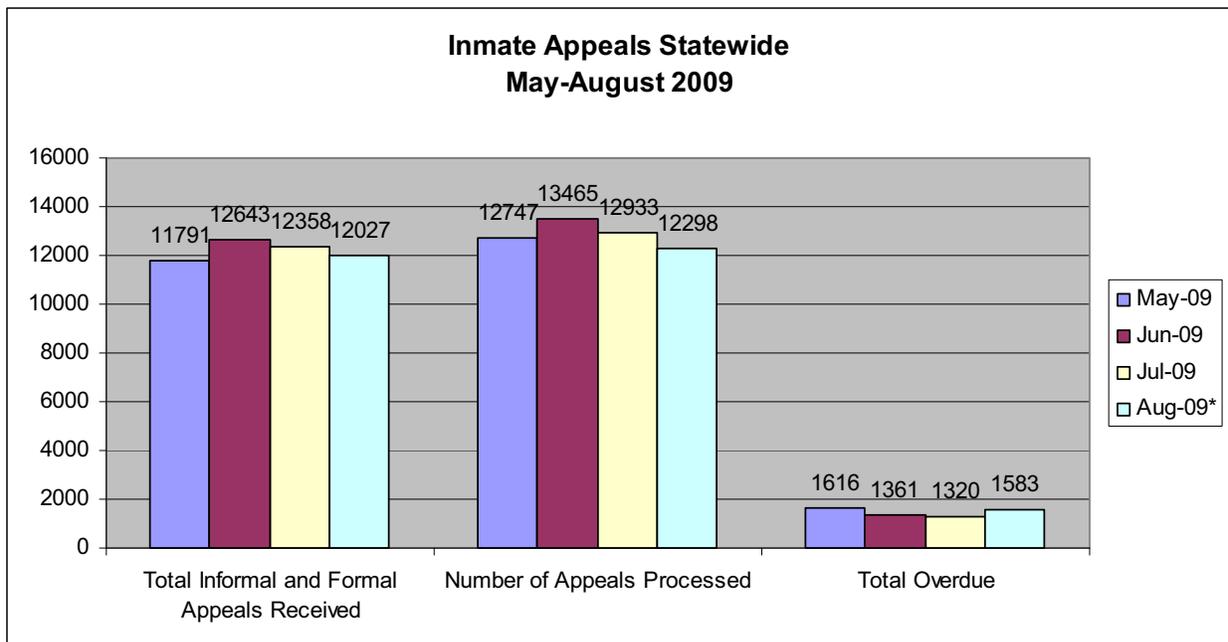
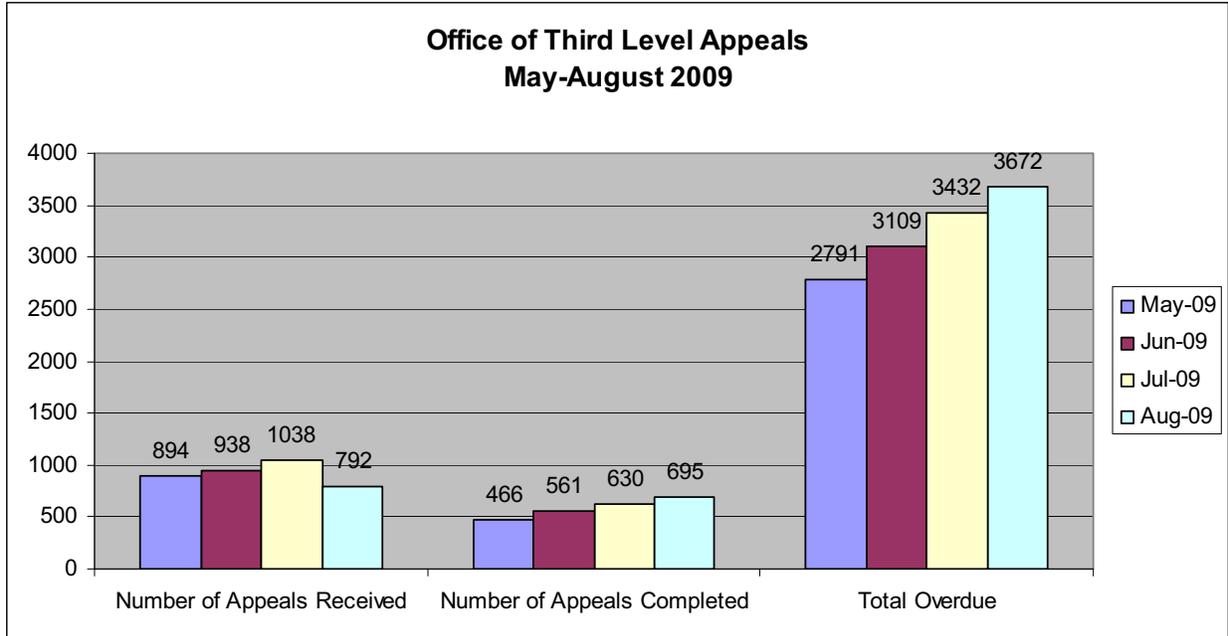


Table 12.



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

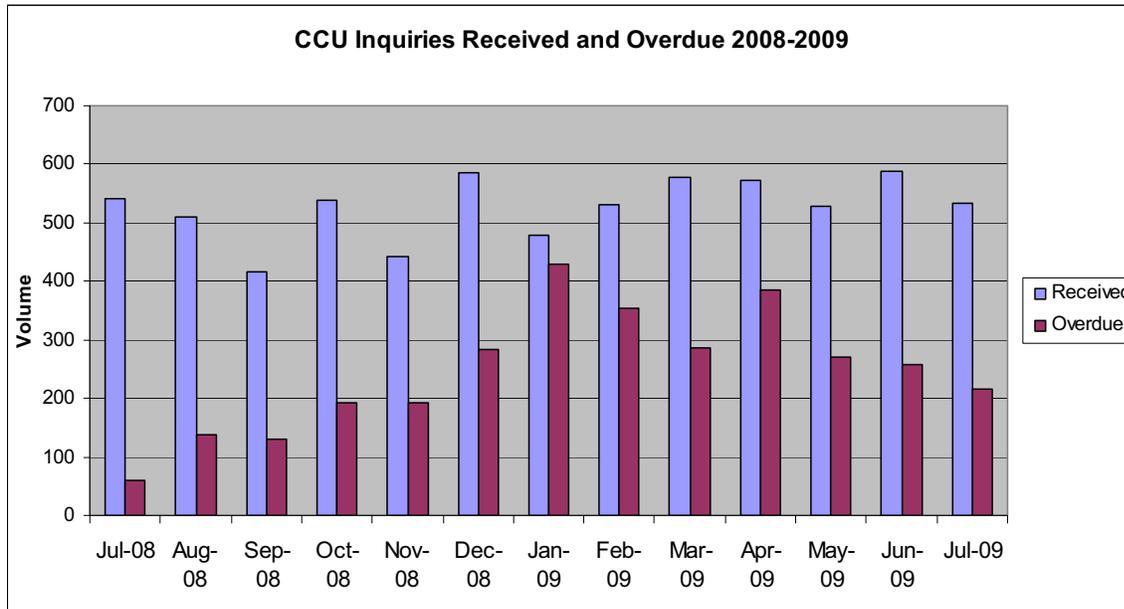
This Action has been completed.

