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2
3 **IN THE UNITED STATES DISTRICT COURT**
4 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

5 MARCIANO PLATA , et al.,)
6 Plaintiffs)
7)
8 v.)
9)
10 ARNOLD SCHWARZENEGGER,)
11 et al.,)
12 Defendants,)

NO. C01-1351-T.E.H.

**APPENDIX OF EXHIBITS TO RECEIVER'S
FIRST BI-MONTHLY REPORT**

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APPENDIX OF EXHIBITS

Exhibit No.

1. "An Analysis of the Crisis in the California Prison Pharmacy System Including a Road Map from Despair to Excellence." Maxor National Pharmacy Services Corporation, June 2006.
2. California Prison Healthcare Receivership Articles of Incorporation.
3. California Prison Healthcare Receivership Bylaws.
4. April 17, 2006 Letter from the Receiver.
5. May 5, 2006 Letter from the Receiver.
6. March 26, 2006 Letter to Molly Arnold from John Hagar.
7. April 10, 2006 Letter to John Hagar from Molly Arnold.
8. April 20, 2006 Letter to Wesley Chesbro, John Laird from Michael Genest.
9. May 30, 2006 Letter to Molly Arnold from Jared Goldman.
10. June 5, 2006 Letter to Jared Goldman from Molly Arnold.
11. June 19, 2006 Letter to Robert Sillen from Molly Arnold.
12. DCHCS Effective Medical Services Contract Process Project Charter.
13. California Prison Healthcare Receivership Balance Sheet, Statement of Expenses.
14. California Prison Healthcare Receivership Financial Statement Projections, Expenditure Worksheet.

EXHIBIT 1



*An Analysis of the Crisis in the California Prison
Pharmacy System Including a Road Map from
Despair to Excellence*

Prepared and Submitted by
Maxor National Pharmacy Services Corporation

To
Robert Sillen, Court-Appointed Receiver
Plata v. Schwarzenegger
June 2006

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Matthew L. Cate, CA Inspector General**

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**California State Auditor
FOX Systems, Inc.
Office of the Inspector General
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TABLE OF CONTENTS

Executive Summary	4
Background	8
Maxor On-Site Inspection Observations	12
Financial Analysis	17
Road Map	27
Comprehensive Action Plan	29
Key Action Plan Goals, Descriptions, and Objectives	31
Crawl, Walk, Run	55
Works Cited	58
Appendices	
Appendix A: CDCR Purchases vs. Dispenses Analysis	
Appendix B-1: Sample Dashboard	
Appendix B-2: Sample Institution Level Balanced Score Card	
Appendix C: Sample Action Plan Tracking Grid	
Appendix D: Sample Unit Inspection Grid	
Appendix E: E-mail Correspondence	
Appendix F-1: Internal Affairs Memorandum	
Appendix F-2: Maxor Response to Internal Affairs Memorandum	

EXECUTIVE SUMMARY

In a letter from Court Appointed Correctional Expert, John Hagar, dated March 30, 2006, Maxor National Pharmacy Services Corporation (Maxor) was requested on behalf of Receiver Robert Sillen to initiate an immediate and comprehensive identification of actions necessary to improve the California prison pharmacy operation. Since correctional pharmacy services are a major expense to the California Department of Corrections and Rehabilitation (CDCR) and a critical component to improving the quality of offender healthcare, the Receiver requested a high priority be given to this vital area.

The CDCR pharmacy service review commenced with an initial assessment that focused on fact finding and updating the current status of the CDCR pharmacy operation. Primary emphasis was given to a review and analysis of available documentation to include previous audits, findings and recommendations. Additionally, during the period 11-13 April 2006, a Maxor team of experienced professionals with extensive backgrounds in pharmacy operations and management of large correctional pharmacy programs performed on-site visits with CDCR staff and selected institutions. On April 13, 2006, the Maxor team gave a close-out briefing of their review and on-site inspection observations to U.S. District Judge Thelton E. Henderson, Receiver Robert Sillen, John Hagar and invited guests.

"In recent years, providing adequate health care to inmates has been increasingly problematic for the Department of Corrections and Rehabilitation. In February 2006, the U.S. District Court for the Northern District of California appointed a receiver over the department's health care operations in connection with a class action suit, Plata v. Schwarzenegger. Under the terms of the court's action, the receiver has broad powers to achieve the goal of 'restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable.' The receiver's powers include the duty to control and direct 'all administrative, personnel, financial, accounting, contractual, legal, and other operational functions of the medical delivery component' of the department."

(2006 OIG Accountability Audit 8).

It is universally accepted that the effective and efficient operation of pharmacy services is an integral component of a quality health care service delivery system. However, despite the recommendations of numerous audits, external reviews and other such evaluations, the CDCR pharmacy services operation remains in a state of disrepair.

Among the deficiencies detailed in prior audits and confirmed by this review are: (1) lack of effective central oversight and leadership; (2) lack of an operational infrastructure of policies, processes, technology and human resources needed to support an effective program; (3) excessive costs and inefficiencies in the purchasing processes employed; and (4) ineffective systems for contracting, procurement, distribution and inventory control.

In summary, initial findings by Maxor confirm that notwithstanding numerous state audits, studies and evaluations followed by specific, detailed recommendations for improvement, the CDCR pharmacy operation remains costly, inefficient, and unsafe. The California taxpayers continue to be denied the most out of their pharmaceutical dollar and more importantly, offender patients are not receiving clinical drug therapy in accordance with quality standards found in the community at large.

Based on the information provided at the time of this report, between January 2005 and April 2006, the State of California incurred avoidable CDCR pharmacy expenditures in excess of \$7 million dollars. A portion of those expenditures amounting to approximately \$1.3 million can be recaptured by immediate, aggressive and prudent pharmacy management actions. However, the opportunity for saving the remaining \$5.8 million has passed and, with it, so has the ability to better utilize scarce resources for improving substandard offender health care.

More alarming, based on a sampling of selected medications, it appears that millions of dollars of purchased medications are not accounted for in the prescription dispensing data. An analysis comparing CDCR institutional CY 2005 drug purchases with CDCR CY 2005 prescription dispensing data identified major discrepancies in the amounts purchased versus the amounts recorded as dispensed. Such disturbing variances (in excess of 30%) indicate a serious lack of pharmacy management and inventory control, as well as a high level of waste and potential for drug diversion. The discrepancy in purchases versus dispenses also creates a precarious clinical environment in which the potential for adverse outcomes is high due to the failure to properly manage, track and evaluate patient medications and

"Procedures to prevent diversion vary greatly between facilities. This variance is not only in the existence of a method, but also the methods themselves and the rigor of enforcement. Over the past 3 years there have been 4 Feasibility Study Reports that have included automated tracking of medications from receipt in the Pharmacy to delivery to a patient or return to the Pharmacy. Each of these proposals have been delayed due to lack of funding"
(CDCR response 05/22/06).

outcomes. When questioned about the procedures for detecting diversion, CDCR responded to Maxor that a “lack of funding” had thwarted efforts to track and account for medications. CDCR management’s repeated failure to respond to this critical issue, as well as the failure of State overhead and control agencies, is fiscally irresponsible to the California taxpayers.

The variance in drugs purchased and prescriptions dispensed, combined with CDCR’s and the State’s failure to take corrective action may explain, in part, why the taxpayers of California pay two-and-a-half to four times more for offender medications than other comparable entities such as the Federal Bureau of Prisons and the State of Texas. The findings tend to show that the absence of corrective action is attributable to a lack of pharmacy management and oversight as opposed to a “lack of funding”. As illustrated in the financial analysis section of this report, if the CY 2005 CDCR drug costs per inmate day were commensurate with that of other major correctional programs (systems with nearly as many prisoners as in California), as much as \$78-99 million dollars would have been saved and been available for allocation toward improving medication accountability and patient care. Even after taking into account the cost differences due to the other programs’ access to preferential pricing, CDCR’s CY 2005 drug costs were still \$46-80 million higher.

While confirming that many of the deficiencies noted in prior reports remain, Maxor also identified an additional key recommendation that must be addressed to implement an effective pharmacy services program. In the past, the CDCR Pharmacy audits and studies have not given primary attention to the establishment of a patient-centered, outcome-based system. Previous emphasis centered on drug distribution and central administration, but included minimal recommendations for an outcome-based, performance-driven system redesign. Future priority and effort must be given to outcome-based decision making as a means of guiding processes, educational focus and infrastructure redesign. By focusing on improvements to how patients are treated clinically and measuring and assessing disease outcomes obtained, the pharmacy systems, policies, prescribing patterns, and necessary competencies can be tailored to meet CDCR system goals. To accomplish this requires a system with measurable performance metrics, the technology to capture and analyze such data and a management team with the knowledge and authority to act upon the data findings in a timely manner. As well, State controlled overhead agencies, State mandated business practices and State laws, rules, regulations, and union contracts

The system focus is decentralized and product-driven rather than patient-centered and outcome-driven.

must be revised in order to enable CDCR's Health Care Services Division (HCSD) to accomplish its tasks and reach its goals.

At this time, the CDCR pharmacy program does not meet minimal standards of patient care, provide inventory controls or ensure standardization. The system focus is bureaucratic rule-driven and product-driven rather than patient-centered and outcome-driven. Therefore, opportunities for improvement based upon the creation of standardized policies, procedures, and a performance-based organizational structure have not been realized.

The action plan included herein provides a detailed road map designed to effectuate the restructuring and development of a constitutionally adequate pharmacy services delivery system. The plan builds from the recommendations of prior audits and reviews, as well as the findings and recommendations of the Maxor team. The action plan identifies key goals and objectives necessary to achieve those goals. Proposed timelines for actions are provided, along with a set of performance metrics to evaluate and monitor progress and success. Priority is given to immediate and/or short-term measures designed to improve safety, efficacy, cost and clinical care of offender patients.

In April 2006, the California Office of Inspector General documented that the CDCR pharmacy services operation has a long history of audits and reviews with repeated identified shortfalls that have yet to be remedied. The lack of meaningful action and the failure to address deficiencies has resulted in a standard of pharmacy care below acceptable industry and community levels. The program requires immediate and comprehensive corrective action. The expeditious implementation of the plan of action outlined in this document will result in a pharmacy services program that is sustainable, effective, outcome-driven, responsive to change and efficient. **Most importantly, patient care will be improved and, as past experiences of other correctional health care models have demonstrated, with enhanced care, fiscal accountability and cost containment follow.**

BACKGROUND

Over at least the past six years, the CDCR pharmacy services program has been reviewed and audited repeatedly. And repeatedly, the CDCR, its parent overhead and control agencies, and the State government itself has failed to effectively implement meaningful improvement in this vital health care delivery system component. This report does not attempt to revisit each and every prior audit report and recommendation. However, it is beneficial to gain a sense of the number, scope and similarity of prior audit findings and recommendations thereby laying the foundation for corrective action. Listed below are excerpts from a number of these prior reviews assembled under several general themes found throughout the documentation. Despite some efforts by CDCR to address these recommendations, the major issues identified by prior audits continue to restrict the ability of the pharmacy system to operate in an effective manner.

The CDCR pharmacy services program has been reviewed and audited repeatedly. And repeatedly, the CDCR, its parent overhead and control agencies, and the State government itself has failed to effectively implement meaningful improvement in this vital health care delivery system component.

Need for Meaningful, Effective Oversight and Management

"The absence of centralization and standardization has led to a lack of coordination and effective communication amongst pharmacies, inability to take advantage of 'best practices' at prison pharmacies, non-compliance with policies and procedures, increased medication cost, staff turnover and general inefficiency" (FOX 9).

"Although there are individual organizations within CDC who are attempting to improve the pharmacy operations within their facility, there seems to be no overall coordinated effort by management to bring together all of the correctional institutions in a unified approach to the pharmacy operations" (Senate Advisory Commission on Cost Control in State Government 25).

"Consistent with the findings of these recent audits and studies, the Office of the Inspector General has found significant evidence of poor management controls over pharmacy operations in management review audits of state correctional institutions"(2003 OIG 7).

Need to Implement and Enforce Effective Clinical Management Processes

"The present system of clinical management is ineffective, resulting in discontinuity of care and inability to control cost or manage patient care through formulary and drug therapy management" (FOX 8).

"Because it has not updated its formulary in several years and because it does not monitor compliance with its formulary, Health Care Services is unable to identify and enforce preferred treatments for specific conditions and to identify which medical practitioners have prescribing practices that are inappropriate or not cost-effective." (California State Auditor 26)

Need to Improve and Monitor Pharmacy Contracting and Procurement

"Business process analyses of ordering and inventory management practices at CDC prisons revealed a number of areas for potential improvement...controlling inventory levels in drug stock areas, management of unused or outdated drugs, and reporting on inventory usage by medical area" (FOX 7).

"There have been issues such as duplicate shipments, delivery of medications for discharged patients, inadequate detailed accounting of items returned for credit and how credit was applied. The contractor may not have followed the criteria for delivering services" (Senate Advisory Commission on Cost Control in State Government 30).

Need to Improve Pharmacy Workforce

"Many pharmacy or nursing medication administration process findings that were problematic seemed to stem from staff's lack of knowledge or proper procedures and inadequate training of pharmacy and/or nursing staff" (FOX 10).

"CDC has not been able to compete with the private sector to recruit adequate highly trained personnel. Although there is a national shortage of pharmacists, CDC functions with barriers to satisfactory staffing due to low salaries, inadequate working conditions and rural or less desirable locations. This has resulted in inadequate pharmacy staffing at many facilities" (Senate Advisory Commission on Cost Control in State Government, Executive Summary vii).

Need to Redesign Pharmacy Distribution System

"The lack of efficient workflow as a result of physical facility limitations and no space planning is negatively impacting productivity and resulting in increased staffing costs. In addition, inadequate space for pouring medication prior to Direct Observed Therapy (DOT) medication administration has resulted in practices that produce a higher probability of medication errors. These errors include missed doses, duplicate doses, administration of the wrong medication and medication documentation inaccuracies" (FOX 13).

"The physical limitations of pharmacies in California's 33 prisons are a significant hindrance to efficiency and an obstacle to meaningful modernization" (Senate Advisory Commission on Cost Control in State Government 30).

Need for a New Pharmacy Information Management System

"The outdated information system has contributed significantly to process inefficiencies for drug dispensing and this system complicates otherwise beneficial process improvements such as central dispensing from remote dispensing facilities" (FOX 8).

"The pharmacy prescription tracking system that the Department of Corrections uses cannot support today's complex medication monitoring and cost-containment requirements or the day-to-day management of its pharmaceutical services. The system contains data on drug interactions that is out-of-date; it cannot transfer data electronically between prisons; and it is unable to track data critical to managing pharmacy operations" (California State Auditor 39).

"The pharmacy information technology system cannot support needed functions. The limitations of the 20-year-old Pharmacy Prescription Tracking System, which is used by all of the institutional pharmacies, prevent the Health Care Services Division from effectively managing the department's use of pharmaceutical supplies to control costs or even to insure that prescription practices are appropriate [...] The system also cannot perform automated checks to prevent the following:

- *Negative reactions from patient allergies to a drug or from incompatible medications.*
- *Filling prescriptions too soon or too late.*
- *Inmates stockpiling medications.*

- *Duplicate therapy from a patient taking more than one drug with similar therapeutic benefits.*
- *Dosages outside acceptable therapeutic ranges.*
- *Prescribing non-formulary medications without required authorizations.*

(2003 OIG 7)

MAXOR ON-SITE INSPECTION OBSERVATIONS

In advance of the on-site visits, Maxor requested and reviewed previous audits, reports and information provided by the CDCR. During the period 11-13 April 2006, a Maxor team of experienced pharmacy managers with correctional backgrounds visited CDCR health services administrative staff and inspected six institutions (California Medical Facility, Corcoran State Prison, Substance Abuse Treatment Facility, San Quentin, Sacramento and Folsom institutions.)

Upon completing the on-site visits, follow-up discussions and correspondence were continued with CDCR staff, State Attorneys and designated California State Agency personnel.

Based on visits and follow-up information, a summary of key observations is provided:

-- Dr Peter Farber-Szekrenyi, Director, CDCR Correctional Health Care Services and his staff facilitated the Maxor visit and arranged opportunities to interview central office and selected institution staff. For the most part, CDCR personnel were courteous, professional and responsive to the visit.

-- It was readily apparent that a number of CDCR health service personnel had made considerable effort to improve the overall pharmacy operation to the extent they could, given the lack of appropriate tools available to fix previously identified deficiencies. However, these efforts are in isolation, resulting in a disjointed system. The resultant lack of standardization places patients at risk for continuity of care failure and medical errors.