Controlled Correspondence and Litigation Support Unit (CCLSU)

Additional staffing for a new Controlled Correspondence team to address the increased workload has been added. Overdue responses spiked in January 2009 to a high of 430, but with the increased staff and a limited amount of overtime, overdue responses have trended downward for the past three consecutive months as follows: May – 271, June – 258, and July – 215. In addition, policies and procedures are currently being reviewed to streamline CCLSU processes, and it is anticipated the number of overdue responses will continue to decrease.

See Table 13 below regarding the tracking of CCLSU incoming inquiries and overdue responses. The CCLSU Executive Summary Reports for May - July 2009 are attached as Appendix 10.

Table 13.



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

This Action has been completed.

Current Activities

During this reporting period, CPHCS’ Field Support Division, Program Oversight Unit and the Corrections Corporation of America (CCA) have continued to work collaboratively on improvements at the Tallahatchie County Correctional Facility (TCCF) in Mississippi. Status updates on remedial measures agreed to be implemented by CCA include:

1. Implement a CAP in a timely manner at TCCF.

The following items were finalized and approved by CPHCS and are pending implementation by CCA; Health Evaluations for Pre-Segregation/Segregation Access to Health Care; Informed Consent/Refusal of Care; Observation Beds; Off-site Care-Consultation; Physician’s Orders and Nursing Protocols; Sick Call; Health Appraisals; Initial Intake Screening; and Inventory Management.

In addition, the policies identified below have been finalized as they relate to the medical program; however, the transportation policy contains outstanding security related issues that must be addressed between CCA and CDCR. Because these policies are interrelated a decision has been made to postpone approving the policies until all outstanding security related issues have been finalized, thereby ensuring no adverse impact to the medical program. It is anticipated that the following policies will be approved by CDCR and CPHCS during the next reporting period are Pharmaceuticals; Transportation; and Transfer/Release Screening and Follow-up.

CPHCS staff continues to work with CCA to resolve the outstanding issues related to the following policies, Medical Records; Infection Control; and Credentialing, Privileging and Licensure which should be finalized during the next reporting period.

The CCA policies related to implementation of chronic care, quality improvement, peer review, investigations, sentinel events and medical emergency response programs remain outstanding. The status of each of these programs will be updated during the next reporting period.

2. Increase clinical staffing at TCCF.
During this reporting period, CCA submitted the modified staffing analysis for TCCF. It is anticipated that CPHCS staff will review the staffing analysis and discussion related to discrepancies in methodology will occur with CCA during the next rating period. Once the staffing levels and classifications have been agreed upon, CCA will be required to follow State processes to obtain any modifications to their existing budgeted/contracted levels.
3. Seek approval by the Receiver's clinical team concerning all future physician hires that will treat California patient-inmates.
During this reporting period, CCA's CMO completed review of the final draft policies related to credentialing, privileging and licensure and peer review policy and identified issues that need to be addressed by CPHCS. The final policy was submitted to CPHCS's clinical leadership for review and final approval during this reporting period. The Receiver's clinical staff continues to perform Clinical Performance Appraisals on all licensed independent practitioners providing care to California patient-inmates.
4. Establish a special CCA oversight organization to monitor and manage the healthcare provided at all CCA facilities that house California patient-inmates.
CPHCS staff is in the process of reviewing the remaining policies associated with the CAP. Additional meetings will be scheduled with CCA to finalize the outstanding policies so that we can obtain final approval and begin the implementation process at TCCF.
5. Over time, CCA will implement the TCCF remedial plan at all CCA facilities that house California patient-inmates, creating an internal CCA structure that will provide consistent medical care to California patient-inmates.

It is anticipated that the rollout of the remedial plan to the remaining CCA facilities will begin in early 2010. Consequently, CPHCS staff will begin developing a rollout plan for the four remaining CCA facilities.

California Out of State Correctional Facilities (COCF) Medical Screening Criteria

During this reporting period, CDCR has been able to fill approximately 95 percent of all out-of-state beds. Consequently, there is no longer a need to report on this issue.

“At Risk” Patient-Inmate Returns to California

CPHCS and CCA have established an ongoing process to identify those patient-inmates that should be returned to California based on medical exclusion for out-of-state placement. Consequently, this issue will be removed from this report during the next reporting period.

COCF Staffing

The 13 positions previously redirected to CPHCS from CDCR expired on June 30, 2009. However, through discussions with the Department of Finance, CPHCS received budgeted position authority for positions effective July 1, 2009. Consequently, this issue will be removed from this report during the next reporting period.

COCF Reception Center Transfer and Screening Process

On June 1, 2009, the COCF Reception Center (RC) Transfer and Screening Process began at Deuel Vocational Institute and North Kern State Prison. CPHCS and CDCR, including the mental health and dental programs, continue to conduct weekly conference calls to identify any program issues related to this process. It is anticipated that beginning in early September 2009, meetings will be held between CPHCS and CDCR to review the outcomes of the 90-day COCF RC test process at Deuel Vocational Institute and North Kern State Prison to determine whether or not to implement COCF transfer and screening at all reception centers. The outcome of these discussions will be provided during the next reporting period.

Community Correctional Facilities

Field Support Division staff continues to provide direction, oversight, and monitoring of the Community Correctional Facilities. Currently CDCR has 13 contracts for Community Correctional Facility beds. Of the 13 contracts, seven will expire by June 30, 2011. This fiscal year the following contracts will expire on June 30, 2010:

- Baker Community Correctional Facility;
- Leo Chesney Community Correctional Facility;
- McFarland Community Correctional Facility; and
- Mesa Verde Community Correctional Facility.

In February 2011, the following contracts will expire:

- Claremont Custody Center; and
- Delano Community Correctional Facility.

In April 2011, the contract with Adelanto Community Correctional Facility will expire.

It is anticipated that the contract renewal process will begin with the release of the Invitation for Bid in October 2009. CPHCS will continue to work collaboratively with CDCR and provide assistance as necessary related to the CCF contract negotiations.

Re-entry Facilities Update

The CDCR continues performing pre-activation activity for the Northern California Re-Entry Facility; however, information obtained this reporting period indicates that the activation may be delayed until 2012. Based on this information, we will no longer report on this issue until such time as CPHCS involvement is actually required.

Goal 5. Establish Medical Support / Allied Health Infrastructure

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

Implementation of the pharmacy services *Road Map to Excellence* continues to move forward and to realize progress. The *Road Map* gives priority to achieving improved patient safety and health outcomes, developing an evidence-based pharmacy practice and increasing cost-efficiency. Progress continues and is detailed below.

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

During this reporting period, revisions to the HIV Disease Medication Management Guidelines (DMMG) were approved to reflect changes in national guidelines and current practice standards. After much consideration, the P&T Committee also approved therapeutic interchanges for two antiretroviral medications (Combivir® and Trizivir®). Combivir® is a combination of two medicines called Epivir® (generic name lamivudine) and Retrovir® (generic name zidovudine) combined into one tablet. Trizivir® is a combination of three medicines called Ziagen® (generic name abacavir), Epivir® (generic name lamivudine) and Retrovir® (generic name zidovudine) combined into one tablet. The therapeutic interchange provides for the component medications of each of these combination drugs to be given as separate tablets rather than as a more expensive combination tablet, resulting in estimated cost savings of about \$800,000 per year. Also approved with the therapeutic interchanges was a patient education flyer that clearly explains and illustrates the change. All updates to the formulary are distributed to provider and pharmacist staff, posted to the CPHCS website and are made available through the online Epocrates web service.

During this reporting period, Clinical Pharmacy Operations Specialists (CPOS) also continued their active support of pharmacy initiatives. CPOS continued to provide in-service to facility staff on Pharmacy Policy and Procedure on a regular basis. During this reporting period, training included Ch.38, Prescription Turn Around Time, Ch. 35, Therapeutic Interchange, Ch. 9, Prescription Requirements and Ch.5, Emergency Drugs Supply. Additionally, CPOS provided in-service training to facility staff on HIV and Gastro-Esophageal Reflux Disease DMMGs and in-service trained pharmacy staff on the Guidelines for Chart and Patient Profile Review.

A formal Pharmacotherapy Management Consult (PMC) and process has been prepared and rolled out to several facilities, along with a pilot project to extend the duration of certain medical prescriptions to twelve-months. CPOS also presented a PMC focusing on non-formulary and OTC drug utilization at California State Prison Los Angeles County and non-formulary utilization at California Institution for Women to the medical leadership. The reports and recommendations were well received by CMOs at both facilities that took immediate actions on some of the recommendations.

As displayed in Table 14, through July 2009, Maxor has documented cost avoidance of \$11,901,766 thus far in calendar year 2009 from the use of targeted contracting strategies linked to P&T Committee decisions.

Table 14.

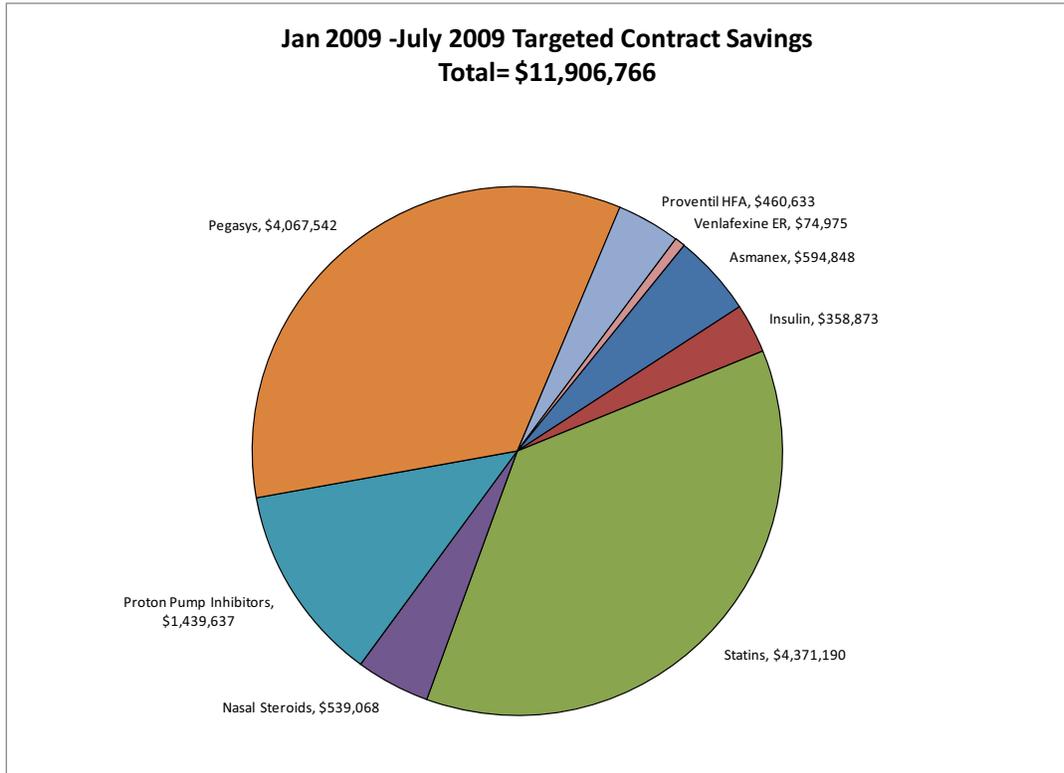


Table 14 Results Explanation: *These categories represent specific P&T Committee initiatives targeting particular drugs or drug classes. Savings calculated by comparing purchases using the actual targeted contract rate to the pre-targeted contract rate.*

Targeted contracts, order management activities and the implementation of a wholesaler agreement tailored specifically to address the pharmaceutical needs of the CDCR healthcare system continue to contribute to savings as displayed in Tables 15 and 16. In this reporting period, through the month of July 2009, almost \$26.4 million in expenditures were avoided when compared to prior historical trends.

Table 15.

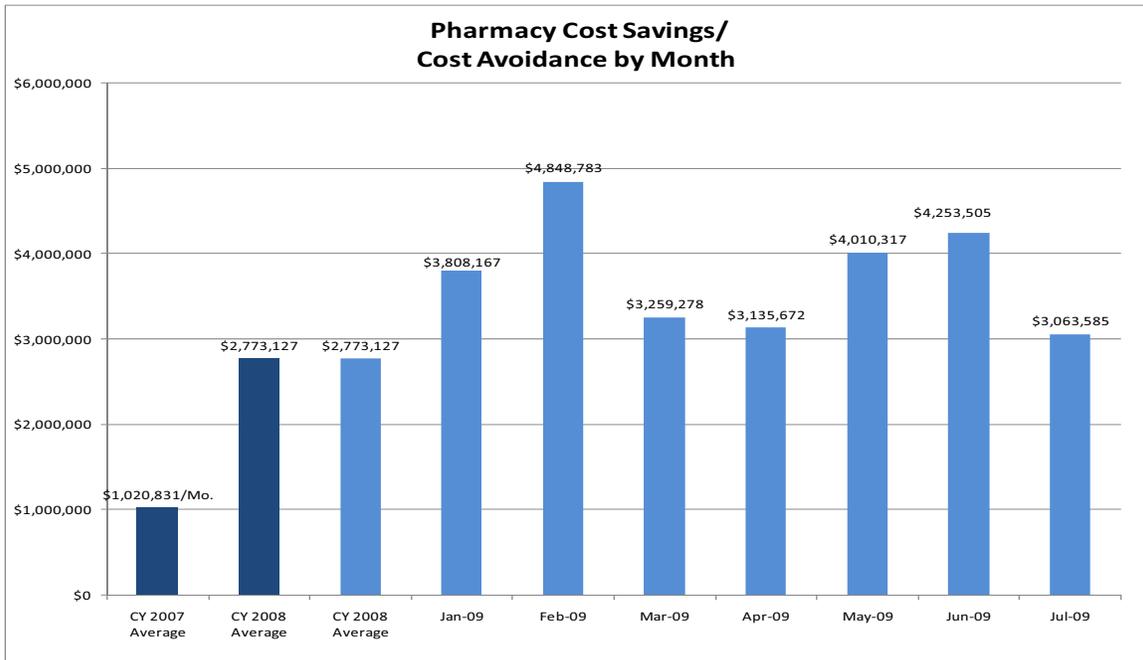


Table 15 Results Explanation: Cost savings/cost avoidance calculated based on comparing actual wholesaler purchases to prior historical trend line (also based on wholesaler purchases). Data pulled monthly from Wholesaler Purchase data. Maxor began managing pharmacy purchasing in April-May 2007.