-- There was a clear absence of central office management and oversight of institution level pharmacy operations. Headquarters-based Pharmacy Services Managers were not empowered with direct line authority and operated in more of an advisory role as "subject matter experts" rather than managers. While these individuals do possess extensive knowledge of the CDCR system, they lack the necessary clinical, managerial, and technological support structure and experience to perform their jobs.

There was a clear absence of central office management and oversight of institution level pharmacy operations.

-- A key issue identified in previous audits is the need for an effective centralized Pharmacy and Therapeutics Committee (P&T). CDCR has responded that a P&T Committee has been established and is functioning well. Based on interviews with CDCR staff, review of P&T minutes, and more importantly results of committee actions, the current CDCR P&T committee is a shell entity

The current CDCR P&T committee is a shell entity with little or no meaningful impact on the overall pharmacy process.

with little or no meaningful impact on the overall pharmacy process. There is little or no support from central medical authorities in regards to P&T Committee participation. Formulary and procedures are not always followed at the institution level and there is no systematic way to monitor formulary compliance. Some one-way, top-down communication regarding formulary, drug use controls and procedures occurs. Data is collected for some parameters (although not clinical outcome-driven) and sent back to administration. No follow-up is provided. There is limited or no cross-pollination between institution pharmacies or collaboration between central administration and institution level teams. A quality, evidence-based guideline for the treatment of HCV was developed, but workforce level education and training appeared lacking and no outcome-based follow-up was conducted to determine if the guideline is used or if desired results are achieved.

-- System-wide policies and procedures for a formulary are established, but left open to institution level interpretations and compliance. Most institutions are aware of the central office directives but elect to develop their own as they deem necessary. In short, while the CDCR health services central office states that updated policies and procedures and formulary have been implemented, institution level observations revealed that in many cases, guidelines are not followed and prescribing practices follow individual institution developed formularies and treatment approaches. With the absence of central office oversight, compliance and monitoring are difficult at best.

-- Due to continued high pharmacy vacancy rates and resultant prevalence of registry staff, there is a discernible division between State and registry personnel, leading to staff morale issues, management challenges, and continuity in terms of constructing a well-trained pharmacy services team with common fiscal, clinical, and operational goals. The heavy reliance on the use of registry pharmacy staff has not only resulted in extremely high costs, but because many of the registry staff are designated Pharmacists-In-Charge, there is little incentive to recruit State employees as replacements. This would be especially true if some of the registry employees are also owners of the contract organizations furnishing the temporary staff. Vacancy rates

currently average 28 % overall and 43 % for pharmacists (*Pharmacy Series Vacancy as of March 31, 2006*).

-- Based on CDCR pharmacy staff vacancy reports and what appear to be excessive hours billed to certain institutions, a total system wide registry staffing audit should be accomplished at the earliest possible opportunity. As of December 2005, 63.5 vacancies existed, although the State was billed for registry hours equaling 95.32 positions (*CDCR Vacancy Information for Pharmacy Classifications Statewide Information December 2005*) at a cost of \$5,942,539 during the first 6 months of fiscal year 2005-2006. From 07/01/05 thru 12/31/05, 1,509 hours were billed at a rate of \$108.41 per hour for a Pharmacist-In-Charge (1.45 FTE's) at one institution, whereas at another institution 4,569 hours were billed at \$51.23 for a Pharmacist-In-Charge, equaling roughly 4.39 FTE's (*HCCUP Report, 07/01/05 thru 12/31/05*).

-- **Fundamental drug dispensing patient safety controls are bypassed**, including a pharmacy prepared, patient specific prescription dispensing process. There is still large-scale use of bulk bottles to dispense medication doses to patients by medication aides with no pharmacist oversight. The standard of care is to dispense medication through a pharmacy after pharmacist review. The medication should be dispensed in a quantity consistent with the prescription needs and specifically labeled with critical information such as the patient name, date, drug, strength and directions for use as well as other labeling requirements. In the acute care setting, medications may be dispensed for single day needs in unit-dose packaging. Non-patient specific medications used for initial doses during hours when the pharmacies are not open or in emergencies should be provided in the most ready to use form such as in unit-dose or other non-bulk systems. The use of bulk bottles of medication is not a safe or responsible method of dispensing or distributing medication. Inconsistency in the drug use process and delayed information regarding patient location results in duplication and/or delays in prescription processing and delivery. Basic safety precautions including regular audits of all drug stock to assure dating and proper storage are not always completed. Error avoidance strategies such as separating high-risk medications from other drugs and quarantine of look-alike, sound-alike drugs are not employed. Pharmacist interventions (provider contacts to improve patient therapy or prevent harm) and medication errors are not systematically documented or trended to identify patient risk and opportunities for improvement. There is no evidence of a system to complete failure mode and effects analysis or root cause analyses on serious medical errors identified in an effort to prevent further comparable problems.

-- In the April 2006 OIG Report referenced earlier, CDCR reports significant progress in monitoring drug utilization and patient care, however, without a sophisticated data warehouse, **there is no capability of tracking utilization and prescribing trends, nor monitoring formulary compliance.** Currently, prescription logs must be transmitted to headquarters on a quarterly basis, at which point the pharmacy services manager must painstakingly extract the data to compile rudimentary reports for managerial oversight. Maxor discovered significant issues with the integrity of this prescription data; in some cases, entire quarters of data were missing from a facility. Prescription data cannot be accessed outside of the pharmacy in which the prescription was dispensed, so real-time patient profiles with relevant medication history and allergies information are not available to medical staff at neighboring prisons or community-based private providers to facilitate the inmate transfer process.

The pharmacy information system is unsatisfactory from a patient safety standpoint.

-- The pharmacy information system is unsatisfactory from a patient safety standpoint. All modern pharmacy systems provide real-time notifications to alert the pharmacist of potentially dangerous drug-to-drug interactions, drug-to-allergy interactions, under-dosing, and over-dosage. The clinical information within the current systems is outdated, so pharmacists must perform manual drug utilization review (DUR), thus relying on their memory and clinical knowledge, which is, unfortunately, not always current or extensive. Even a well-trained pharmacist would not be able to safely perform DUR on the volume of prescriptions processed, especially considering the complexity of many inmates' medication regimen to treat, HCV, HIV, and mental illness.

-- **Key Maxor Finding:** While the previous audits identified centralized clinical management and control issues, **the CDCR Pharmacy recommendations lacked a patient-centered, outcome-based focus.** The focus has been on drug distribution and central clinical administration such as formulary management, drug use

The healthcare system should use outcome-based criteria to drive treatment decisions, processes, educational focus and infrastructure redesign.

evaluation and treatment guidelines, but lacks a patient-centered, outcome-based, performance-driven focus. The healthcare system should use outcome-based criteria to drive treatment decisions, processes, educational focus and infrastructure redesign. By reviewing how patients are treated, and assessing disease outcomes obtained, systems / prescribing / competency can be tailored to meet determined goals.

-- An example of the system described would include an ongoing monitoring of primary morbidity and mortality over time. If CDCR asthma death rate and/or emergency room visit rate were found to be in excess of the benchmark, an analysis would ensue. The investigation would include an evaluation of the actual treatment approach to asthma, including the drugs used, monitoring methods, frequency of follow-up and patient care teaching. Other parameters assessed would be patient compliance to medications and the approach to treatment once the asthma exacerbation occurred. The actual data would be compiled and an interdisciplinary team would develop evidence-based treatment guidelines addressing all factors for implementation with an educational focus on those parameters identified in which previous treatment approach was inconsistent with best practices. The formulary and procedures would be adjusted to meet the newly identified needs. Thereafter, data would be gathered at a defined frequency to follow the implementation and adherence to the treatment approach as well as the clinical patient outcomes. The cycle would continue until the outcomes met defined goals. This approach marries the centrally administered clinical programs to patient-centered care to develop an outcome-driven system based on sound scientific principles and health care improvement methodologies.

FINANCIAL ANALYSIS

A financial analysis of CDCR's pharmacy services was conducted using CDCR and Department of General Services (DGS) purchasing data obtained directly from the drug wholesalers. In addition, CDCR provided Maxor with dispensing data to facilitate an in-depth analysis of product purchased versus drug dispensed. During the course of this analysis, numerous contacts were initiated and maintained with the California Attorney General's Office, CDCR, and DGS regarding Maxor findings and observations. On several occasions, either DGS or CDCR provided new or previously requested information which Maxor integrated into the analysis. The financial data presented herein is based upon the most recent information available at the time of finalizing this report.

-- The financial analysis, coupled with Maxor's on-site observations and CDCR's responses to the findings, indicate an overall lack of central oversight, infrastructure and technology to properly manage drug costs, including contracting, procurement, distribution, reclamation and inventory control. The fragmentation of responsibilities and oversight of the CDCR/DGS pharmacy procurement and distribution program has resulted in the absence of clear lines of authority and

The fragmentation of responsibilities and oversight of the CDCR pharmacy procurement and distribution program has resulted in the absence of clear lines of authority and accountability, a breakdown in communications, inefficiencies, waste and the potential for illegal diversion, the sum result of which has seriously endangered the quality and appropriateness of offender health care.

accountability, a breakdown in communications, inefficiencies, waste and the potential for illegal diversion, the sum result of which has seriously endangered the quality and appropriateness of offender health care. The current system has minimal controls to preclude or detect diversion and does not meet basic patient care and safety needs, fundamental standards of practice, or medical/pharmacy practice regulations. Furthermore, the system's lack of such controls places patients at serious risk and opens the door to large scale fraud and/or theft of State property in the form of prescription drugs.

-- Based on the information provided at the time of this report, between January 2005 and April 2006, the State of California incurred avoidable CDCR pharmacy expenditures in excess of \$7 million dollars. A portion of those expenditures amounting to approximately \$1.3 million can be recaptured by immediate, aggressive and prudent

pharmacy management actions. However, the opportunity for saving the remaining \$5.8 million has passed and, with it, so has the ability to better utilize scarce resources for improving substandard offender health care.

-- The CDCR data provided to Maxor in April 2006 overstated CY 2005 drug purchases by approximately \$6.3 million (See table below). CDCR reviewed Maxor's findings and concurred that information received later from DGS more accurately reflects actual CY 2005 purchases.

	CDCR Prime Vendor Data		DGS Data	Difference
Jan-05	\$ 10,016,235.00	\$ 9,907,014.94	\$ 109,220.06	
Feb-05	\$ 13,821,425.00	\$ 9,575,967.66	\$ 4,245,457.34	
Mar-05	\$ 10,971,804.00	\$ 10,732,744.70	\$ 239,059.30	
Apr-05	\$ 10,812,253.00	\$ 10,585,400.61	\$ 226,852.39	
May-05	\$ 10,699,424.00	\$ 10,425,006.63	\$ 274,417.37	
Jun-05	\$ 12,081,102.00	\$ 12,031,147.81	\$ 49,954.19	
Jul-05	\$ 10,898,567.00	\$ 10,306,956.53	\$ 591,610.47	
Aug-05	\$ 12,229,335.00	\$ 12,146,795.05	\$ 82,539.95	
Sep-05	\$ 11,191,672.00	\$ 10,996,363.06	\$ 195,308.94	
Oct-05	\$ 11,032,125.00	\$ 10,837,864.93	\$ 194,260.07	
Nov-05	\$ 11,806,804.00	\$ 11,788,596.08	\$ 18,207.92	
Dec-05	\$ 12,146,176.00	\$ 12,056,879.94	\$ 89,296.06	
	\$ 137,706,922.00	\$ 131,390,737.94	\$ 6,316,184	

-- No demonstrable controls over purchasing or inventory were seen, nor was there evidence of process standardization. There is no mechanism for maximizing inventory turns or tracking / quantifying the financial loss due to returned medications that must be destroyed. Rudimentary systems to determine serviceability of returned medications do exist, but are minimal to non-existent due to the labor intensiveness involved in the process.

-- In spite of repeated assertions by DGS that they are not an enforcement agency and do not have the authority to enforce the pharmacies' contract adherence, it seems as though California has succeeded on at least one occasion to control costs by implementing market share type contracts. This initiative alone resulted in savings of approximately \$945,000 to the State and a 98% contract penetration rate. CDCR developed and implemented a treatment protocol for HCV in concert with a market share purchasing agreement to coincide with that treatment protocol. This is an excellent example of how savings can be achieved when pharmacy operations, contracting, and clinical authorities are successfully integrated.

-- DGS has also negotiated favorable drug manufacturer rebate contracts, although it is clear that there is no central reconciliation of rebates, as evidenced by the estimated \$650,000 in outstanding rebates CDCR, through DGS, has yet to receive. Similarly, there is no systematic method for ensuring that DGS-contract pricing is honored by the wholesaler and that individual pharmacies purchase contract items in lieu of more expensive non-contract items. As a result, during CY 2005, the State of California was overcharged by more than \$700,000 and failed to take advantage of another \$5.8 million in preferable contract pricing by not purchasing the most cost effective DGS contracted items. Maxor compiled all Generic Code Numbers (GCN's) in CDCR's purchase data and within each GCN, determined the most cost-effective National Drug Code (NDC) and compared it to the NDC purchased, adjusting for package size. The difference between what should have been purchased and what was actually purchased for each GCN is the missed savings opportunity of \$5.8 million. The table below illustrates CDCR's top 20 missed savings opportunities in 2005-2006.

CDCR TOP 20 MISSED SAVINGS OPPORTUNITIES

GCN	Generic Name	Missed Savings Opportunity
33530	OMEPRAZOLE 20 MG CAPSULE	\$761,732.77
46223	PAROXETINE HCL 20 MG TABLET	\$212,780.58
13724	FLUCONAZOLE 200 MG TABLET	\$154,033.18
6460	LOVASTATIN 20 MG TABLET	\$130,658.14
41805	GABAPENTIN 600 MG TABLET	\$129,405.13
4240	METHADONE HCL 10 MG TABLET	\$124,231.54
11673	RANITIDINE 150 MG TABLET	\$111,872.74
47198	QUETIAPINE 300MG	\$105,624.92
8350	IBUPROFEN 800 MG TABLET	\$94,223.96
8349	IBUPROFEN 600 MG TABLET	\$87,189.24
46451	MIRTAZAPINE 30 MG TABLET	\$86,329.77
4521	PHENYTOIN SOD EXT 100 MG CAP	\$83,389.92
8362	NAPROXEN 500 MG TABLET	\$81,354.49
46203	CITALOPRAM HBR 20 MG TABLET	\$76,909.91
1775	GLYBURIDE 5 MG TABLET	\$70,924.41
4655	METHOCARBAMOL 750 MG TABLET	\$69,536.19
21414	GABAPENTIN 300 MG CAPSULE	\$67,801.03
9339	CLINDAMYCIN HCL 150MG CAPS	\$57,922.28
8182	HYDROCHLOROTHIAZIDE 25 MG TB	\$55,652.66
384	ENALAPRIL MALEATE 10 MG TAB	\$55,226.04

-- Maxor compared the quantity of doses dispensed by CDCR pharmacies to the quantity of doses purchased during CY 2005. The dispensing data was provided by CDCR and the purchasing data was obtained from McKesson, the CDCR drug wholesaler used in 2005. The drugs compared included some commonly used antipsychotic medications and narcotic controlled substances used for pain control.

The expectation is that the drugs purchased should equal the drugs dispensed by the pharmacy plus the amount of medication used for stock and some very small amount of product that expires unused. Stock would be expected to include the inventory within the pharmacy (can be estimated based on the inventory turns and would be expected to be <5% of annual purchases) and a small amount of floor stock medication placed in treatment areas for doses needed during emergencies and the hours the pharmacies are closed.

However, significant discrepancies in the prescription dispensing data were identified that indicate a high potential for drug diversion and negative clinical outcomes. Upon initial review, the difference between quantity purchased and quantity dispensed was up to 99% varying by drug and facility, indicating that purchases exceeded documented use by vast margins. It was later explained to Maxor by CDCR staff that the quantity dispensed may be documented in the computer system in nontraditional ways. A quantity entered as "one" in the PPTS system at one institution might actually translate to a quantity of 60 units dispensed (one per med pass). This practice seems in direct conflict with California pharmacy regulations. Moreover, this practice is variable even within the same facility. At the same institution, one might observe the same medication being dispensed as a quantity of 60, to meet the same med pass needs. Following the practice described, every effort was made to determine the most likely quantity dispensed. Even after adjusting for the explanation provided, however, the quantity purchased frequently exceeded the quantity dispensed by over 30%.