Table 16.

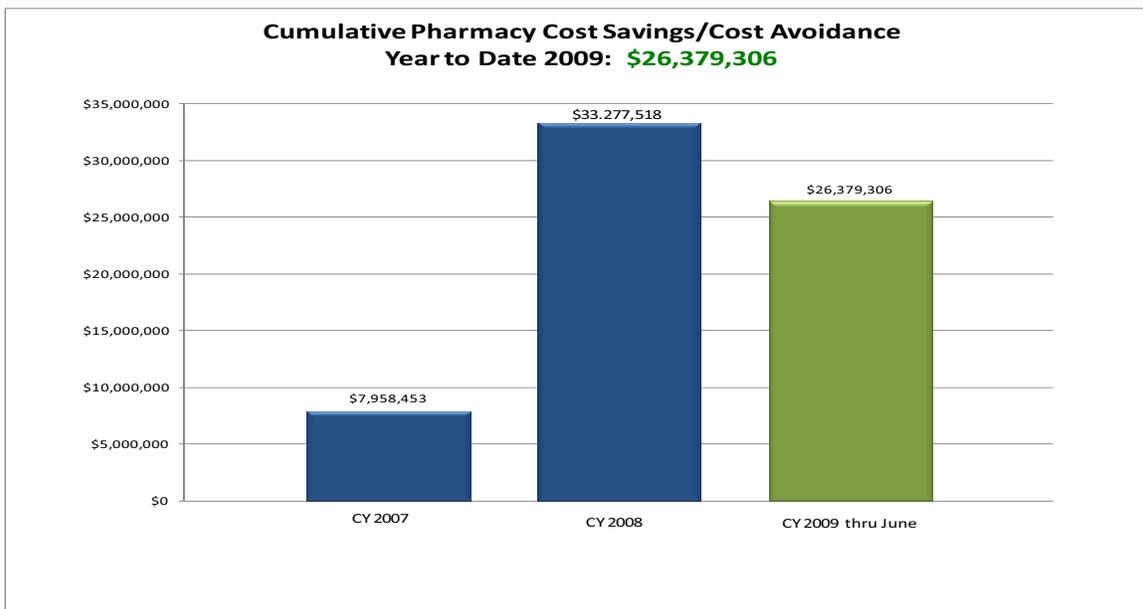


Table 16 Results Explanation: *Savings/Cost Avoidance is calculated by comparing actual wholesaler purchases to prior wholesaler purchase trend line. Maxor began managing pharmacy purchasing in April-May 2007.*

Action 5.1.2. By March 2010, improve pharmacy policies and practices at each institution and complete the roll-out of the GuardianRx® system

Pharmacy Policies and Practices

During this reporting period, the CDCR P&T Committee has completed its comprehensive annual review and update of the Pharmacy Policies and Procedures manual. This process involved reviewing and updating each of the policies to reflect improved practice standards, implement quality control measures, and standardize pharmacy processes. Along with the annual update and review, a revised Chapter 11 – Dental Urgent Medication Process was approved by the P&T Committee during this period. Additionally, a new policy relating to the purchase of specialty pharmaceuticals was developed and presented to the P&T Committee in August.

During this reporting period, pharmacy leadership has continued to focus on implementation of policy and procedures at the facility level to ensure compliance. To aid in this effort, a renewed emphasis has been placed on the use of the *MC Strategies* online training and assessment tool to provide in-service training. Facility Pharmacists in Charge (PIC) were given instruction and introduced to *MC Strategies* management reports in order to monitor staff progress. Expectations were established with a targeted goal of a 95 percent completion rate. Facilities deficient in compliance are required to submit a written plan of action to bring training compliance up to the targeted levels. During this reporting period, overall completion rates were 88.7 percent. However, it was necessary to extend the deadline for completion of MC Strategies lessons to 90 days to accommodate scheduling and staffing shortages due to furloughs. Compliance will be evaluated quarterly.

Recruitment efforts continue in an effort to fill pharmacy positions across the State. Work continues through the centralized hiring process to identify, interview and select qualified applicants. It should be noted that interviews for state pharmacy positions are down 35 percent over the same time period as last year possibly related to the impact of the furlough policies. From May 2009 through July 2009, 19 pharmacist interviews were conducted, 17 offers of employment were made, 6 pharmacists were hired, and 11 declined the offer.

Pharmacy inspections are conducted and documented monthly, with slow but steady progress forward 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 85 percent in July 2009. The Maxor team is also continuing to objectively validate the improvements for any facility moving from non-passing to passing status in their monthly inspection reports by conducting independent onsite validations (an important verification process which began in 2008). Pharmacy inspection status data is displayed in Table 17.

Table 17.