There are a number of reasons that might contribute to the purchasing versus dispensing disparity, such as reprinting a label, but not documenting a new prescription or refill dispensed. Maxor staff was told that this is a common practice to save time, despite the fact that medications are being dispensed without documentation legally required by California regulations. Beyond the fact that this practice is inconsistent with California pharmacy regulations, patient safety concerns are particularly alarming. A pharmacist reviewing the patient profile in the future would not know that the medication had been dispensed and was being taken by the patient. There is a clear risk that the patient could still be taking the medication when an unknowing pharmacist dispenses a new medication with a serious adverse drug

interaction consequence. In the event that the dates are changed in the computer during reprint of the label, there would be awareness that the patient is on the drug. However, it would not be possible to determine the actual dates or quantities dispensed for a compliance assessment, nor would legal requirements be met.

Other reasons for the gap might be medication administered without pharmacist involvement. This could include medication administered from floor stock by nurses or aides with a doctor's order. This is an acceptable process in the event that there is an emergency and the provider is present or after hours when there is no pharmacist available to review the patient profile and dispense the medication. However, as soon as the pharmacy opens, a clinical review of the new order should be conducted and a prescription processed after completing all the appropriate safety and clinical reviews. CDCR staff has acknowledged that this is not necessarily the practice and that dispensing of floor stock medication without pharmacist involvement and without record in the pharmacy system is commonplace. Nonetheless, this should only account for a very small amount of the disparity between purchases and dispenses.

*Excerpt from California Code of Regulations
Division 17. Article 2. Pharmacies
1707.1. Duty to Maintain Medication Profiles*

(B) For each prescription dispensed by the pharmacy:

1. The name, strength, dosage form, route of administration, if other than oral, quantity and directions for use of any drug dispensed;
2. The prescriber's name and where appropriate, license number, DEA registration number or other unique identifier;
3. The date on which a drug was dispensed or refilled;
4. The prescription number for each prescription; and
5. The information required by section 1717.

Another explanation is the disturbing possibility that medication is being administered without a prescription. For example, during the April 2006 site visit to San Quentin, a Maxor team member came across a recently documented medication error which described a pharmacist giving methadone pills, a narcotic controlled substance, to a nurse without proper documentation. Without further review, it is not possible to determine how widespread such occurrences are, but this incident raises serious practice standard, patient safety, and legal concerns. Startlingly, this practice may occur quite frequently in an unresponsive system in which medication delays occur, despite the fact that such practice is prohibited by State and Federal regulations. Nursing staff can become desensitized by delays and assume that since the patient has been on a medication for some time, they are still supposed to be, and continue to administer the

medication based on historical treatment. The patient safety concern is that the drug may have been intentionally not renewed. The provider is now under the assumption that the patient is not taking the drug. This can lead to dangerous combinations of medications, toxicity or misdirected treatments when the physician is no longer aware of the patient's overall regimen and makes changes based on misinformation. The pharmacist will not have a current medication profile and will not be able to support the patient safety and clinical review process accurately. Due to the size of the health care system and large volume of medications used, poor inventory control and lack of central oversight, it is highly reasonable to assume that serious drug-to-drug interactions, drug-to-disease interactions and medication errors with potential for serious harm and death have and are occurring. In the case of HIV therapy, continuing the wrong medication when a change was intended, or improper dosing and/or combinations is very likely to result in significantly increased toxicity or a rapid loss of antiviral activity, causing the virus to become resistant to the limited drug combination options available. The result is a patient at risk for advancing illness with early progression to AIDS and the associated life-threatening infections, as well as avoidable financial consequences.

-- Of crucial note, two line items with the highest percentage of discrepancies are narcotic controlled substances with a very high abuse potential. Roxicodone® and Oxycontin® had greater than 95% gaps between purchases and dispensing as shown in the table below. See Appendix A for greater detail of the purchases versus dispenses analysis.

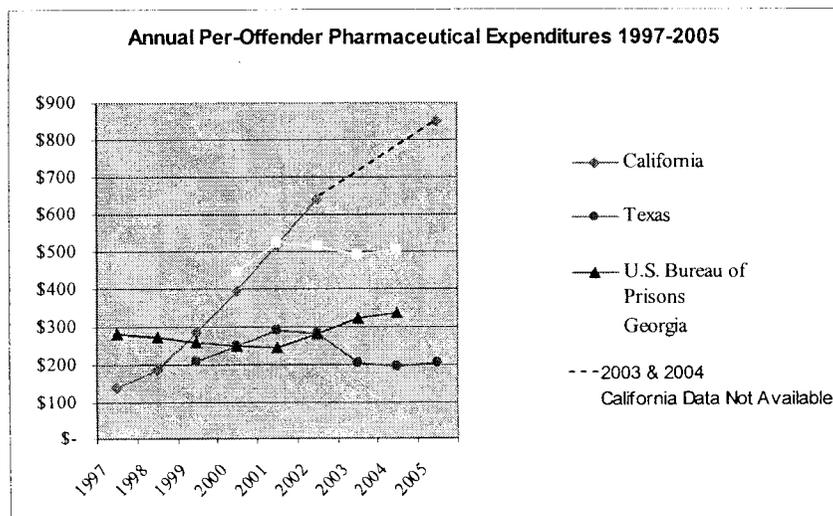
CDCR Purchases vs. Dispenses of Selected Antipsychotic and Narcotic Medications – CY 2005

Institution	Drug	Qty Purchased	Qty Dispensed	Qty Difference	% Not Dispensed
SOL	RISPERIDONE 2MG	41,040	2,738	38,302	93.33
SOL	SEROQUEL 300 MG	63,120	5,679	57,441	91.00
PBSP	GEODON 80 MG	32,320	15,279	17,041	52.73
CIW	GEODON 20 MG	3,440	1,767	1,673	48.63
CMF	ROXICODONE 5 MG	186,000	5,488	180,512	97.05
SOL	OXYCONTIN 20 MG	9,175	280	8,895	96.95

In summary, none of the examples provided are justifiable explanations for such a shocking disparity between quantities dispensed and purchased. Moreover, the dispense data is so grossly inconsistent and unreliable that it is virtually impossible to provide a meaningful audit of pharmaceutical dispenses. The entry of dispense data is so inconsistent that attempting to track, identify or prevent diversion under the current systems is not possible. It is noteworthy that even after Maxor adjusted the quantities

dispensed upward, the differences in purchases versus dispenses remain questionable. The potentially catastrophic effect on clinical patient care and safety cannot be overstated. Some of the medications in question are serious pain medications that should be used with extreme caution and oversight, especially in a population of patients in which substance abuse prior to incarceration is widespread. The street value, high abuse potential, and propensity towards diversion of these medications are well established. It is for these very reasons that State and Federal regulations dictate the prescribing and dispensing of such medications to be tightly controlled – regulations that CDCR does not always follow. The enormous discrepancies between purchases and dispenses warrant an immediate, system-wide controlled substance audit. On June 19-21, 2006, agents from the CDCR Office of Internal Affairs conducted an emergency audit/inventory of specific narcotics at the California Medical Facility (CMF) and California State Prison-Solano (SOL). A memorandum of the Internal Affairs findings and Maxor’s response are included as Appendix F.

-- The dramatic difference between CDCR drug cost per offender and other comparable adult correctional health care programs, as identified in the 2003 OIG report, continues to worsen. In the chart below, 1997-2002 data has been reproduced from the 2003 OIG Report. Because of the previously identified CDCR overstatement of drug expenditures, Maxor was unable to verify reported drug purchases for 2003 and 2004. However, Maxor was able to verify that CY 2005, actual annual drug expenditures per inmate were 400 % higher in California than in Texas (\$836 compared to \$204). Even with factoring out the favorable 340b (public health) drug purchasing arrangement achieved by Texas, CDCR is still 250 % above benchmarks achieved by another large governmental entity. Similar differentials were evident in comparison with the Federal Bureau of Prisons.



-- The table below quantifies the aggregate differential in 2005 drug costs between California and other adult correctional health care programs. Maxor projected 2005 medication expenditures utilizing actual data for California and Texas and trending the Federal Bureau of Prisons and Georgia's actual 2000-2004 expenditures forward (Federal Bureau of Prison Pharmacy Services OIG Audit Report 2005, Georgia DOC Health Care Services Overview 2004, Texas CMHCC Quarterly Reports, 2003-2005). Additionally, Texas and the Federal Bureau of Prison numbers were adjusted upward to reflect their ability to achieve preferential pricing (e.g. 340 B, Federal Supply Schedule). Each system's 2005 adjusted drug cost per inmate day was then multiplied by California's 2005 average daily census to estimate total drug expenditures for each system based on California's inmate population. The "difference" illustrates the aggregate variation in drug expenditures when comparing California to other analogous systems and adjusting for preferential pricing and population. In summary, California's 2005 drug costs are approximately \$46 to 80 million dollars higher than comparable correctional programs, even after adjusting for pricing and population.

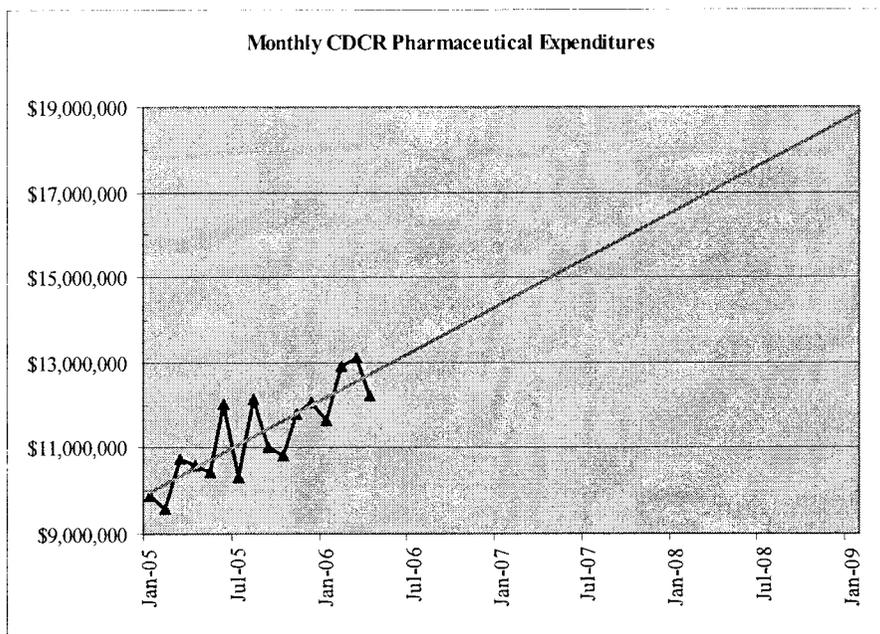
DRUG COST EXPENDITURES COMPARISON 2005

	California	Texas	Federal Bureau of Prisons	Georgia
Drug Cost Per Inmate Day	\$2.29	\$0.56	\$0.93	\$1.42
Adjusted Drug Cost Per Inmate Day	\$2.29	\$0.90	\$1.49	\$1.42
Adjusted Drug Cost Per Inmate Year	\$835.85	\$327.04	\$543.12	\$518.30
Average California Inmates	157,149	157,149	157,149	157,149
Total Drug Expenditures	\$131,352,992	\$51,394,009	\$85,350,765	\$81,450,327
Difference		\$79,958,983	\$46,002,227	\$49,902,665

Maxor recognizes that some may point out that adjusting these benchmarks for the preferential pricing available in some jurisdictions does not account for differences in utilization of items such as psychotropic medications between the jurisdictions. However, it is our belief, given the size of the differentials illustrated, and our observations and analysis, that the lack of adequate, effective pharmacy management is manifesting itself in the high costs experienced by the CDCR.

-- In spite of numerous audits identifying the need to improve pharmacy management, accountability, and internal controls, CDCR, DGS, and the State have repeatedly failed to implement meaningful change, as evidenced by the fact that

pharmaceutical expenditures continue to rise at an alarming rate. If immediate and substantial corrective action is not initiated, CDCR offender drug purchases are projected to rise more than 50 % over the next three years.



-- Pharmaceutical procurement and management of purchasing is an important aspect of cost control. However, the greatest cost controls are obtained by designing rational therapeutic regimens that encompass sound scientific evidence, patient specific morbidity and co-morbidity, and purchasing contracts. The CDCR has not developed clinical guidelines utilizing this methodology. The optimal system designs treatment approaches that step through therapy becoming more complex and expensive as patient factors dictate. Properly applied, the same clinical outcomes can be obtained for a fraction of the cost. Because this equation is complex, it is unrealistic to expect each prescriber to independently derive the best combination of effectiveness, safety and cost consciousness for all diseases. As a result, development of the disease treatment guidelines require input from persons experienced in the disease, pharmacy benefits management and pharmacotherapy. As an example, hypertension basic guidelines recommend starting with a single agent, often a diuretic, then adding additional agents as needed and in deference to the patient's concomitant diseases and physiologic condition. In general terms, one could choose not to use a diuretic and then instead choose an expensive proprietary agent of preference. As therapy steps up, the dosage can be increased, or a new agent can be added. Once again, preference may be an expensive brand agent. As an alternative, a clear treatment guideline can identify

optimal choices for each step incorporating most concomitant diseases and use equally effective, yet different drugs that are available in generic forms. The dosage ranges can target optimal response and avoid side effects from too high or too low a dosage. The result is a regimen that may cost 75-90% less. This methodology also allows regimens to be designed that are less likely to be a patient safety risk due to toxicities and interactions.

-- The findings of this financial analysis correspond with the observations and findings noted by the Maxor team in their on-site reviews detailed earlier in this report. They echo many of the findings from previous audits and reviews. The lack of meaningful and effective corrective action has directly contributed to the ongoing difficulties and challenges faced by the pharmacy services program within CDCR. Only by taking immediate, determined, and enforceable action can these challenges be addressed. A patient-centered, outcome-driven, accountable, cost-efficient and effective pharmacy program can be achieved through a commitment to reforming the program as outlined in this report. This includes revising, as necessary, existing State laws, rules, regulations, policies and operating procedures of overhead/control agencies of State government.

THE ROAD MAP CONCEPT

This document outlines a road map for achieving necessary improvements to the CDCR pharmacy services. The road map envisions a three year program that relies on outside expertise and leadership to assist the State of California, CDCR and the Receiver to implement many of the recommendations offered by past audits and reviews, thus achieving a clinically sound, professionally managed and cost-effective pharmacy operation. **The road map maintains a primary focus on producing sustainable, patient-centered, outcome-driven processes. The goal is to create a stand-alone, CDCR managed and operated “best practice” pharmacy system over 3 years.**

As clearly demonstrated by past audits and recent reports, change in the way of doing business does not come easy or quickly. Obstacles such as resistance to change, lack of resources, inadequate staffing, and antiquated technology will not be corrected overnight.

Therefore, the road map’s goals and supporting objectives are packaged in a crawl, walk and run sequence that outline the destinations that must be reached and a general timeframe for reaching them. Should the goals and objectives in this report be formally adopted, detailed scheduling for each goal and objective will follow. The “road to recovery” will begin with critical, incremental steps (“crawl”) toward progress. By building on the strong foundation achieved in the “crawl” phase, greater progress will be achieved in the “walk” phase, with the eventual “run” phase in which all the previous steps culminate into a high performing system. In all phases, however, improved patient care remains the first priority and a primary driver.

Key performance goals in the “crawl” phase will be to provide the Receiver with experienced pharmacy managers who have centralized direct line authority over all pharmacy operations. Soon thereafter, regional clinical pharmacists will be trained and deployed to assist institutional pharmacy operations. Immediate, proactive steps will be taken with the Receiver/CDCR clinical leadership to develop purchasing and inventory controls, treatment guidelines, re-engineer the formulary and establish a meaningful and credible pharmacy and therapeutics committee.

“In light of the flexible options likely to be available under the February 2006 federal court order appointing a receiver over the (CDCR) department’s medical health care delivery system, reconsider the option of contracting with a private pharmacy services management firm to implement the recommendations submitted in the (previous California) reports and studies conducted since 2000” (2006 OIG Accountability Audit 64).

As the plan progresses to the “walk” phase, greater emphasis will be placed on the establishment of key performance metrics and management reporting systems. Performance metrics will be provided to the Receiver with progress toward the achievement of corrective actions. Prescribing practices, adherence to formulary treatment guidelines, drug utilization reviews, and patient outcomes will become paramount in the “walk” phase, as new systems are implemented to allow for better reporting. Creative measures will be implemented to bridge the gap between existing information technology and readily available, off-the-shelf, relatively inexpensive pharmacy management software.

In the second year of the plan, the design, construction and operation of a centralized pharmacy facility must become a reality. The concept of a central fill allows institutional pharmacists to focus less on “pushing the pills” and more on clinical pharmacology and patient care. Comprehensive, clinically integrated, system-wide policies and procedures coupled with treatment guidelines and associated formulary management under the oversight of a proactive P&T committee will establish the road to success.

The road map is outlined in seven key goals. Each of the goals is supported by a number of objectives outlining necessary tasks to be accomplished to achieve the desired outcome. Each objective is further defined by identifying detailed actions to be taken. It should be noted that the actions proposed herein are based on what is presently known. This document

This document should be considered a living plan that will change and adapt to the conditions encountered as actions move forward.

should be considered a living plan that will change and adapt to the conditions encountered as actions move forward. Nevertheless, **effective implementation will result in a system that is sustainable over the long haul – that means making changes, internalizing those changes, and having mechanisms in place to continually evaluate, modify and improve the overall pharmacy systems.**

COMPREHENSIVE ACTION PLAN

Purpose: To provide bi-monthly reporting to the Receiver and CDCR HCSD regarding progress, successes, and impediments to progress action items to be addressed. To outline in detail the steps necessary to achieve meaningful improvement in the quality, efficiency and effectiveness of pharmacy operations for the Receiver, California Department of Corrections and Rehabilitation, HCSD, and State government. To establish a state-of-the-art, accredited pharmacy services operation that assures optimal outcomes and safety for patients, as well as cost-effectiveness for the State of California.

KEY ACTION PLAN GOALS

- Goal A:** Develop meaningful and effective centralized oversight, control and monitoring over the pharmacy services program.

- Goal B:** Implement and enforce clinical pharmacy management processes including formulary controls, Pharmacy and Therapeutics committee, disease management guidelines, and the establishment of a program of regular prison institution operational audits.

- Goal C:** Establish a comprehensive program to review, audit and monitor pharmaceutical contracting and procurement processes to ensure cost efficiency in pharmaceutical purchases.

- Goal D:** Develop a meaningful pharmacy human resource program that effectively manages staffing, compensation, job descriptions, competency, performance assessment, discipline, training, and use of the workforce including temporary employees and non-pharmacist staff.

- Goal E:** Redesign and standardize overall institution level pharmacy drug distribution operations for inpatient and outpatient needs. Design, construct and operate a centralized pharmacy facility.

- Goal F:** Based on a thorough understanding of redesigned work processes, design and implement a uniform pharmacy information management system needed to successfully operate and maintain the CDCR pharmacy operation in a safe, effective and cost efficient way.
- Goal G:** Develop a process to assure CDCR pharmacy meets accreditation standards of the designated healthcare review body (NCCHC or ACA) and assist in obtaining accredited status.

KEY ACTION PLAN GOALS, DESCRIPTIONS, AND OBJECTIVES

Goal A: Develop meaningful and effective centralized oversight, control and monitoring over the pharmacy services program.

The central leadership team will provide direction, continuity and standardization in reaching the goals outlined in the roadmap.

A critically necessary component of the plan identified by every audit group is the development of a core pharmacy leadership structure using key staff with demonstrated performance in strategic and operational development skills matched to the project. The central leadership team will provide direction, continuity and standardization in reaching the goals outlined in the roadmap. The team will include a senior leader, an administrative director, a clinical director and two central pharmacy operations supervisors (for the central pharmacy facility). The team will serve in line authority over all pharmacy staff and as liaisons to other disciplines within health care and corrections. The leadership team office will be established in proximity to medical leadership and moved into the central pharmacy facility once constructed.

Clinical pharmacy specialists are integral to institution level implementation and training of centrally developed clinical strategies and disease management guidelines. In concert with the leadership team, six to eight highly trained clinical specialists will provide regional and institution level feedback regarding performance of the institution level health care team, providers and pharmacy staff, as well as training and clinical care consultative support to front-line providers for the most complex patients (those at highest risk for poor outcomes and adverse medical events). The clinical specialists will also conduct outcome-based reviews of formulary adherence, prescribing practices, treatment guideline implementation, and process improvement. The clinical specialists will work in parallel with the local pharmacy staff rather than as line authority supervisors. Each clinical specialist will serve an assigned region,

working at the institution level. The overall framework is intended to provide an organizational structure and line-of-sight for all members of the CDCR patient care team.

Objective A.1: Establish a central pharmacy services administration, budget and enforcement authority.

Objective A.1.1: Identify and hire leadership and clinical specialists.

Objective A.2: Establish direct lines of authority to all pharmacy services personnel and define linkage to central medical staff.

Objective A.2.1: Define and communicate roles and responsibilities of leadership and clinical specialist to workforce and medical staff.

Objective A.2.2: Meet with pharmacy workforce and outline the road map, identify early adopters and delineate expectations for the pharmacy workforce.

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

Objective A.3.1: Review existing central P&P; obtain input from institution level P&P to identify best practices.

Objective A.3.2: Create single standardized P&P for all institutions (and care levels).

Objective A.3.3: Roll out standardized P&P to institutions.

Objective A.3.4: Monitor adherence to new standardized P&P.

Objective A.3.5: Implement a continual readiness system for standards, regulations and P&P.

Objective A.4: Establish key performance metrics used to evaluate the performance of the pharmacy services program.

Objective A.4.1: Identify available information sources and establish data reliability.

Objective A.4.2: Define operational targets for pharmacy and institution level teams.

Objective A.4.3: Develop a pharmacy initiative tracking grid (for projects with finite timelines), balanced scorecard (clinical, service, financial and workforce measures), and dashboard (workload measures) to include historical benchmarks, measures, targets and milestones for the program (see Appendix B for examples).

Objective A.4.4: Create institution level dashboards to provide performance benchmarks and comparisons, and set targets to structure improvement (institution level report card for prescribers and pharmacy).

Objective A.4.5: Institute culture in which the balanced scorecard and dashboard are central themes in meetings at every level. Over time, allow institution level scorecards and/or dashboards to become unique to strategic needs locally while assuring alignment with overall program goals and strategies. Future initiatives and operational enhancements will be considered around the agreed upon central strategies indicated on the scorecard.

Objective A.5: Establish standardized monitoring reports and processes designed to continually assess program performance.

Objective A.5.1: (See Objective A.4).

Objective A.5.2: (See Objective A.3.5).

Objective A.5.3: Use an action plan tracking grid to establish timelines and monitor implementation of the road map (see Appendix C for example).

Objective A.5.4: Establish standardized institution audit process to assess adherence to standards of practice and P&P.

Objective A.5.5: Create a stoplight grid to post institution audit results with links to detail reports. Post on website or other shared forum to allow comparison between institutions. Discuss at monthly P&T committee meetings. Require corrective action plans from institutions not meeting requirements (see Appendix D for example).

Objective A.5.6: Develop standardized pharmaco-economic analysis consultations for institutions not meeting overall goals. The analysis will include assessment of scorecards, dashboards, adherence to operational and disease management guidelines, prescribing practices and local issues based on care level and type. The consultation provides detailed recommendations for change to close the performance gap.

Objective A.5.7: Develop a standardized format for identification of needed disease management guidelines, criteria development, data collection, reporting, monitoring and follow-up.

- Objective A.5.8: Develop and implement disease management guidelines and treatment protocols.
- Objective A.5.9: Monitor provider use of the guidelines and provide findings to central medical administration and communicate findings to institution level provider; implement process improvement strategy to meet goal.

Goal B: Implement and enforce clinical pharmacy management processes including formulary controls, P&T committee, disease management guidelines and the establishment of a program of regular prison institution operational audits (using the framework of methodology identified under Goal A)

Uniformity in policies and procedures, formulary development, treatment guidelines and drug use processes including selection, procurement, prescribing, dispensing, administration, inventory, storage and controls will be achieved.

Through the use of interdisciplinary committees and work groups such as the P&T Committee, standardization will be established and maintained for all institutions to optimize patient care and assure safe, rational, cost-effective therapy. Uniformity in policies and procedures, formulary development, treatment guidelines and drug use processes including selection, procurement, prescribing, dispensing, administration, inventory, storage and controls will be achieved. Committees and workgroups comprised of CDCR medical, pharmacy, nursing and administrative leadership, with input and participation from institution level workforce, will develop policies, procedures, processes, formulary and treatment approaches for all to follow. More complex initiatives will be piloted in a representative sample of institutions with targeted patient care needs; initiatives will be improved using standard quality improvement methodology and then implemented statewide. Outcomes and desired measures identified will be monitored and initiatives will be implemented when targets are not realized. The group will develop and disseminate a clear performance-based system of goals, measures and targets, including performance feedback and initiatives to reach goals. Implementation of a system of routine institution level inspections will ensure adherence to procedures, standards of practice, and regulations.

Objective B.1: Revise and reconstitute, as needed, the current P&T committee and implement measures to allow for strong P&T oversight of prescribing and dispensing patterns.

- Objective B.1.1 Develop an interdisciplinary P&T Committee with membership experienced in formulary management. Include central, regional and institution level participation as appropriate.
- Objective B.1.2: Establish a clear committee charter utilizing principles stated in Objectives A3, A4, and A5.
- Objective B.1.3: Assign committee members responsibility for various functions; assign implementation oversight and ownership to gain accountability from all members.
- Objective B.1.4: Methodically work through the formulary categories and various reports and measures identified under Goal A to implement initiatives as identified.

Objective B.2: Establish methodologies and schedules for tracking and monitoring formulary compliance and prescribing behavior.

Objective B.2.1: See Objective A.4 and A.5.

Objective B.3: Develop and implement effective and enforceable peer-reviewed treatment protocols.

Objective B.3.1: See Objectives A4 and A5.

Objective B.4: Develop and implement effective and enforceable institution audit process.

Objective B.4.1: See Objectives A3, A.5.4 and A.5.5.

Goal C: Establish a comprehensive program to review, audit and monitor pharmaceutical contracting and procurement processes to ensure cost efficiency in pharmaceutical purchases.

Contracting will have a direct line of communication with the activities of the P&T committee, so that formulary additions support cost-effective purchasing contracts.

Pharmaceutical contracting and procurement will be centralized within HCSD and standardized to maximize purchase values and market share, as well as to monitor contract compliance. Contracting will have a direct line of communication with the activities of the P&T committee, so that formulary additions support cost-effective purchasing contracts. The central purchasing authority will monitor individual pharmacies to ensure that the right quantities of the right products are purchased at the institution level. Central review, editing, and submission of all purchase orders will assure optimal contract adherence and cost-effective purchasing. A computerized perpetual inventory system with integrated reclamation software will be utilized to achieve inventory control, monitor diversion, increase inventory turns, track returned medications, and re-circulate returns when possible to maximize inventory value.

Objective C.1: Monitor wholesaler (vendor) to ensure contract compliance.

- Objective C.1.1: Load purchasing contracts in a central data repository to allow for electronic monitoring of contract pricing.
- Objective C.1.2: Electronically monitor contract pricing on a continual basis and identify those items for which contract pricing is not being received.
- Objective C.1.3: Work with wholesaler account to ensure that the correct contract pricing is loaded.
- Objective C.1.4: Reconcile credit processes to ensure that wholesaler credits are received in the amount equal to the loss in contract pricing.

Objective C.2: Develop process to monitor inventory shrinkage.

Objective C.2.1: Implement perpetual inventory system in which dispenses are subtracted from inventory in real-time and daily inventory orders are automatically posted to the individual pharmacies' inventory.

Objective C.2.2: Monitor purchases versus dispenses to identify potential shrinkage. Shrinkage identified through either of these processes will be referred to the Receiver for determination of appropriate investigative and corrective action.

Objective C.2.3: Develop trend-analysis procedures to automatically reset stock levels based on current utilization.

Objective C.2.4: Eliminate the use of bulk stock and have institution level pharmacist/pharmacy technician monitor drug use processes across the continuum of care.

Objective C.3: Implement process to insure that the best value contracted item is used.

Objective C.3.1: Establish a direct line of communication between contracting and P&T committee.

Objective C.3.2: Evaluate current formulary as compared to purchasing contracts.

Objective C.3.3: Secure purchasing contracts for those drugs with preferred status on the formulary and eliminate costly non-contracted drugs from the formulary if there are other more cost-effective drugs for which contracts can be obtained.

Objective C.3.4: Mandate the purchase/use of generics and therapeutic interchanges when possible.

Objective C.4: Consolidate and standardize pharmacy purchasing through development of a centralized procurement system.

Objective C.4.1: Obtain purchasing data and establish inventory levels based on historical trends.

Objective C.4.2: Train pharmacy staff on central purchasing procedures and supply system.

Objective C.4.3: Transition all pharmacies to central purchasing.

Objective C.4.4: Ensure that the best value contracted item is stocked by the wholesaler and purchased by the individual pharmacies in the correct quantities to maximize inventory turns.

Objective C.5: Evaluate feasibility of achieving 340 B preferential pricing on all drug purchases.

Objective C.5.1: Explore sub-contracting possibilities with covered 340 B entities.

Objective C.5.2: Conduct a cost-benefit analysis of 340 B pricing potential.

Objective C.5.3: Evaluate potential for contracting with a covered entity to allow for 340 B eligibility.

Objective C.5.4: If contracting opportunities are available, feasible, and cost-effective, contract with a covered entity, establish 340 B status, and obtain pricing.

Goal D: Develop a meaningful pharmacy human resource program that effectively manages staffing, compensation, job descriptions, competency, performance assessment, discipline, training, and use of the workforce including temporary employees and non-pharmacist staff.

A complete skill set inventory of State employees will be conducted to identify knowledge deficits in clinical, operational, and fiscal matters.

Employees will be hired and trained to replace registry personnel. Scheduling and use of floater/PRN positions will be maximized to decrease use of registry personnel to cover vacation and sick leave. Clearly defined criteria, procedures, and processes will be implemented to monitor and reduce the use and cost of registry personnel. A complete skill set inventory of State employees will be conducted to identify knowledge deficits in clinical, operational, and fiscal matters. Required training and in-services will be provided as needed for existing employees to ensure adherence and comprehension of policies. Local, regional, and state-wide meetings, conference calls, and/or visits with pharmacy managers will be conducted on a routine basis to facilitate management, communication and standardization of pharmacy practices. An effective means of documenting and tracking employee training, education, and disciplinary action will be developed and all employee job descriptions and personnel files will be updated to include a current evaluation completed within the last year. The use of pharmacy technicians and clerks will be maximized to allow pharmacist staff to perform needed clinical functions, while delegating clerical and administrative functions to other staff. Staffing patterns will be established for each institution based on prescription volume and personnel will be reassigned as needed.

Objective D.1: Hire and train new employees as needed to replace registry personnel.

Objective D.1.1 Reevaluate staffing pattern versus workload and interim practice model (prior to full system redesign) to

- determine appropriate staffing compliment and numbers.
- Objective D.1.2: Hire employees to fill all vacant pharmacy manager (Pharmacist II) positions.
- Objective D.1.3: Recommend and implement meaningful salary levels as determined by the Receiver.
- Objective D.1.4: Hire employees to fill all other vacant positions.
- Objective D.1.5: Train new employees and define methodologies for monitoring and evaluating employee competence and performance.

Objective D.2: Complete skill set inventory of State and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing personnel.

- Objective D.2.1: Identify knowledge deficits in clinical, operational, and fiscal matters.
- Objective D.2.2: Prioritize in-services and develop time frames for conducting training.
- Objective D.2.3: Assign team leaders and implementation teams to conduct in-services in the identified knowledge deficits.
- Objective D.2.4: Conduct in-services on a monthly or quarterly basis, as needed. Use web-based e-authoring tools to develop "smart," self-paced competency and training system.

Objective D.3: Develop effective means of documenting and tracking employee training, education, performance, and disciplinary action.

Objective D.3.1: See Objective D.1 and D.3.

Objective D.4: Reevaluate previous staffing patterns at each institution in light of the adoption of new technologies to improve efficiency and the transition of volume to the centralized pharmacy.

Objective D.4.1: Track prescription volume, define current staffing levels, and identify ideal staffing patterns.

Objective D.4.2: Maximize use of pharmacy technicians to perform administrative and clerical functions.