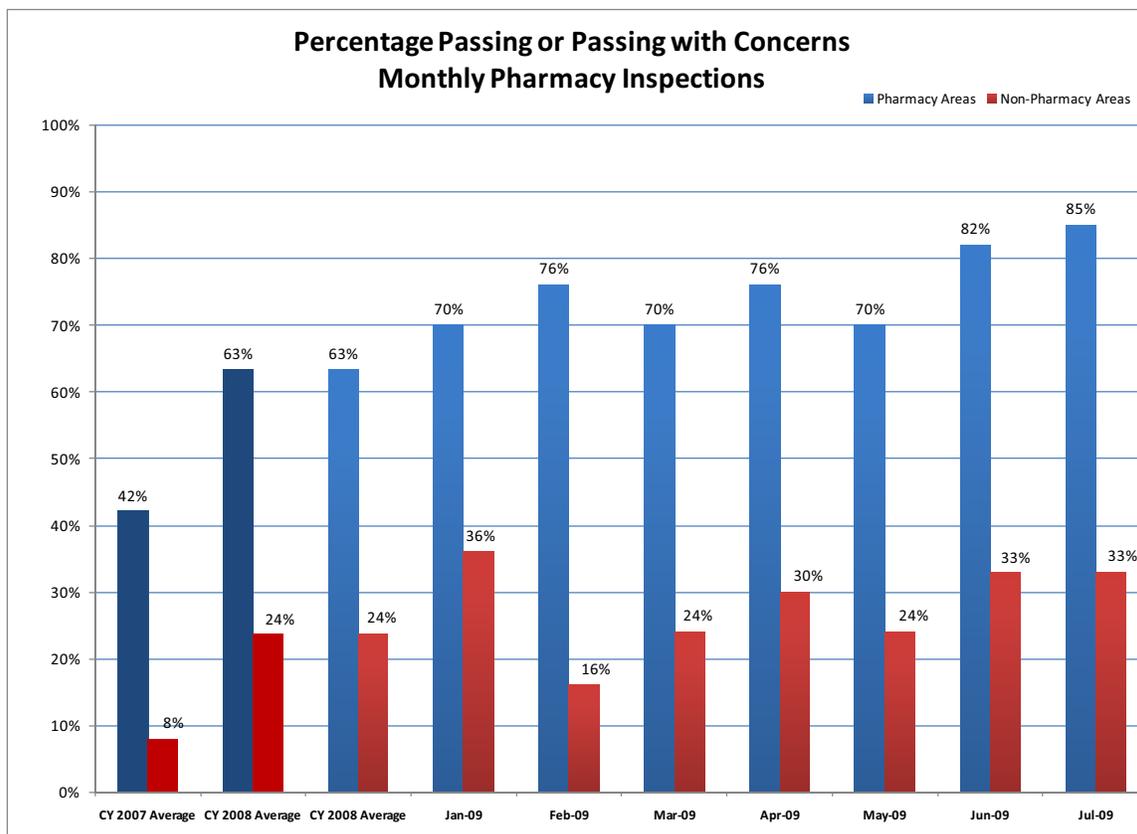


Table 17 Results Explanation Pharmacy areas are denoted in blue, and non-pharmacy locations (medication administration locations) are denoted in red: Independent Maxor Validation of Monthly Inspection Data began in Feb 2008.

Roll-out of the GuardianRx® System

The GuardianRx® pharmacy operating system has now been successfully implemented in 24 of the 33 CDCR institutions. Group training for PICs on the GuardianRx® system and the implementation process has continued as scheduled.

A review of the GuardianRx® implementation schedule conducted by the GuardianRx® Steering Committee resulted in a decision to revise the roll-out schedule in order to allow time for more training, to allow a reasonable period of time to orient newly recruited nursing implementation leadership staff, to improve efficient use of limited roll-out team resources and to allow facilities with significant infrastructure issues additional time to address those challenges. A revised schedule for the remaining conversion sites has been approved by the Steering Committee (Refer to Appendix 11).

The Receiver has completed initial efforts to improve pharmacy policies and practices at each institution by the initial target date of June 2009, having completed a comprehensive initial

review and revision of all pharmacy policies and procedures. Efforts to enhance training and improve compliance with these policies and procedures continue. However, the timeline for rollout of the GuardianRx® system has been extended, as described above, and will not be fully implemented statewide until March 2010.

Action 5.1.3. By May 2010, establish a central-fill pharmacy

Work continues towards 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, work under the contract for the automation design and equipment and coordination with Department of General Services architects and the building contractor continued. Specifications needed to incorporate the planned facility automation have been completed, along with detailed floor plans for the new pharmacy facility and build-out specifications, including the identification of specific site adaptation requirements needed to accommodate the automation system. Final lease terms between the property owner and DGS were approved and executed during this reporting period. Demolition, permitting and renovation work on the facility is now scheduled to follow. Based on current schedules, the Central Fill Pharmacy Facility is now estimated to be operational by May 2010. Once opened, it is expected to take 12-18 months to transition all prisons completely over to central fill.

The Monthly Summary Reports for the months of May, June and July are attached as Appendices 12 - 14.

Objective 5.2. Establish Standardized Health Records Practice

Implementation of the Health Information Management (HIM)/Health Records remediation road map continues to move forward to achieve improved patient health records management based on evidence-based practices and increased cost-efficiency. Progress continues and is detailed below.

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

The initial draft work plan for the stabilization effort was developed during this reporting period and presented to, and approved by, the HIM Steering Committee. A final stabilization action plan with timelines for work activities and performance measures will be completed and action initiated during the next reporting period.

The approach to the HIM improvements is currently focused on low cost stabilization of critical HIM processes affecting unit health record availability, content and storage in order to stabilize core functions and provide a foundation for the migration to electronic records. Stabilization objectives this fiscal year include: elimination of loose filing backlogs, request for information centralization, implementation chart tracking processes, improved timeliness of unit health

record transfer, improvements to chart room efficiency, actions to repair and volumize unit health records, defining and documenting HIM department responsibilities, restricting use of HIM space to HIM related activities and standardizing selected HIM processes.

Health Records Center

At the Health Records Center (HRC) there is currently a loose filing backlog of 50,000 inches at the HRC. Youth aids and student assistants have been hired to alleviate, as much as possible, the loose filing backlog. Further interventions to address this backlog are currently being considered and will be covered in the next Tri-Annual Report.

HIM Leadership

Progress has been made during this reporting period towards filling key statewide leadership positions in HIM. Two HIM CEA positions are being established with the State Personnel Board providing for a Chief of Health Information Management and an Assistant Chief/Privacy Officer. These critical managers will provide CPHCS leadership guidance over stabilization, remediation and ongoing enterprise-wide HIM operations. In addition, the manager position overseeing the Health Records Center was filled during this reporting period.

Remediation Roadmap

A three-year HIM remediation roadmap has been drafted into a current Budget Change Proposal (BCP). This BCP is focused on securing funding and resources to fully remediate HIM operations and fully integrate many CPHCS technology initiatives that impact patient-inmate health records (e.g., the Clinical Data Repository, Health Care Scheduling, Dictation and Transcription).

Dictation and Transcription

Centralized Transcription implementation began during this reporting period. Supervisor training for the Crescendo transcription equipment and pilot implementation occurred during the week of April 6, 2009. In June, a second round of training for the Medical Transcriptionists who support the pilot institutions was completed. “Go-live” for the three pilot institutions: Valley State Prison for Women, Central California Women’s Facility, and California State Prison, Los Angeles County occurred in July 2009. Additional facilities will be converted to Centralized Transcription in the coming months.

Other Activities

Also during this reporting period, the HIM team worked on assessment of the impact of the March 31st and June 17th, 2009 Coleman court ordered short/intermediate and long range bed needs of the Plaintiff class on HIM and other allied health areas. In addition, the team developed a budget change proposal for long term HIM remediation activities. The Dental proposal for more efficient organization of the Dental portion of the unit health record has been approved and implementation of the changes will begin during the next reporting period.

Objective 5.3. Establish Effective Imaging/Radiology and Laboratory Services

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

Medical Records

The strategy and plan related to Health Records is addressed under Objective 5.2.

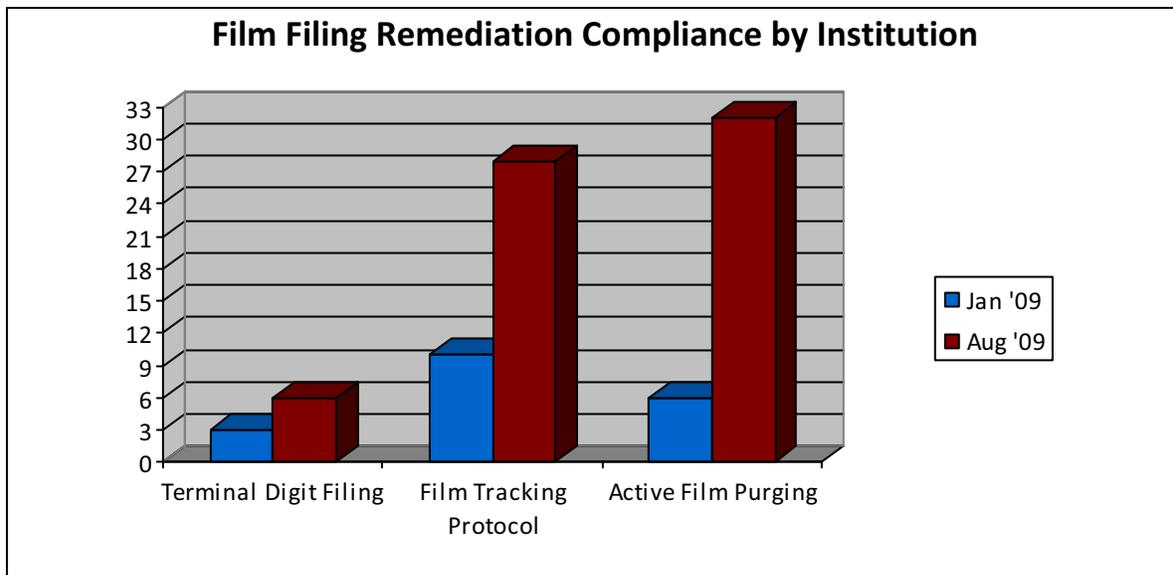
Imaging/Radiology Services

This Action has been completed.

McKenzie Stephenson, Inc. (MSI) was engaged in January 2009 to execute remediation in compliance with the Strategic Roadmap originally proposed in the Imaging Assessment.

During this reporting period, MSI completed its first round of site visits to all 33 institutions. These efforts include a focus on stabilizing and standardize film filing of patient-inmate files, to ensure access to health records is reliable and compliant with regulatory requirements. This effort included the implementation of local operating procedures (LOPs) to ensure current active patient films are returned from offsite Professional Service providers. These LOPs also ensure that films are filed accurately for future reference and follow the patient-inmates between institutions at time of transfer. MSI Operations team members continue to conduct follow up calls and visits to ensure standardized procedures at all institutions are adopted and followed. Progress on film filing remediation across all institutions is indicated below in Table 18.

Table 18.

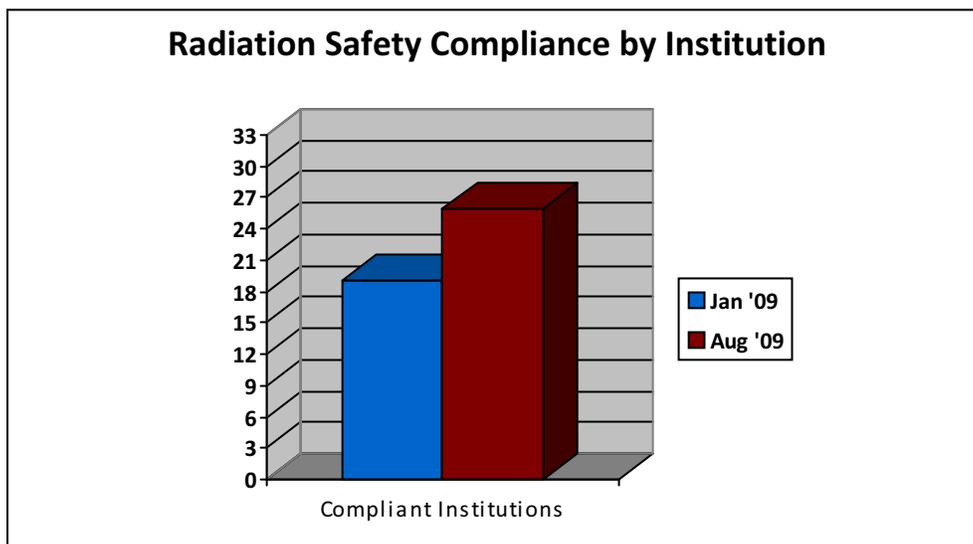


MSI is also working with Health Records to determine a possible central storage solution for parolee records to ensure the availability of files upon a parolee's return to custody.

MSI expects to complete Mammography Quality Standards Act (MQSA) certification at Valley State Prison for Women in the next 60 days at which time all three women's facilities will be MQSA certified. This program ensures that each site is meeting quality standards related to image quality, proper handling of patient records, and HIPAA compliance.

At the outset of this project, MSI identified a number of institutions that were out of regulatory compliance related to radiation safety and documentation. Progress has been made resolving the most serious issues with several institutions still in the process of remediating these issues as indicated in Table 19.

Table 19.



MSI has also provided workflow and operational solutions as well as working with Mobile Service Providers to reduce the number of backlogs (as defined as 30 or more scheduled patients waiting for service) to ensure compliance to *Plata* 14-day guidelines.

The Professional Services Team has completed the assessment and revision of multiple contracts related to Mobile Services (CT, MRI, Mammography), as well as several medical group contracts and has discovered significant opportunities to revise contract language that builds accountability, improves turn-around times, improves performance, reduces cost, and brings reimbursement in line with standard Medicare rates.

Also during this reporting period, the MSI Technology Team, working collaboratively with CPHCS staff, supported the procurement of new Radiology equipment for the San Quentin construction project. They have also initiated work on procuring new equipment for Avenal State

Prison, which currently cannot provide on-site Radiology services due to non-functioning equipment. In addition, the MSI Technology Team has started to prepare the Request For Proposal (RFP) for the Radiology Information System (RIS) acquisition, which will provide enterprise accuracy, and metrics for patient records, volumes, and history related to Imaging. MSI continues to work with Dental leadership to address dental imaging needs in coordination with CPHCS staff and the *Perez* court representatives.

Currently, Imaging Services are directed by MSI under the guidance and leadership of the Director of Clinical Operations. By June 2010, Imaging Services leadership will be recruited to continue to refine and develop Imaging operations as well as policies and procedures, while also facilitating the transition from the MSI contract to a State managed sustainable Imaging Services program.

Current plans include the build and initial rollout of the RIS to provide accurate patient tracking and demographics. Procurement of the Picture Archival and Communication System (PACS) and its build and initial rollout is also scheduled for this phase. Equipment procurement will also complete during this timeline to ensure all Imaging modalities are capable (either by replacement or upgrade) to integrate to both RIS and PACS systems.

Laboratory Services

Implementation of the Laboratory Services remediation efforts continues to move forward and to realize progress. Priorities are focused on achieving improved patient outcomes, developing evidence-based laboratory services, and increasing cost-efficiency. Progress continues and is detailed below.

To continue laboratory service improvements in Fiscal Year 09/10, the Receiver's efforts are focused on supporting the recruitment of Laboratory Services leadership as well as remediating the existing Reference Lab contract. During this reporting period, the Receiver has started both of these initiatives.

Approximately half of CPHCS lab tests are performed through the CPHCS Reference Lab contract. This contract requires substantial changes to improve reimbursement costs, services for institutions, and reportable result quality. The Receiver has begun construction of a plan to stabilize/reform the Reference Lab Contracts. Additionally, research to characterize appropriate compensation models for reference lab services has been initiated.

The Receiver has begun the development of a recruitment strategy for a Chief of Laboratory Services. By June 2010, Laboratory Services leadership will be recruited to implement a State managed sustainable Laboratory Services program.

Objective 5.4. Establish Clinical Information Systems

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

The goal of the Clinical Data Repository (CDR) project is to store key patient health information, such as current medications, allergies, lab results, healthcare encounters, problems, etc., in a standardized manner and ensure availability of this information to providers at the point-of-care to support clinical decision-making.