Objective D.4.3: Transition excess staff to the central pharmacy and other areas as needed. Eliminate any remaining PRN and registry positions to meet new, lower staffing needs.

Objective D.4.4: Develop a centralized pharmacist intern program to improve the public image of the CDCR HCSD as an employer and to help recruit talented pharmacists and support personnel entering the field.

Goal E: Redesign and standardize overall institution level pharmacy drug distribution operations for inpatient and outpatient needs. Design, construct and operate a centralized pharmacy facility.

An automated centralized pharmacy will be developed to gain advantages of scale related to efficient purchasing, inventory control, volume production, drug distribution, workforce utilization, and increased safety.

To ensure that patient needs are met based on care level and to achieve safety, accountability, efficiency and consistency, institution level operations will be redesigned and standardized. An automated centralized pharmacy will be developed to gain advantages of scale related to efficient purchasing, inventory control, volume production, drug distribution, workforce utilization, and increased safety. A plan created by pharmacy leadership and based on appropriate regulations and best practices, including input from central, regional and institution level medical staff and pharmacists, will be implemented. The plan will consider segmented populations such as preventative care, acute hospital care, ambulatory care, long-term care, chronic care, mental health, and dental care and systems that optimize available technology and identified best practices. Pilots will be used for highly complex changes using goals, measures and targets. Institution level redesign will be defined and implemented while the central pharmacy proposal is under development.

The concept for the majority of patients served includes the eventual use of a prescriber order entry system with clinical tools to promote developed treatment guidelines and prescribing principles. A limited number of on-site pharmacist(s) and technician(s) will provide prospective patient profile review, correct any problems, intervene with prescribers as indicated to optimize therapy, and release the prescription for processing. Acute care medications will be filled at the institution using a bar code checking system. All other medications will be filled and processed at the central pharmacy for subsequent delivery. Institution level pharmacy staff will ensure proper controls are in place and that unused medications are accounted for, returned to inventory and documented. These returns will serve as the inventory for any needed floor stock and acute care

prescriptions filled. Central staff will handle all vendor contracting, purchasing, packaging, and non-acute medication dispensing, as well as support unit level services during staffing shortages.

Objective E.1: Prior to centralization, implement standardized operations in all existing institution level operations to correct problems identified in audits.

Objective E.1.1: Implement best practice for “ambulatory” care distribution model using existing resources and pre-centralization model (correct high risk safety and control issues).

Objective E.1.1.1: Assess if external support or regionalization is needed to bridge the gap between the current system and infrastructure rebuilding and centralization.

Objective E.1.1.1.1 If external support or regionalization is needed, implement on small scale and adjust operational model to meet inmate/patient needs.

Objective E.1.1.1.2 Expand service agreement as appropriate.

Objective E.1.2: Develop straw model for institution level operations (see under Goal E) under centralization plan.

Objective E.1.2.1: While implementing centralization, pilot straw man at institution level, establish measures to evaluate and adjust model.

Objective E.1.2.2: Finalize institution unit level model and spread to all institutions.

Objective E.1.3: Establish best practices for “inpatient” care areas and implement model in all sites.

Objective E.1.3.1: Assess technology and operations to develop optimal model of operations for inpatient care areas.

Objective E.1.3.2: Establish resource needs and create action plan to pilot optimal inpatient model with measures and goals.

Objective E.1.3.3: Finalize model and spread to remaining inpatient areas.

Objective E.2: Design, construct and operate a centralized pharmacy facility.

Objective E.2.1: Develop straw model for centralization concept (see under Goal F).

Objective E.2.2: Finalize model based on available automation and institution level operational technology; assess staffing needs.

Objective E.2.3: Determine general location, survey real estate and identify a suitable location for the centralized pharmacy facility.

Objective E.2.4: Design and complete architectural build out of facility.

Objective E.2.5: Procure and install necessary mechanization, robotics, fixtures, conveyor belts, and electronics.

Objective E.2.6: Relocate, hire and train pharmacy personnel to staff centralized pharmacy.

- Objective E.2.7: Obtain California State Board of Pharmacy and DEA licenses.
- Objective E.2.8: Transition prescription workload from individual institutions to centralized pharmacy.

Goal F: Based on a thorough understanding of redesigned work processes, design and implement a uniform pharmacy information management system needed to successfully operate and maintain the CDCR pharmacy operation in a safe, effective and cost efficient way.

Connectivity will be established and/or upgraded for all 33 institutions to facilitate web-based software access and reporting. An interdisciplinary team of pharmacy experts with clinical, operational, fiscal, and technological backgrounds will comprehensively review the pilot pharmacy system, VistA, to evaluate whether it accommodates CDCR's complex challenges. This team will explore alternative pharmacy systems utilizing comparable analysis techniques before final evaluation and implementation of a suitable software product. Steps will be taken to improve data collection and facilitate management/clinical oversight by assembling a development team to design and implement improved reporting and monitoring capabilities in the interim using the current Prescription Tracking System.

Technology upgrades will include barcode checking and physician order entry to ensure the right medication is administered to the right patient at the right time.

Once conversion to a state-of-the art pharmacy information management system is complete, ancillary software tools will be developed and customized in order to improve patient safety and cost effectiveness. Technology upgrades will include barcode checking and physician order entry, to ensure the right medication is administered to the right patient at the right time. Real-time adjudication of pharmacy claims will perform patient adherence and provider prescribing review based on established guidelines and protocols. An enterprise reporting tool will be developed to allow for customized utilization reports with available data elements such as patient name, age, disease state, therapeutic class, dispense date, drug, institution, and cost per prescription.

Objective F.1: Develop and implement improved reporting and monitoring capabilities with existing pharmacy system.

Objective F.1.1: Create a data repository of all drug names and assign an industry identifier to all drug names.

Objective F.1.2: Develop rudimentary utilization management and pharmacy reports based on standard managed care and pharmacy benefit manager practices.

Objective F.1.3: Establish provider report cards that compliment the goals and clinical initiatives of the P&T function.

Objective F.1.3.1 Develop an effective mechanism for distribution of report cards, performance monitoring, and follow-up with detailed recommendations for change on how to improve performance.

Objective F.2: Identify and propose solutions to connectivity issues throughout all pharmacies to ensure that web-based software, reporting, and data can be easily accessed at each facility.

Objective F.2.1: Conduct site visits to evaluate current connectivity issues.

Objective F.2.2: Procure new hardware as needed to modernize technology in all institutions.

Objective F.2.3: Achieve high-speed connection in as many sites as possible, replacing dial-up and slow connections with sufficient bandwidth to support institutions' needs; implement back-up systems to ensure connectivity in the event that the primary connection is unavailable.

Objective F.3: Procure a state-of-the-art pharmacy dispensing system.

Objective F.3.1: Organize an interdisciplinary team of pharmacy experts with clinical, operational, fiscal, and technological backgrounds to evaluate the current pilot program, VistA.

Objective F.3.2: Establish guidelines for product evaluation using financial, operational, clinical, and technological indicators.

Objective F.3.3: Evaluate VistA and alternate products on the market.

Objective F.3.4: Compile findings based on product evaluation; choose the most suitable pharmacy information management solution.

Objective F.3.5: Install needed hardware and software to support uniform pharmacy information management system.

Objective F.4: Transition each institution to uniform pharmacy information management system.

Objective F.4.1: Conduct inventories at each pharmacy and input inventory in pharmacy system.

Objective F.4.2: Conduct data conversion where possible and input current prescriptions and allergies information for data that cannot be converted.

Objective F.4.3: Introduce transition teams of highly trained staff to train pharmacy employees on new system to minimize implementation time.

Objective F.4.4: With the direct participation and oversight of transition teams, "go live" on uniform pharmacy information management system.

Objective F.4.5: Withdraw transition teams, monitor progress, and provide retraining and software reconfiguring as necessary.

Objective F.5: Develop and implement reporting tools to facilitate clinical, operational, and fiscal management of the CDCR pharmacy operation.

Objective F.5.1: Utilize enterprise Pharmacy Benefit Manager reporting experience to develop reporting tools for management, such as Formulary Compliance, Cost per Rx, Top Therapeutic Category, and Top Drug by Cost reports.

Objective F.5.2: Develop provider report cards and other unique reports required by correctional environment including reports that compliment outcome-based, patient centered approach.

Objective F.5.4: Establish web-based method for distributing reports, communicating information to medical staff and management, and providing follow-up as needed to ensure compliance and improvement.

Objective F.6: Integrate pharmacy information management system with auxiliary technologies such as central supply management, physician order entry, electronic MAR, and barcode checking.

Objective F.6.1: See Objective C.4

Objective F.6.2: Develop physician order entry system that maintains and communicates formulary information to providers to enable them to choose the most clinically-effective therapies, while

ensuring that cost control initiatives are maximized.

Objective F.6.3:

Integrate use of electronic MAR and barcode checking to ensure that the right medication is administered to the right patient at the right time.

Goal G: Develop a process to assure CDCR pharmacy meets accreditation standards of the designated healthcare review body (NCCHC or ACA) and assist in obtaining accredited status.

The process of seeking and maintaining accreditation is intended to provide organizations with guidelines and tools to standardize and improve processes for the delivery of health care. As stated by one such accrediting body, The National Commission for Correctional Health Care:

“Standards for Health Services are our recommendations for managing the delivery of medical and mental health care in correctional systems. The Standards have helped the nation’s correctional and detention facilities improve the health of their inmates and the communities to which they return; increase the efficiency of their health services delivery; strengthen their organizational effectiveness; and reduce their risk of adverse legal judgments. Written in separate volumes for prisons, jails and juvenile confinement facilities, the Standards cover the general areas of care and treatment, health records, administration, personnel and medical-legal issues.”

(<http://www.ncchc.org>).

The mission and purpose are similar for other accrediting bodies as are the intended benefits to the organization undergoing accreditation. Furthermore, agencies under court oversight may be required to obtain accreditation as a method of qualifying performance and then be required to maintain the accreditation thereafter, to assure that standards of practice are maintained.

Objective G.1: Establish Receiver and CDCR commitment to pursue accreditation and determine the accrediting organization standards to be followed.

- Objective G.1.1: Assemble an interdisciplinary committee with input from persons experienced in both ACA and NCCHC systems.
- Objective G.1.2: Assess the standards of both ACA and NCCHC to determine the best match for the healthcare and custody system.
- Objective G.1.3: Develop a standards audit readiness team.

Objective G.2: Develop a readiness grid identifying the standards and assigning assessment responsibilities to members of the team.

- Objective G.2.1: Begin the process of mock audits to identify standards in violation.
- Objective G.2.2: Implement process improvement and procedural change to become compliant with standards in violation.
- Objective G.2.3: Continue mock audits until violations are resolved.

Objective G.3: Complete mock audits using a credentialed auditor for target accrediting body.

- Objective G.3.1: Complete processes G.2.1 through G3 until confident that the CDCR meets accrediting body standards.

Objective G.4: Apply for accreditation at one or more institutions. Expand audits to all institutions on a defined schedule.

PHASE I: CRAWL (0-12 MONTHS)

- Objective A.1: Establish a central pharmacy services administration, budget and enforcement authority.
- Objective A.2: Establish direct lines of authority to all pharmacy services personnel and define linkage to central medical staff.
- Objective B.1: Revise and reconstitute, as needed, the current P&T committee and implement measures to allow for strong P&T oversight of prescribing and dispensing patterns.
- Objective B.2: Establish methodologies and schedules for tracking and monitoring formulary compliance and prescribing behavior.
- Objective C.1: Monitor wholesaler (vendor) to ensure contract compliance.
- Objective C.2: Develop process to monitor inventory shrinkage.
- Objective C.3: Implement process to insure that the best value contracted item is used
- Objective D.1: Hire and train new employees as needed to replace registry personnel.
- Objective D.2: Complete skill set inventory of State and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing personnel.
- Objective D.3: Develop effective means of documenting and tracking employee training, education, performance, and disciplinary action.
- Objective F.1: Develop and implement improved reporting and monitoring capabilities with existing pharmacy system.
- Objective F.2: Identify and propose solutions to connectivity issues throughout all pharmacies to ensure that web-based software, reporting, and data can be easily accessed at each facility.

PHASE II: WALK (12-24 MONTHS)

- Objective A.3: Update and maintain system-wide pharmacy policies and procedures.
- Objective A.4: Establish key performance metrics used to evaluate the performance of the pharmacy services program.
- Objective B.3: Develop and implement effective and enforceable peer-reviewed treatment protocols.
- Objective C.4: Consolidate and standardize pharmacy purchasing through development of a centralized supply procurement system.
- Objective E.1: Prior to centralization, implement standardized operations in all existing institution level operations to correct problems identified in audits.
- Objective F.3: Procure a state-of-the-art pharmacy dispensing system.
- Objective F.4: Transition each institution to a uniform pharmacy information management system.
- Objective F.5: Develop and implement reporting tools to facilitate clinical, operational, and fiscal management of the CDCR pharmacy operation.

PHASE III: RUN (2-3 Years)

- Objective A.5: Establish standardized monitoring reports and processes designed to continually assess program performance.
- Objective B.4: Develop and implement effective and enforceable institution audit process.
- Objective C.5: Evaluate feasibility of achieving 340 B preferential pricing on all drug purchases.
- Objective D.4: Reevaluate previous staffing patterns at each institution in light of the adoption of new technologies to improve efficiency and the transition of volume to the centralized pharmacy.
- Objective E.2: Design, construct and operate a centralized pharmacy facility.
- Objective F.6: Integrate pharmacy information management system with auxiliary technologies such as central supply management, physician order entry, electronic MAR, and barcode checking
- Objective G.1: Establish Receiver and CDCR commitment to pursue accreditation and determine the accrediting organization standards to be followed.
- Objective G.2: Develop a readiness grid identifying the standards and assigning assessment responsibilities to members of the team.
- Objective G.3: Complete mock audit using credentialed audit for target credentialing body.
- Objective G.4: Apply for accreditation audit at one or more institutions. Expand audits to all institutions on a defined schedule.

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APPENDIX A: CDCR PURCHASES VS. DISPENSES ANALYSIS -- 2005 CALENDAR YEAR

Institution	GCN	Drug	Qty		Qty Difference	% Not Dispensed
			Purchased	Dispensed		
California Institution for Women	21414	GABAPENTIN 300 MG CAPSULE	16700	219	16481	98.69
	47563	GEODON 20 MG CAPSULE	3440	1767	1673	48.63
California Medical Facility	41806	GABAPENTIN 800 MG TABLET	24700	200	24500	99.19
	4225	ROXICODONE 5 MG TABLET	186000	5488	180512	97.05
California State Prison, Corcoran	34188	SEROQUEL 100 MG TABLET	20000	15628	4372	21.86
	27961	ZYPREXA 5 MG TABLET	4410	3463	947	21.47
California Rehabilitation Center	46222	PAROXETINE HCL 10 MG TABLET	3960	2403	1557	39.32
Chuckawalla Valley State Prison	27462	PROTONIX 40 MG TAB EC	300	30	270	90.00
	50137	PAXIL CR 12.5 MG TABLET	390	30	360	92.31
Deuel Vocational Institution	4204	HYDROCODONE-APAP 5/500 TAB	9440	3316	6124	64.87
	46484	RENAGEL 400 MG TABLET	360	90	270	75.00
High Desert State Prison	27462	PROTONIX 40 MG TAB EC	90	30	60	66.67
	8361	NAPROXEN 375 MG TABLET	400	178	222	55.50
	21414	GABAPENTIN 300 MG CAPSULE	2000	1056	944	47.20
North Kern State Prison	45652	KEPPRA 750 MG TABLET	480	208	272	56.67