As of July 2009, the production environment Solution Build Phase was completed. Initially, historical data is being loaded from custody, pharmacy and laboratory partners. This will be followed by activation of live data feeds from these partners.

During User Acceptance Testing (UAT) a team comprised of the clinical user community and stakeholders will conduct scripted application functional tests of the production environment. The purpose of UAT is to validate that the system built meets the requirements established earlier in the project. Failed scripts will be logged as defects, fixed and retested.

Following UAT the project will prepare for the Pilot Phase, in which staff at CDR pilot institutions, will be trained on the CDR application followed by CDR roll out. Currently, training and project roll out to Valley State Prison for Women; California Correctional Facility for Woman and Los Angeles County institutions is scheduled to occur between mid August and late September 2009.

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 has been completed.

A Telemedicine Service Core Leadership Team (TSCLT) has been identified. This replaces the larger telemedicine steering committee previously established, and provides an agile leadership framework for the oversight and expansion of telemedicine services. With the TSCLT, the Nurse Manager overseeing the Office of Telemedicine Services (OTS), a Project Manager, a Project Charter, and a Roadmap in place, the leadership for the program will be secured.

During this reporting period, a six-institution initiative to expand telemedicine services was launched. This initiative will engage with the healthcare management at six selected institutions (North Kern State Prison, Kern Valley State Prison, Richard J. Donovan Correctional Facility, Centinela State Prison, California State Prison at Corcoran and Substance Abuse Treatment Facility) to remove barriers to increased telemedicine, expand the network of telemedicine providers and specialties and monitor the expansion of telemedicine services as well as the corresponding decrease in off-site specialty services.

These institutions were selected based on, but not limited to, the current backlog of requests for specialty consultation requests, geographic location, the availability of staff, space, equipment to conduct telemedicine, and the availability of telemedicine providers. California State Prison

Corcoran and the Substance Abuse Treatment Facility were specifically chosen because of the CPHCS focus on improving access to care in the new mini-region. Centinela State Prison and Richard J. Donovan Correctional Facility were chosen because of their relationship with Alverado Hospital, a new provider that will provide additional telemedicine capacity.

During this reporting period, Phase II of the “Provider On-Boarding” process has been initiated. In this phase the expansion of telemedicine providers and specialties will continue. Priority will be given to recruiting providers to support the six-institution initiative and to adding providers for specialties where we have the greatest demand for telemedicine services. The Office of Telemedicine Services continues to engage in discussions with prospective medical groups located in the central region.

The OTS is working with Contract Services to include telemedicine language in all medical general services agreements as well as the Credentialing and Privileging unit to establish telemedicine credentialing protocol. In addition, the OTS is working closely with the Information Technology staff to identify the most cost-effective approach to developing and expanding the technology infrastructure.

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

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

Progress on this objective continues to be impacted due to lack of construction related funding. Assessments, planning, design and construction progress were limited due to the funding impacts. The timeframes originally established in this action item are no longer feasible and will continue to be negatively impacted until such time that funding is available.

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

Preliminary site assessments for 15 existing institutions not yet Master Planned were conducted by teams from Vanir over a two week period and completed in July 2009. These site assessments document existing conditions for medical, mental health, and dental care spaces, and allowed staff to review both in-patient and out-patient functions. Preliminary site assessments have taken place at the following locations:

Sites Assessed	
<ul style="list-style-type: none"> • Centinela State Prison • North Kern State Prison • Chuckawalla Valley State Prison • Kern Valley State Prison • Valley State Prison for Women • Central California Women’s Facility • Ironwood State Prison • Salinas Valley State Prison • California State Prison – Corcoran • Wasco State Prison 	<ul style="list-style-type: none"> • California State Prison – Los Angeles County • Pleasant Valley State Prison • California Substance Abuse Treatment Facility and State Prison, Corcoran • California Correctional Institution • Pelican Bay State Prison

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

Upgrade Construction at Avenal State Prison:

Construction at Avenal State Prison has made significant progress. Work completed to date includes temporary installation of inmate clinics, installation of a nurse call system in the OHU, improvements to the TTA, and the relocation and expansion of the institution pharmacy. Work currently under construction includes three yard clinics to provide medical and mental health treatment space, an Administrative-Segregation clinic and a healthcare administration building to provide support for healthcare access and administration. The new construction projects are

scheduled for completion in Fall 2009. A transition team is in place to provide furnishings and move-in to the new buildings sequentially, starting in September 2009, and completing in December 2009.

Work is on hold due to funding limitations includes the following: expansion of medical records, conversion and expansion of the pill room, new inmate waiting building, canopies at pill lines and waiting areas. Construction of a new medical warehouse has been cancelled. Once the funding for the Upgrade Program has been identified, there will be a statewide master planning effort that will address the need to complete those construction projects currently on hold.

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

The Receiver has been working collaboratively with CDCR and the Governor's office to identify proposals that would utilize the AB 900 bond funding, already authorized by the legislature, to begin a joint long-term construction program. As a result of on-going negotiations, on September 9, 2009, Receiver Kelso agreed to a construction plan that will provide 4,801 health care beds, including one 1,702 bed Consolidated Care Center (CCC). The \$1.010 billion CCC will provide 1,602 healthcare beds to address the high and low medical acuity beds and the high acuity mental health beds needed to appropriately care for CDCR patient-inmates. The plan also includes additional healthcare beds in converted Division of Juvenile Justice facilities, and healthcare upgrades in some institutions. Overall the revised plan provides \$2.362 billion in AB 900 moneys for healthcare construction.

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

During this reporting period, pre-planning activities for a new construction prototype facility, staffing model, and integrated healthcare program model were completed to a level that will allow one or more facilities to be constructed within twenty-four months with Final Environmental Impact Reports prepared for certification and funding.

Additionally, a concerted effort to integrate and transition the CPHCS construction and activation management structure into CDCR's Facilities Management Division began, and is expected to be completed within the next reporting period. As part of the integration process, Receiver Kelso agreed to the appointment by the Governor of a construction project and management expert to combine all construction efforts and begin construction on all AB 900 projects as quickly as possible.

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

It is expected that during the next reporting period a schedule to begin construction at the first site will be identified.

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

It is expected that during the next reporting period a new schedule for phased construction will be developed.

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

With the exception of small closeout “punch list” items, construction is complete. All projects are complete and the areas are occupied by staff and inmates as appropriate, including: the medical warehouse; east and west rotunda clinics; personnel offices; triage and treatment area; clinic heat project; and replacement parking spaces. Exercise yards have been relocated and office modular buildings have been added.

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

The Central Health Services Building is approximately 87 percent complete and remains ahead of schedule. The forecast completion date is November 13, 2009, approximately three months prior to the required contract completion date of February 8, 2010. The building is completely weatherized. The work currently in progress is installation of finishes, such as painting, flooring, doors/hardware and installation of plumbing and electrical fixtures. Furniture installation has started on levels 2, 3 and 5. Installation of the telephone and data infrastructure is ongoing. Activation and transition meetings are held on a regular basis and plans are being developed for procuring movers and organize the various healthcare departments that will move into the new facility.