APPENDIX A: CDCR PURCHASES VS. DISPENSES ANALYSIS -- 2005 CALENDAR YEAR

Pelican Bay State Prison	51800	RISPERDAL 2 MG M-TAB	11256	677	10579	93.99
	46228	SERTRALINE 50 MG TABLET	14400	1653	12747	88.52
	34189	SEROQUEL 200 MG TABLET	94300	42544	51756	54.88
	47568	GEODON 80 MG CAPSULE	32320	15279	17041	52.73
Pleasant Valley State Prison	21415	GABAPENTIN 400 MG CAPSULE	5900	416	5484	92.95
Richard J. Donovan Correctional Facility	4000	LITHIUM CARBONATE 150 MG CAP	400	42	358	89.50
	21413	GABAPENTIN 100 MG CAPSULE	6900	946	5954	86.29
California State Prison Sacramento	23381	COZAAR 25 MG TABLET	1330	614	716	53.83
California Medical Facility	47568	GEODON 80 MG CAPSULE	21620	590	21030	97.27
	47563	GEODON 20 MG CAPSULE	1760	50	1710	97.16
	46403	EFFEXOR XR 37.5 MG CAP SA	9800	317	9483	96.77
	47198	SEROQUEL 300 MG TABLET	124020	4720	119300	96.19
	21155	RISPERIDONE 2MG	22300	976	21324	95.62
Sierra Conservation Center		None Outstanding				
California State Prison Solano	24505	OXYCONTIN 20 MG TABLET SA	9175	280	8895	96.95
	46223	PAROXETINE HCL 20 MG TABLET	25220	874	24346	96.53
	47563	GEODON 20 MG CAPSULE	7320	268	7052	96.34
	21155	RISPERIDONE 2MG	41040	2738	38302	93.33
	41027	ZYPREXA 20 MG TABLET	6210	468	5742	92.46
	46401	EFFEXOR 75 MG TABLET	9300	780	8520	91.61

APPENDIX A: CDCR PURCHASES VS. DISPENSES ANALYSIS -- 2005 CALENDAR YEAR

	47198	SEROQUEL 300 MG TABLET	63120	5679	57441	91.00
	41026	ZYPREXA 15 MG TABLET	7620	711	6909	90.67
	46452	MIRTAZAPINE 45 MG TABLET	18000	1699	16301	90.56
	4225	ROXICODONE 5 MG TABLET	600	57	543	90.50
	46405	EFFEXOR XR 150 MG CAPSULE SA	3000	297	2703	90.10
	34189	SEROQUEL 200 MG TABLET	82000	8721	73279	89.36
San Quentin	50760	LEXAPRO 20 MG TABLET	2100	3	2097	99.86
	29077	ZYPREXA 2.5 MG TABLET	1060	11	1049	98.96
	46450	MIRTAZAPINE 15 MG TABLET	30390	5888	24502	80.63
	46452	MIRTAZAPINE 45 MG TABLET	14450	2850	11600	80.28
	34189	SEROQUEL 200 MG TABLET	61900	12853	49047	79.24
Salinas Valley State Prison	4204	HYDROCODONE-APAP 5/500 TAB	7500	4289	3211	42.81
	29928	LEVAQUIN 500 MG TABLET	550	320	230	41.82
	27780	TRILEPTAL 600 MG TABLET	4400	2594	1806	41.05
Valley State Prison for Women	22647	PREMPRO 0.625/5 MG TABLET	588	16	572	97.28
	53321	PREMPRO 0.3 MG/1.5 MG TABLET	672	22	650	96.73
	4242	METHADONE 5 MG TABLET	200	14	186	93.00
	22648	PREMPRO 0.625/2.5 MG TABLET	8400	1052	7348	87.48
Wasco State Prison	21983	ZERIT 20 MG CAPSULE	240	4	236	98.33
	29077	ZYPREXA 2.5 MG TABLET	120	4	116	96.67
	46403	EFFEXOR XR 37.5 MG CAP SA	900	31	869	96.56
	41286	CELEBREX 200 MG CAPSULE	200	20	180	90.00
	21984	ZERIT 30 MG CAPSULE	120	28	92	76.67
	27961	ZYPREXA 5 MG TABLET	6540	1882	4658	71.22

APPENDIX B-1: SAMPLE DASHBOARD

Green - On target													
Yellow - At risk for not meeting target/off target													
Red - Will not meet target/significantly off target													
Measure	Measure Definitions	Actual	FY 2005	FY 2006 YTD	Jan	Feb	Mar	Apr	May	etc	FY06 Target	Stoplight Status (R/Y/G)	Data Link
Workload													
Rx Volume Total	Rx Processed/1000 patients											G	
Rx Volume Central Pharmacy	Rx Processed/1000 patients											R	
Rx Volume X institution	Rx Processed/1000 patients											Y	
Returned Drug Institution X	# Rx and \$												
Clinical													
Rx Errors Total	leaving pharmacy control												
Rx Errors Institution X	leaving pharmacy control												
Guidelines Deployed	Disease Management Practice/ Guidelines Deployed												
Staffing Vacancies													
RPh	#(%)												
Tech	#(%)												
Institution X RPh	#(%)												
Institution X Tech	#(%)												
Compliance													
Institution Audits	% passing												
Initiatives (Milestones)													
Central Pharmacy	Milestones												
Procedures Updated & Deployed	Milestones												
Institution level Redesign	Milestones												
Budget													
Drug	% Variance to budget												
Salary/Benefits	% Variance to budget												

APPENDIX B-2: SAMPLE INSTITUTION LEVEL BALANCED SCORE CARD

Measure	Measure Definitions	Actual		Jan	Feb	Mar	Apr	May	etc	FY06 Target	Stoplight Status (R/Y/G)	Data Link
		FY 2005	FY 2006 YTD									
Service and Finance												
Rx #	Rx # (per inmate per month)										G	
Rx \$	Rx \$ (per inmate per month)										Y	
Nonformulary Rx #	#											
Nonformulary Rx \$	\$											
Internal Process												
Guidelines adherence	% patients treated following target guideline											
Guidelines adherence system Average	% patients treated following target guideline											
Learning & Growth												
RPh	Training modules completed											
Tech	Training modules completed											
Initiatives (Milestones)												
Elimination of floor stock	Milestones											
Implementation of automation	Milestones											

Green - On target

Yellow - At risk for not meeting target/off target

Red - Will not meet target/significantly off target

APPENDIX C: ACTION PLAN TRACKING GRID

Goal:	A	Develop meaningful and effective centralized oversight, control and monitoring over the pharmacy services program.	Key Target Date
Objective:	A.1	Establish a central pharmacy services administration, budget and enforcement authority.	Month day, Year
Action Officer:		John Doe (title, contact info here)	
Prior Audit References:		CPR-IRP Report, Chap. 6; Senate Report, p.4; FOX Report Solution Package A,D	

(ROUGH EXAMPLE ONLY)

Action Item ID	Action Step	Assigned	Start Date	Targeted Completion Date	Status/Comments	Expected Outcome or Performance Metric	Key Milestone?
A.1.1	Identify and hire leadership and clinical specialists.	XXX	05-15-06	06-10-06		Central Office Staffing Pattern	Y
A.1.2	Establish written job descriptions and set salary rates.	XXX	05-30-06	06-15-06		Complete set of Position Descriptions; Salary Schedule	N
A.1.3	Prepare Operating Budget for central office.	YYY	05-20-06	06-15-06		Budget Document	N
A.1.4	Select Chief Pharmacist and administrator for Pharmacy Services program	XXX	06-15-06	07-01-06		Chief Pharmacist and Administrator in place	Y

APPENDIX D: SAMPLE UNIT INSPECTION GRID

Unit	Jan	Feb	Mar	Apr	May	Jun	etc	Links to Detail
Unit W	Pass	Fail	Pass	Pass	Pass	Pass	Pass	
Unit X	Fail	Pass	Pass	Fail	Pass	Pass	Pass	
Unit Y	Pass	Pass	Pass	Pass	Pass	Pass	Problem	
Unit Z	Pass	Pass	Pass	Pass	Pass	Pass	Fail	
Percent Passed	75%	75%	100%	75%	100%	100%	75%	

APPENDIX E: E-MAIL CORRESPONDENCE



"Rick Pollard"
<rpollard@maxor.com>
05/24/2006 01:55 PM

To <ASerio@maxor.com>
cc
bcc
Subject email

-----Original Message-----

From: Paul B. Mello [mailto:Pmello@hansonbridgett.com]
Sent: Monday, May 22, 2006 12:11 PM
To: Rick Pollard
Cc: Jon Wolff
Subject: Maxor Audit -- Purchase v. Dispense Questions

Mr. Pollard,

Below (and attached) is a response to your purchase v. dispense questions from Eugene (Gene) Roth, PharmD, Pharmacy Services Manager, Division of Correctional Health Care Services, CDCR:

1. Describe the CDCR policy about entering prescriptions into the pharmacy dispensing system.

Pharmacy Law (California Code of Regulations, Title 16, Division 17 Board of Pharmacy, Article 2, 1707.1) is the requirement for Pharmacies to maintain a Patient Medication Record. This record must be reviewed prior to dispensing (1707.3).

2. If facilities are not required to enter prescriptions into the system, what safeguards exist to insure that pharmacists have complete patient profiles when dispensing.

By producing a label in the Pharmacy Prescription Tracking System (PPTS) the prescription is on file in the patient's profile. Labeling is required by Pharmacy law (Business and Professions Code, Chapter 9, Division 2, Article 4, 4076.) The exception may be floor/ward stock medications that are issued on a separate document, not entered in PPTS at some facilities.

3. Describe procedures used to detect and prevent diversion.

Procedures to prevent diversion vary greatly between facilities. This variance is not only in the existence of a method, but also the methods themselves and the rigor of enforcement. Over the past 3 years there have been 4 Feasibility Study Reports that have included automated tracking of medications from receipt in the Pharmacy to delivery to a patient or return to the Pharmacy. Each of these proposals have been delayed due to lack of funding.

4. Describe any flaws you see in my methodology that may impact the results.

Floor stock, controlled substances (not patient specific), or some similar issue not recorded in PPTS may impact Maxor's results.

Regarding the purchase vs. dispensed numbers (see spreadsheet): I spoke with Rick Pollard and the analyst who produced the numbers this morning. It

APPENDIX E: E-MAIL CORRESPONDENCE

appears that they took the Qty number out of PPTS as the total number of units dispensed. I pointed out the fallacy in this thinking. Psychotropic medications are Direct Observed Therapy (DOT) administered and often have the number of units in one med pass (e.g. Qty=1 for 1 tab twice daily; (so the Medication Administration Record is easily readable) when 60 tabs are actually dispensed). This would cause the difference between purchased and dispensed medication counts to be inflated. Mr. Pollard is reevaluating his information given these new facts.

<<cdc_pvsd_final.xls>> <<cdc_pvsd_final2.xls>>

Please contact us if you have any questions.

Paul Mello

-----Original Message-----

From: Rick Pollard [mailto:rpollard@maxor.com]
Sent: Thursday, May 11, 2006 4:54 PM
To: greg.doe@dgs.ca.gov; Roth, Eugene
Cc: 'Jon Wolff'
Subject: Purchase vs Dispense Questions

Mr. Doe/Mr. Roth

Attached is a copy of a spreadsheet showing a review of purchases vs. dispenses for the various CDCR facilities. To accomplish this review we used the purchase data provided by DGS and compared it to the dispensing data provided by CDCR. We used First Data Bank to establish the generic code for each line item purchased. We then used Maxor resources to assign generic codes to a sampling of the items dispensed, since items are only tracked by drug name within the pharmacy dispensing system. We excluded any facilities that did not have a complete set of a data for the Calendar year 2005.

My first impression of the data is that it shows that not all prescriptions are entered into the pharmacy dispensing system, resulting in incomplete profiles. Or, that there are issues with diversion within the facilities. I have not been able to identify any other potential explanations for the discrepancies.

To further refine these results I would appreciate your response to the following questions.

1. Describe the CDCR policy about entering prescriptions into the pharmacy dispensing system.
2. If facilities are not required to enter prescriptions into the system, what safeguards exist to insure that pharmacists have complete patient profiles when dispensing.
3. Describe procedures used to detect and prevent diversion.
4. Describe any flaws you see in my methodology that may impact the results.

Because of the short time frames involved, I would appreciate a response by the 18th of May 2006, so the responses can be included in the final report to Mr. Sillen.

APPENDIX E: E-MAIL CORRESPONDENCE

Please call if you would like to discuss the data.

Thank you
Rick Pollard

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To ensure compliance with requirements imposed by the IRS, we inform you that any tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

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APPENDIX E: E-MAIL CORRESPONDENCE



"Rick Pollard"
<rpollard@maxor.com>
05/24/2006 01:36 PM

To <ASerio@maxor.com>
cc
bcc
Subject email

From: Jon Wolff [mailto:Jon.Wolff@doj.ca.gov]
Sent: Thursday, May 18, 2006 7:12 PM
To: rpollard@maxor.com
Cc: Greg Doe; Linda.Cabatic@dgs.ca.gov; Ron LaSala; pmello@hansonbridgett.com
Subject: Plata - Responses to Pricing Questions

Mr. Pollard-

Thank you for the opportunity this morning during the conference call to discuss the issues raised in your pricing questions. We hope that Mr. Doe's and Mr. LaSala's responses were of assistance. As requested, the following are Mr. Doe's written responses to your questions regarding pricing. Thank you.

1. What processes are used to verify contract pricing is received?

Contract pricing is loaded into the pharmaceutical prime vendor from Managed Health Care Associates (MHA) on a daily basis. Because of the volume, frequency of change, and available resources, we have not been able to verify MHA pricing changes unless a challenge has been discovered due to billing (such as an add bill). For our state contracts, we notify the prime vendor of contract pricing and issue an effective date for the pricing. We manually confirm pricing has been loaded by going into the prime vendor's computer system.

We have just hired additional resources and are working with our IT department to develop methods for better managing and confirming pricing on contracts.

2. What process is used to notify the Prime Vendor that a credit and re-bill should be initiated on items where contract pricing was not received?

When contract pricing was not received on state contract items, we notify the prime vendor to correct price and credit the agency for any incorrect overages. Price corrections that result from MHA contract pricing are the result of notification from MHA based upon reports received from the prime vendor. Some rebilling may occur based upon late notification of price changes do to contract relationships between MHA and their contract holders.

As we finalize processes to track pricing within the system we will initiate the requests for correction and credit.

3. What procedures are in place to insure that ordering facilities utilize the best contract price available?

The Department of General Services (DGS) mails copies of the current state drug contracts to each pharmacy, and provides internet access to state contracts and revisions. In addition, DGS, through the prime vendor contract, provides electronic ordering systems which identify the contract items and associated pricing. This system also provides pharmaceutical management tools, allowing pharmacies to manage the purchasing of drugs within their

APPENDIX E: E-MAIL CORRESPONDENCE

facilities. DGS cannot force contract compliance over the physicians prescribing habits. DGS works as an agent on behalf of the state agencies to develop pricing contracts for pharmaceuticals. DGS works with a Common Drug Formulary committee and Pharmacy Advisory Board with membership appointed by the Department Directors. The Common Drug Formulary Committee identifies drugs, policies and procedures which will be used at the local level. DGS then develops contracts based on these recommendations. The Pharmacy Advisory Board has the responsibility for implementation and enforcement.

4. Describe any flaws you see in my methodology that may impact the results.

1. Does this sheet take into account the ___ % service fee charged by McKesson?
2. We do not understand why the discount provided in column (R) is calculated at a loss when this is a prompt payment savings.
3. Some of the companies have a single source contract, meaning that the company only allows a contract with MHA or the State. Lilly is one such company. We are working on identifying the other companies with MHA. We would not have contract pricing through MHA on Lilly products because we have a contract for Zyprexa. We sent the pricing files current of 4-17-2006 and 12-13-2005. These files do not contain historical pricing changes. Ron will provide you with the historical pricing changes.
4. We are assuming column (P) is MHA or State contract price when appropriate.
5. We are assuming column (L) is WAC pricing.
6. I am having trouble confirming contract pricing, and will continue to work with Ron on that.

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APPENDIX E: E-MAIL CORRESPONDENCE



"Rick Pollard"
<rpollard@maxor.com>
05/24/2006 02:05 PM

To <ASerio@maxor.com>
cc
bcc
Subject email

From: Paul B. Mello [mailto:Pmello@hansonbridgett.com]
Sent: Monday, May 22, 2006 2:02 PM
To: Rick Pollard
Cc: Jon Wolff
Subject: Maxor -- Zyprexa Rebates

Mr. Pollard,

Per DGS, we believe that this email addresses your questions regarding the Zyprexa Rebates.

Question 1A : All Zyprexa 30 counts were added on October 12, 2005 via letter and the IM dosage form was added July 1, 2004 by amendment.

Question 1B: All Zyprexa products eligible for rebates are on the contract by notification letters and amendments.

Question 2: Rebates are calculated and validated by Lilly through the quarter usage report sent by DGS. A quarterly usage report is generated by DGS using the prime vendor's custom reporting system. DGS identifies the product to the NDC level for each agency. Lilly verifies this information with the Prime Vendor charge backs. To date their has not been any disputes with Lilly on usage.

Question 3: Rebates are only received by crediting to the account.