There have been no funding issues since the Pooled Money Investment Board action to freeze funds in January 2009. The contractor is up to date with progress payments.

Section 4

Additional Successes Achieved by the Receiver

A. Focus on Cost Efficient Health Care

As part of the 2009-10 budget solution, the Receiver has been authorized to cap the rates outside hospitals, doctors and ambulance services can charge the state for inmate patient care. The caps, which are tied to Medicare rates, were introduced by the State Legislature through SBX4 13 (Ducheny) and approved by the Governor. The new state law caps payments for contract providers of: Hospital Services at 130 percent; Physician Services at 110 percent; and Ambulance Services at 120 percent. Noncontract providers of hospital or physician services (both in state and out-of-state,) are now limited to a rate equal to or less than the amount payable under the Medicare Fee Schedule. It is expected that these caps will save the state at least \$50 million per year.

In response to these new caps, the Receiver's staff is working quickly to develop policies and procedures and regulations to ensure that access to care is available if a contract is not available with a provider(s) at the legislatively-mandated reimbursement rates. The maximum reimbursement rates do not apply to services provided pursuant to competitively bid contracts, contracts executed prior to September 1, 2009, and contracts entered into through a CPHCS-designated healthcare network provider. It is too early to tell what impact, if any, this legislation will have on contracting with medical service providers, but early signs indicate a lesser, rather than greater, impact in the ability to continue to contract, regardless of the reduced reimbursement rates.

In addition to these new rates, a Request for Proposal to obtain a medical services network from a Preferred Provider Organization (PPO), as allowed under the new legislation, is expected to be released during the next reporting period. The use of a PPO will greatly enhance the availability of consistent healthcare services throughout the State for our patient-inmate populations.

Additional information on the new rates can be viewed on the Receiver's Internet website at <http://www.cphcs.ca.gov/rates.aspx>.

B. Intranet Site

On August 25, 2009 the CPHCS Communications Department launched the new CPHCS virtual private network entitled "Lifeline Intranet." The new system was developed to support the increased flow of communication required as CPHCS projects and programs develop.

Designed and dedicated exclusively for employees of CPHCS by existing Communications Department and Information Technology staff members, the site was developed and launched

with minimal expense. The Lifeline Intranet site is available to all CPHCS employees on any CDCR network computer.

It includes important Turnaround Plan of Action updates on policies and programs, and provides a portal to many features designed to help CPHCS employees increase their efficiency and effectiveness. The intranet design was created with an employee's day-to-day desktop needs in mind, with features that include a system-wide calendar, monthly automated timesheets, memo and letterhead templates, Information Technology support numbers, a comprehensive supplies contact list for all 33 institutions, a staff bulletin board for ridesharing etc, Web X system information to increase web conferencing and decrease travel and a link to the automated CalATERs Travel Portal for those occasions when travel is absolutely necessary.

Marketed by the communications staff as "Your place on the web," the home page features rotating pictures of actual field staff and a video introduction of the site and its features by the Receiver. Specialized sections are designed to give CPHCS employees a personal experience that is tailored to their role on the CPHCS team (Primary Care Providers, Nurses, Allied Health, etc.).

Maintenance and Sustainability

The communications staff asked each department director to assign a content manager to be responsible for information about their department to be included in the web site. The content managers are enabled to maintain their portions of the site by being trained to use the software. The content managers were also informed about new internal security regulations to ensure that only content which is pre-approved by the department head is posted on the site. This enables each CPHCS department to customize the type of content and information they display within their individual portals without relying on Communications Department staff. Additionally, having a content manager from each department within CPHCS allows the Communications Department to achieve a new level of coordination and collaboration across all sections of the organization. This results in more comprehensive coverage of news and events within CPHCS and its 33 institutions on both the site and in the Lifeline Newsletter.

The site has been launched successfully and feedback from the field has been overwhelmingly positive.

Section 5

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

While the Receivership continues to make progress in many key areas that close in on the goal of providing a constitutional level of healthcare within California's adult correctional system, the State's fiscal crisis and resulting employee furlough program has had an impact. This impact however is difficult to measure and define. Many staff intensive administrative functions such as inmate appeals processing and invoice processing have failed to meet their goals. While blame for these failures can not be placed solely on furloughs or the lack of funding for new positions, there is little doubt that budget cuts and furloughs are contributing factors to some of these setbacks.

Section 6

An Accounting of Expenditures for the Reporting Period

A. Expenses

The total net operating and capital expenses of the Office of the Receiver for the year ended June 2009 were \$21,896,994 and \$72,050,383 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 15.

For the two months ending August 31, 2009 the net operating and capital expenses were \$876,706 and \$74 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 16.

B. Revenues

The Receiver did not request any additional funding for the period of May 1, 2009 through June 30, 2009. Total year to date funding for the 2008-2009 Fiscal Year to the California Prison Health Care Receivership Corporation (CPR) from the state of California is \$96,147,258.

On July 10, 2009 and on August 3, 2009, the receiver requested a transfer of \$250,000.00 respectively from the state to the CPR to replenish the operating fund of the office of the Receiver for the first two months of the 2009-2010 Fiscal Year.

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 July 20, 2009, and August 18, 2009, and September 22, 2009. Progress has continued, as follows, during this reporting period:

1. As reported in the Receiver’s Eleventh Tri-Annual Report, Coordination agreements have been prepared and submitted to the courts for approval in the areas of healthcare appeals, transcription and dictation, and the transition, activation and management of the Receiver’s construction program. At this time, the agreements on transcription and dictation and the transition, activation and management of the Receiver’s construction program have been put on hold pending further discussions with CDCR. The Receiver is working currently to resolve the objections by the State.

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, included as Appendix 17 is a summary of each contract the Receiver has awarded during this reporting period, including (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.)

Section 8

Conclusion

With the Receiver's agreement to a healthcare facilities construction program funded by AB 900 lease-revenue bonds and implemented by CDCR, the Receivership has entered a new and, hopefully, more productive phase. The year-long disagreement between the Administration and the Receivership over the details of capital improvements slowed down our overall progress and diverted our attention from implementation of other important elements of the Turnaround Plan of Action to contentious negotiations over construction and time and effort spent in litigation.

Over the course of the last six months, we have restructured our internal organization and begun the process of reintegrating with CDCR the executive leadership and management of the healthcare program. This process of reintegration is a crucial step towards establishing a sustainable healthcare program that can be managed by the State. The collaborative spirit demonstrated by many State employees has helped smooth this process.

The most significant risk to our future progress is the State's continuing budget crisis. Although last year is likely to have been the worst budget year within the current cycle, next year promises more multi-billion dollar deficits, more cuts to State programs, and more fights over State priorities. The Receivership has worked very hard this year to establish programs and initiatives to reduce our expenditures so that we would be better positioned to face next year's budget deliberations.

Maintaining momentum through a fiscal crisis of this magnitude will test all of our leadership and executive skills, but maintaining that momentum is crucial to our success. We have completed 40 percent of our action items, but that means that 60 percent of our work remains unfinished. Most of the action items among the 60 percent are underway and proceeding, albeit with some delays. Our focus must be on completing this unfinished work as promptly and cost-effectively as our resources will allow.