Questions 4 & 5 : Any rebates received from MHA and the Lilly are provided as credits. MHA and Prime vendor price corrections would appear as credits. Overcharges from manufacturers, errors from other companies, and damages from other parties may appear under this title.

Question 6: DGS is still evaluating this.

Thank you.

Paul Mello

-----Original Message-----

From: Rick Pollard [mailto:rpollard@maxor.com]
Sent: Thursday, May 18, 2006 2:57 PM
To: LaSala, Ron; Doe, Greg
Cc: 'Jon Wolff'; 'Jerry Hodge'; 'Jim Riley'
Subject: FW: Zyprexa Rebates

APPENDIX E: E-MAIL CORRESPONDENCE

Mr. LaSala/Mr. Doe

I am forwarding an email by one of our analysts. He has reviewed the Lilly contract and compared it to the purchasing data received.

His evaluation indicates some issues that need to be clarified before we finalize our evaluation.

1. Reference the products identified as not being listed in the contract:
 - a. Is there an amendment adding those NDC's?
 - b. Were those items eligible for rebates based on some other agreement?
2. What process is used to validate rebates due and reconcile the actual receipts?
3. Other than credits to the account, is there any other way that rebate credits are received?
4. Is our assumption that the credits identified as "THIRD PARTY DEBITS/CREDITS" represent Lilly rebates correct?
5. Are there any credits other than Lilly rebates that would be identified as "THIRD PARTY DEBITS/CREDITS" in the purchase file?
6. Describe any flaws in our evaluation process that may impact the results?

Because we are under severe time constraints in providing the final report to Mr. Sillen combined with the late receipt of the Lilly contract I would appreciate your response by close of business on May 19, 2006 so we can work on the report over the weekend.

Rick

From: Ryan Ahern [mailto:rahern@maxor.com]
Sent: Thursday, May 18, 2006 3:53 PM
To: 'Rick Pollard'
Subject: Zyprexa Rebates

Rick,

Attached is my analysis of the Zyprexa rebates.

I excluded the following Zyprexa NDC's from the Purchase file data as they were not referenced specifically in the Lilly contract:

NDC/UPC
00002411230
00002411530
00002411630
00002411730
00002441530
00002442030
00002759701

In reviewing the credits in the Purchase file, I identified only six Item Descriptions that did not reference an NDC number or a specific drug. I totaled their credits for the five quarters beginning in January 2005:

APPENDIX E: E-MAIL CORRESPONDENCE

Item Description	SumOfCredits
\$0.00 MFG. DENIED CHARGEBACK	-37.44
FLF LOST OR DAMAGED EQUIPMENT	-245.58
MISC ADJUST MENT	-42,098.95
RETURNS OF GM	-1.42
THIRD PARTY DEBITS/CREDITS	-130,168.76
TOTAL SERVICE FEE	-754.3

After reviewing these credits to determine which may be associated with the rebates, I determined that DVI received a "MISC ADJUST MENT" credit of \$41,435.48 on 4/17/06. Since this is far more than the \$15,338.11 they actually earned as a ___% rebate from eligible Zyprexa purchases from Jan 2005 through March 2006, one can only assume that if there are any rebates for Zyprexa, they must be reflected in the "THIRD PARTY DEBITS/CREDITS".

With that assumption in mind, for each "THIRD PARTY DEBITS/CREDITS" credit received, I matched it up to the ___% rebate earned during the previous quarter for each facility. There is not an exact science to pairing the two numbers up as the contract states that every effort will be given to credit the wholesaler within 90 days of the report by the state and local agencies, but does not guarantee it. The end result, however, can not be disputed by the timing of the credits received.

Also, it is interesting to note that no relating credits appear to have been received after the agencies reported their second quarter Zyprexa purchases (credit received in 3Q2005). The contract is not up until August 31, 2006.

As for the credit received that exceed the rebates earned in the attached Excel file, my only guess would be that the excluded NDC's mentioned above may also have been eligible under the contract or the excess credits received were for prior quarters.

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APPENDIX E: E-MAIL CORRESPONDENCE

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To ensure compliance with requirements imposed by the IRS, we inform you that any tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

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APPENDIX E: E-MAIL CORRESPONDENCE



"Rick Pollard"
<rpollard@maxor.com>

05/24/2006 02:04 PM

To <ASerio@maxor.com>

cc

bcc

Subject email

From: Rick Pollard [mailto:rpollard@maxor.com]
Sent: Friday, May 12, 2006 8:22 AM
To: 'greg.doe@dgs.ca.gov'; 'Ron LaSala'
Cc: 'Jon Wolff'
Subject: RE: Plata v. Schwarzenegger

Please clarify

Any additional information you think might be useful in my evaluation. DGS also has a rebate agreement with Lilly for Zyprexa (___% discount off WAC with a ___% rebate).

These numbers seem to be inconsistent with the contract file provided by Mr. Doe on 4/25/2006. As an example:

ZYPREXA 7.5mg, MHA contract price is \$___ per tab, Lilly contract price (provided by Mr. Doe with the effective date of 12-18-2005) \$___, Current WAC – ___% would be \$___ and after rebate of would net \$___ per unit. The average price paid in the data provided for calendar year 2006 was \$___ and the last price paid on April 24th 2006 was ___.

In my conversations during the site visit, it was my impression that it had been determined that CDCR was not eligible for DGS rebate contracts.

1. Is that not true?
2. Is this an exception?
3. Where would the rebates be received and reconciled?

I am disappointed that I am finding out about this contract at this late date. The first item on my initial data request dated 4/19/2006 was "1. A copy (preferably in PDF format) of all manufacturer pricing contracts used by CDCR." Please provide me a copy of this and any other contracts available to CDCR that have not been previously provided.

Rick

APPENDIX E: E-MAIL CORRESPONDENCE

From: Jon Wolff [mailto:Jon.Wolff@doj.ca.gov]
Sent: Thursday, May 11, 2006 2:01 PM
To: rpollard@maxor.com
Cc: Greg Doe; Laurie.Giberson@dgs.ca.gov; Linda.Cabatic@dgs.ca.gov; Ron LaSala; jschaefer@hansonbridgett.com; Pmello@hansonbridgett.com
Subject: Plata v. Schwarzenegger

Mr. Pollard-

The following are Greg Doe's responses to your questions:

1. The redacted contract with Roche Labs details market baskets and market share requirements for specific pricing. What market share levels were realized? Discounts are being given at the highest market level.
2. Were these market share levels verified by DGS? No.
3. Is this contract related to the Denied Chargebacks in the McKesson purchase data? Do not understand question.
4. If the maximum market share levels were not achieved, what is your opinion as to why the initiative failed? Does not apply. DGS is being paid at the highest market level.
5. What actions were used to increase market share of Pegasys? None have been needed.
6. This appears to be the only market share based contract. Can you tell me if there are plans to enter into more of these types of agreements? If so, are there processes in place (i.e. enforceable treatment protocols) to maximize these contracts? Possibly, enforceable treatment protocols will be developed specific to the procurements.
7. Any additional information you think might be useful in my evaluation. DGS also has a rebate agreement with Lilly for Zyprexa (__% discount off WAC with a __% rebate).

Please contact Greg with any questions. Because Greg is on jury duty this week, you may also want to contact Ron La Sala at 916-375-4461 with any questions.

Thank you.

-Jon

Jonathan L. Wolff
Supervising Deputy Attorney General
California Department of Justice
Office of the Attorney General
455 Golden Gate Avenue, Suite 11000

APPENDIX E: E-MAIL CORRESPONDENCE

San Francisco, CA 94102
Direct: 415-703-1113
Fax: 415-703-5843
Email: jon.wolff@doj.ca.gov

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APPENDIX E: E-MAIL CORRESPONDENCE



"Jim Riley"
<jriley@maxor.com>
05/24/2006 10:08 AM

To "Angela Serio" <aserio@maxor.com>
cc
bcc
Subject Fw: Pharmacy Series Vacancy--March

----- Original Message -----

From: Sallade, Denny
To: Jim Riley
Sent: Wednesday, April 26, 2006 2:56 PM
Subject: RE: Pharmacy Series Vacancy--March
His name is Dave Salacci and he is a Registry person.

-----Original Message-----

From: Jim Riley [mailto:jriley@maxor.com]
Sent: Wednesday, April 26, 2006 9:02 AM
To: Sallade, Denny
Subject: Re: Pharmacy Series Vacancy--March

GM Denny:

Can you help me with one follow up question? The name of the individual who fills the pharmacist II position at San Quentin?

Thanks,

Jim

----- Original Message -----

From: Sallade, Denny
To: jriley@maxor.com
Sent: Tuesday, April 25, 2006 5:56 PM
Subject: FW: Pharmacy Series Vacancy--March

-----Original Message-----

From: Lieng, Helen
Sent: Tuesday, April 25, 2006 1:50 PM
To: Sallade, Denny
Cc: Grader, Lindsay
Subject: Pharmacy Series Vacancy--March

Denny, this is the latest data we have for Pharmacy Series Vacancy. If this is not what you need, please let me know.

APPENDIX E: E-MAIL CORRESPONDENCE

Helen Lieng
Resource Management Unit
Division of Correctional Health Care Services
Department of Corrections and Rehabilitation
Phone (916) 322-6939
Fax (916) 327-8972

APPENDIX E: E-MAIL CORRESPONDENCE



"Jim Riley"
<jriley@maxor.com>
05/24/2006 10:10 AM

To "Angela Serio" <aserio@maxor.com>
cc
bcc
Subject Fw: Pharmacy Series Vacancy--March

----- Original Message -----

From: Sallade, Denny
To: Jim Riley
Sent: Thursday, May 04, 2006 1:39 PM
Subject: RE: Pharmacy Series Vacancy--March

There is no additional information regarding San Quentin. Apparently the situation is as was indicated in the e-mail.

SCO does not release reports until the 5th so we cannot provide you an update just yet.

-----Original Message-----

From: Jim Riley [mailto:jriley@maxor.com]
Sent: Thursday, May 04, 2006 7:21 AM
To: Sallade, Denny
Subject: Re: Pharmacy Series Vacancy--March

GM Denny:

Have you received any follow up from Ms VanOrnum? I would also appreciate getting the most recent (April 2006?) vacancy rate report for Pharmacy staff as a whole and that for just pharmacist positions.

Thanks,

Jim

----- Original Message -----

From: Sallade, Denny
To: jriley@maxor.com
Sent: Wednesday, April 26, 2006 6:52 PM
Subject: FW: Pharmacy Series Vacancy--March

I'm not sure if this helps or just makes you more confused.

-----Original Message-----

From: VanOrnum, Terry
Sent: Wednesday, April 26, 2006 4:35 PM
To: Sallade, Denny
Subject: RE: Pharmacy Series Vacancy--March

I called Tracy McCrary, she is the IPO at SQ, she said it's odd that the Pharmacist II is showing up on the SCO report as being filled. A short history is: the position has been vacant since 12/28/01, they have hired Patricia Ono, a retired annuitant off and on over the years, the latest re-hire for Patricia was in January 06 and her employment will be terminated shortly. Tracy

APPENDIX E: E-MAIL CORRESPONDENCE

noticed that Patricia was never paid so she doesn't really know what happened there.

Dave Salacci has been employed as registry person even though they show Patricia as the retired annuitant, I forgot to ask Tracy when did Dave Salacci start his employment. I faxed Tracy SQ's vacancy report we had for March, so we plan to research a bit more to find out what happened. Tracy did indicate that SCO gets their information from a database, SCO can access and obtain all department vacancies, she believes SCO picked up a wrong number. I looked on our database as far as I could go and it shows the position as being filled. I also called Sadie because she used to track the Pharmacy positions to see if she recalls anything or maybe how to research further.

I'll let you know what I find out.

*Terry Van Ornum, Staff Services Analyst
The Division of Correctional Health Care Services,
Resource Management Unit
Department of Corrections and Rehabilitations
(916) 322-8582 Fax: (916) 327-8972
Terry.VanOrnum@cder.ca.gov*

-----Original Message-----

From: Sallade, Denny
Sent: Wednesday, April 26, 2006 2:51 PM
To: VanOrnum, Terry
Subject: FW: Pharmacy Series Vacancy--March

We provided an SCO report showing that a 1.0 Pharm II was allocated to San Quentin and that the position is filled. This obviously conflicts with our information regarding Mr. Salacci. Could you see if San Quentin can provide clarification? Thanks. It could be that someone is on Administrative Leave/Military Leave or something.

-----Original Message-----

From: Jim Riley [mailto:jriley@maxor.com]
Sent: Wednesday, April 26, 2006 2:36 PM
To: Sallade, Denny
Subject: Re: Pharmacy Series Vacancy--March

Hi Denny:

In your response to my question on the "filled" SQ Pharmacist II position your response was "His name is Dave Salacci and he is a Registry person." Now I am confused. If Helen Lieng's list is only for state employees and does not reflect any registry personnel; and the list shows the SQ Pharm II as filled, wouldn't it have to be filled by someone other than Mr. Salacci? Can you help me understand this issue?

Thanks for taking the time to clarify this for me.

Jim

----- Original Message -----

APPENDIX E: E-MAIL CORRESPONDENCE

From: Sallade, Denny

To: Jim Riley

Sent: Tuesday, April 25, 2006 6:39 PM

Subject: RE: Pharmacy Series Vacancy--March

That is correct. The SCO only reports those EMPLOYEES who have been issued a check. It does not reflect any registry personnel.

-----Original Message-----

From: Jim Riley [mailto:jriley@maxor.com]

Sent: Tuesday, April 25, 2006 4:31 PM

To: Sallade, Denny

Subject: Re: Pharmacy Series Vacancy--March

Thanks Denny!

Am I correct that "filled" positions are State employees and do not include registry employees? For example, of the 86.7 pharmacist I positions allocated, 47 are filled by state employees and 39.7 are vacant and have to covered by registry pharmacists?

Jim

----- Original Message -----

From: Sallade, Denny

To: jriley@maxor.com

Sent: Tuesday, April 25, 2006 5:56 PM

Subject: FW: Pharmacy Series Vacancy--March

-----Original Message-----

From: Lieng, Helen

Sent: Tuesday, April 25, 2006 1:50 PM

To: Sallade, Denny

Cc: Grader, Lindsay

Subject: Pharmacy Series Vacancy--March

Denny, this is the latest data we have for Pharmacy Series Vacancy. If this is not what you need, please let me know.

Helen Lieng

Resource Management Unit

Division of Correctional Health Care Services

Department of Corrections and Rehabilitation

Phone (916) 322-6939

Fax (916) 327-8972

APPENDIX F-1: INTERNAL AFFAIRS MEMORANDUM

State of California

Department of Corrections and Rehabilitation

Memorandum

Date : June 23, 2006

To : Erin Parker
Senior Special Agent
Internal Affairs-Northern Region

Subject: **RESPONSE TO MAXOR NATIONAL PHARMACY SERVICES CORPORATION REGARDING NARCOTICS INVENTORY AT CALIFORNIA MEDICAL FACILITY AND CALIFORNIA STATE PRISON-SOLANO**

In June 2006, Maxor Pharmacy Services Corporation submitted a report (Exhibit A) which included the comparing of the quantity of narcotic doses dispensed by CDCR pharmacies to the quantity of doses purchased during the calendar year (CY) 2005.

The report indicated the dispensing data was provided by the CDCR and the purchasing data was obtained from McKesson, the CDCR drug wholesaler during CY 2005. The drugs compared included some commonly used antipsychotic medications and narcotic controlled substances used for pain control.

Rick Pollard, Maxor's Vice President of Operation Support, was contacted via telephone. Pollard said the dispensed data provided by CDCR was from the Patient Profile Tracking System (PPTS) reports provided by Health Care Services Division (HCSD).

The report indicated that the expectation is drugs purchased should equal the drugs dispensed by the pharmacy plus the amount of medication used for stock and some very small amount of product that expires unused. Stock would be expected to include the inventory within the pharmacy and a small amount of floor stock medication placed in treatment areas for doses needed during emergencies and the hours the pharmacies are closed.

Maxor indicated the highest percentages of discrepancies were at California Medical Facility (CMF), and California State Prison-Solano (SOL) of the narcotic controlled substances with a very high abuse potential. Roxicodone® and Oxycontin®, had a greater than 95% gap between purchases and dispensing.

The report showed that CMF purchased a quantity of 186,000 Roxicodone 5 mg units from McKesson Drug Company during CY 2005. Of the 186,000 units purchased the

APPENDIX F-1: INTERNAL AFFAIRS MEMORANDUM

report indicated only 5,488 units were dispensed or 97.05% of the purchased Roxicodone were not dispensed.

Maxor reported that at SOL, a quantity of 9,175 Oxycontin, 20mg units were purchased from McKesson Drug Company during CY 2005 with only 280 units being dispensed or 96.95% of the purchased Oxicontin were not dispensed.

Also included in the report regarding SOL were the quantities of Risperidone, 2 mg and Seroquel 300 mg purchased during CY 2005. SOL purchased 41,040 units of Risperidone dispensing only 2,738 or 93.33% were not dispensed. SOL purchased 63,120 units of Seroquel dispensing only 5,679 or 91.00% were not dispensed.

Of obvious concern were the differences in the quantities of drugs purchased to the quantities of drugs dispensed during the review period.

On June 19-21, 2006, Special Agents Ballard, Kingston and McCoy, Office of Internal Affairs, Northern Region conducted an emergency audit/inventory of specific narcotics at California Medical Facility (CMF) and California State Prison-Solano (SOL). Specifically, at CMF the accountability of the Roxicodone was reviewed and at SOL the accountability of the Oxycontin, Risperidone and Seroquel were reviewed.

The agents conducted a physical count of the narcotics identified at each of the institutions assuring the units inventoried were accurately reflected on the institutional pharmacy inventory log.

Upon entrance into the pharmacy cage at CMF the inventory log reflected that they currently possessed 6,850 units of Roxicodone 5 mg. All units were accounted for accurately.

A review of the CY 2005 running inventory of Roxicodone 5 mg showed each shipment being received from McKesson Drug Company. The review indicated 186,000 units were ordered by CMF and received from McKesson. The institutional orders were compared to the shipping invoices from McKesson and accurately reflected units ordered to units received.

During the CY 2005, the on hand inventory within the CMF pharmacy cage was at its highest in July at 12,600 units of Roxicodone and in September the institution was at zero units prior to receiving their shipment from McKesson.

Our review of CMF pharmacy records showed 186,000 units of Roxicodone 5 mg were purchased and received in CY 2005. This amount is in agreement with Maxor. The pharmacy records showed a dispensed amount of 185,783 units in 2005. The dispense rate for 2005 is 99.88%. Maxor's report showed a "Not Dispensed" rate of 97.05% or the dispense rate of 2.95%.

APPENDIX F-1: INTERNAL AFFAIRS MEMORANDUM

Upon entrance into the pharmacy cage at SOL the inventory log reflected that they currently possessed 40 units of Oxycontin 20 mg. All units were accounted for accurately.

A review of the SOL CY 2005 running inventory of Oxycontin 20 mg. showed each shipment being received from McKesson Drug Company and indicated 8,975 units were received from McKesson.

Our review of SOL pharmacy records showed 9,474 units of Oxycontin 20 mg. were dispensed from their pharmacy in 2005 which equate to a dispense rate of greater than 100%. Maxor's reported dispensed rate 3.05% or a "Not Dispensed" rate of 96.95%.

During the CY 2005, the on hand inventory within the SOL pharmacy cage was at its highest in September and November at 475 units and at its lowest in June and July at 4 units prior to receiving their shipment from McKesson.

It should be noted that in April 2005 it is noted on the pharmacy log that 100 units of the Oxycontin 20 mg. were missing. The log indicates that the Drug Enforcement Agency (DEA) was notified.

The units of the Risperidone and Seroquel were considered atypical antipsychotic drugs and not accounted for as were the narcotics. Two medical staff members escorted the agents for a review of the H-Dorm med cart on Yard 2 within SOL. The observation revealed that the Risperidone and Seroquel are maintained under a controlled environment, locked within a pharmaceutical cart and distributed to the patients by prescription. A scenario was presented to the two staff members in which two bottles of Risperidone were removed covertly from the cart's working supply drawer. They were then asked how would they be able to prove two bottles were missing from their supply and they replied , they couldn't.

The running inventories at CMF and SOL indicate that upon receipt of the narcotics into the pharmacy cage the narcotics are distributed to the individual clinics, carts, wings, hospice, dental, emergency rooms, hospice, surgery and to individual inmates upon their parole.

A breakdown of the individual carts and a review of the Medical Activity Reports (MAR) for the individual patients are to follow upon request.

The differences between the Internal Affairs and Maxor's findings are in the incomplete electronic data provided to Maxor by HCSD and the manually recorded data located at the individual institutions.

Should you have any further questions or need any additional information please feel free to contact any of the below listed agents at (916)-464-3758.

Bob Ballard
Special Agent
Internal Affairs-North

Bryan Kingston
Special Agent
Internal Affairs-North

Ernie McCoy
Special Agent
Internal Affairs-North

APPENDIX F-2: MAXOR RESPONSE TO INTERNAL AFFAIRS MEMORANDUM



SENT VIA EMAIL

June 27, 2006

Robert Sillen, Court-Appointed Receiver
2457 Golf Links Circle
Santa Clara, CA 95050

Dear Mr. Sillen:

Per our conversation, I am forwarding a copy of a CDCR Internal Affairs Memorandum, dated June 23, 2006, subject: *RESPONSE TO MAXOR NATIONAL PHARMACY SERVICES CORPORATION REGARDING NARCOTICS INVENTORY AT THE CALIFORNIA MEDICAL FACILITY AND CALIFORNIA STATE PRISON-SOLANO.*

The memorandum correctly identifies the issue of comparing the quantity of narcotic doses dispensed by CDCR pharmacies to the quantity of doses purchased for CDCR during CY 2005, and the findings of significant differences in "Not Dispensed" rates. The memorandum concludes that the purchased-dispensed differences are in the electronic data from the official CDCR Patient Profile Tracking System (PPTS) when compared to the manually recorded data located at the individual institutions. The disparity in the records not only creates the opportunity for diversion, but points to serious patient safety concerns as well.

Maxor concurs with the Internal Affairs general finding. The fact that the CMF and SOL pharmacy records are in such wide disparity with the official PPTS, particularly for sensitive, supposedly tightly controlled narcotic medications is a matter of grave concern. Perhaps more alarming are the disparities identified by Maxor in other more expensive non-narcotic medications where less control and oversight exists.

The Maxor report highlighted the inadequacy of inventory controls and high potential for shrinkage and diversion. The Internal Affairs scenario of covertly diverting two bottles of the expensive medication, Risperidone (approximately \$881 per 100-count bottle), clearly illustrates a lack of proper inventory controls and accountability. A systemwide assessment of unaccounted for narcotics, such as those identified as missing in the SOL pharmacy, should be accomplished as soon as possible. Trends developed from frequent assessments would serve as a useful tool for improving accountability and oversight.

APPENDIX F-2: MAXOR RESPONSE TO INTERNAL AFFAIRS MEMORANDUM

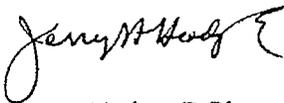
*Robert Sillen
Page Two
June 27, 2006*

Based on follow-up discussions with Internal Affairs investigators, the audits did not attempt to verify that a valid physician prescription was written for each narcotic medication dispensed by the pharmacy and relied on a spot audit on a single wing to review inventory and the administration records of eight (8) patients. With the transient nature of inmate housing and difficulty in obtaining inmate records, it would be virtually impossible to audit the controlled substance system full-circle. While there was not a finding of large-scale diversion, the IA audit methods were primarily designed to consider our finding of a disparity between purchases versus dispenses and perhaps identify diversion on a macro-scale. The current pharmacy management system and inventory control processes are markedly antiquated and possess limited or no ability to prevent micro-scale diversion at the prescription level.

As mentioned earlier, the greatest potential for misuse or diversion rests with non-narcotic medication, which can be diverted at any scale, as there are virtually no inventory controls. Individuals with access to medications, with almost no risk of being detected, may divert unlimited medications from the CDCR stock. The value of these lost medications could easily represent millions of dollars per year.

In summary, the findings in the IA report are consistent with Maxor's findings. The PPTS dispense data is inaccurate and unreliable, making diversion extremely difficult to identify. Not all dispenses are entered into the patient profile, which raises serious patient safety concerns, in addition to the obvious accountability issues. Maxor appreciates the efforts of Internal Affairs to further investigate this issue and validate the findings of our report.

Sincerely,



Jerry Hodge, R.Ph.
Chairman

Enclosure

EXHIBIT 2

2864826

State of California
Secretary of State



I, BRUCE McPHERSON, Secretary of State of the State of California, hereby certify:

That the attached transcript of 3 page(s) has been compared with the record on file in this office, of which it purports to be a copy, and that it is full, true and correct.



IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of

APR 22 2006

BRUCE McPHERSON
Secretary of State

2864826

ENDORSED - FILED
in the office of the Secretary of State
of the State of California**ARTICLES OF INCORPORATION****APR 21 2006****OF****CALIFORNIA PRISON HEALTHCARE RECEIVERSHIP CORPORATION**

A California Nonprofit Public Benefit Corporation

- FIRST:** The name of the Corporation is California Prison Healthcare Receivership Corporation (the "Corporation").
- SECOND:** This Corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes. In furtherance of such purposes, the Corporation shall conduct activities aimed at lessening the burdens of government by serving as the office of the Receivership established to take control of the delivery of medical services to California state prisoners confined by the California Department of Corrections and Rehabilitation.
- In furtherance thereof, the Corporation may receive property by gift, devise or bequest, invest or reinvest the same, and apply the income and principal thereof, as the Board of Directors may from time to time determine, either directly or through contributions to any charitable organization or organizations, exclusively for charitable purposes, and engage in any lawful act or activity for which corporations may be organized under the California Nonprofit Public Benefit Corporation Law.
- In furtherance of its corporate purposes, the Corporation shall have all the general powers enumerated in Sections 5140 and 5141 of the California Nonprofit Public Benefit Corporation Law, as now in effect or as may hereafter be amended, together with the power to solicit grants and contributions for such purposes.
- THIRD:** The name of the Corporation's initial agent for service of process in the State of California is National Registered Agents, Inc.
- FOURTH:** The sole member of the Corporation shall be the Receiver appointed by Order of Judge Thelton E. Henderson of the United States District Court for the Northern District of California dated February 14, 2006, or any successor Receiver as may be appointed by Order of the Court. The sole member shall have the right to vote.
- FIFTH:** The Corporation is organized and operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as now in effect or as may hereafter be amended (the "Code").

No substantial part of the activities of the Corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation (except as otherwise

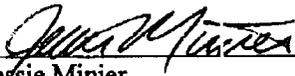
permitted by Section 501(h) of the Code and in any corresponding laws of the State of California), and the Corporation shall not participate in or intervene in any political campaign (including the publishing or distribution of statements concerning) on behalf of (or in opposition to) any candidate for public office.

Notwithstanding any other provision of these Articles of Incorporation, the Corporation shall not directly or indirectly carry on any activity which would prevent it from obtaining exemption from Federal income taxation as a corporation described in Section 501(c)(3) of the Code, or cause it to lose such exempt status, or carry on any activity not permitted to be carried on by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

SIXTH: The property of the Corporation is irrevocably dedicated to charitable purposes meeting the requirements for exemption under Section 214 of the California Revenue and Taxation Code. No part of the net income or assets of the Corporation shall inure to the benefit of, or be distributable to, any director, or officer thereof, or any other private person, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth in Article SECOND hereof.

In the event of dissolution of the Corporation, all of the remaining assets and property of the Corporation, after paying or making provision for the payment of all liabilities and obligations of the Corporation and for necessary expenses thereof, shall be distributed to one or more organizations which are organized and operated exclusively for charitable purposes and which meet the requirements for exemption under Section 214 of the California Revenue and Taxation Code and that shall at the time qualify as exempt under Section 501(c)(3) of the Code and Section 23701d of the California Revenue and Taxation Code or to the Treasury of the State of California, to be used exclusively for charitable purposes, as the Board of Directors shall determine. In no event shall any of such assets or property be distributed to any director or officer, or to any private individual.

For purposes of forming the Corporation under the laws of the State of California, the undersigned, constituting the incorporator, has executed these Articles of Incorporation as of April 21, 2006.



Jessie Minier
Sole Incorporator

I-WA/2554654.1



EXHIBIT 3

BYLAWS

OF

**CALIFORNIA PRISON HEALTHCARE RECEIVERSHIP
CORPORATION**

TABLE OF CONTENTS

	Page
ARTICLE I OFFICES	1
Section 1. Principal Office.....	1
ARTICLE II MEMBERSHIP	1
Section 1. Members	1
Section 2. Liability.....	1
Section 3. Action without a Meeting.. ..	1
ARTICLE III BOARD OF DIRECTORS	1
Section 1. Power of Board	1
Section 2. Number of Directors	2
Section 3. Election and Term of Office	2
Section 4. Resignation	2
Section 5. Removal.....	2
Section 6. Vacancies.....	2
Section 7. Place of Meetings	2
Section 8. Annual Meetings.....	2
Section 9. Regular Meetings.....	2
Section 10. Special Meetings.....	2
Section 11. Notice.....	3
Section 12. Waiver of Notice.....	3
Section 13. Quorum and Action of the Board	3
Section 14. Participation in Meetings by Conference Telephone.....	3
Section 15. Adjournment	3
Section 16. Action Without Meeting.....	3
ARTICLE IV COMMITTEES	4
Section 1. Board Committees	4
Section 2. Advisory Committees	4
Section 3. Meetings and Actions of Committees.....	4
ARTICLE V OFFICERS.....	5
Section 1. Officers	5

TABLE OF CONTENTS
(continued)

	Page
Section 2. Election	5
Section 3. Subordinate Officers	5
Section 4. Removal and Resignation	5
Section 5. Vacancies	5
Section 6. Chair of the Board	6
Section 7. President	6
Section 8. Vice President(s)	6
Section 9. Secretary	6
Section 10. Chief Financial Officer	6
ARTICLE VI PROHIBITED TRANSACTIONS	7
Section 1. Loans	7
Section 2. Self-Dealing Transactions	7
Section 3. Approval	7
ARTICLE VII INDEMNIFICATION, INSURANCE AND DIRECTOR LIABILITY	7
Section 1. Right of Indemnity	7
Section 2. Approval of Indemnity	7
Section 3. Advancing Expenses	8
Section 4. Insurance	8
ARTICLE VIII MISCELLANEOUS	8
Section 1. Fiscal Year	8
Section 2. Corporate Seal	8
Section 3. Checks, Notes and Contracts	8
Section 4. Amendment of Articles of Incorporation and Bylaws	8
Section 5. Governing Law	9

**Bylaws
of
California Prison Healthcare Receivership Corporation**

A California Nonprofit Public Benefit Corporation

ARTICLE I

OFFICES

Section 1. Principal Office. The principal office of the California Prison Healthcare Receivership Corporation (the "Corporation") shall be located within or without the State of California, at such place as the Board of Directors shall from time to time determine. The Board is granted full power and authority to change the principal office from one location to another. The Corporation may establish or maintain additional offices at such other places as the Board of Directors may determine.

ARTICLE II

MEMBERSHIP

Section 1. Members. The sole member of the Corporation shall be the Receiver appointed by Order of Judge Thelton E. Henderson of the United States District Court for the Northern District of California dated February 14, 2006, or any successor Receiver as may be appointed by Order of the Court.

Section 2. Liability. The sole member of the Corporation shall not be liable for the debts, liabilities or obligations of the Corporation.

Section 3. Action without a Meeting. Any action required or permitted to be taken by the sole member may be taken without a meeting if the sole member consents in writing to such action.

ARTICLE III

BOARD OF DIRECTORS

Section 1. Power of Board. Subject to any limitations in the Articles of Incorporation or these Bylaws, the activities and affairs of the Corporation shall be conducted and all corporate powers shall be exercised by or under the direction of the Board of Directors. The Board may delegate the management of the activities of the Corporation to any person or persons, management company, or committee or committees however composed, provided that the activities and affairs of the Corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board.

Section 2. Number of Directors. The number of directors of the Corporation shall be no less than three (3) and no more than nine (9), with the exact number of directors to be fixed from time to time, within such limits, by approval of the Board. The authorized number of directors of the Corporation, whether fixed or subject to a minimum and maximum number of directors, may be changed by an amendment to these Bylaws which is approved by the Board.

Section 3. Election and Term of Office. Directors shall be appointed by the sole member. Each director, including a director appointed to fill a vacancy, shall hold office for a term of one year or until his or her successor is appointed and qualified.

Section 4. Resignation. Any director may resign effective upon giving written notice to the Chair of the Board, the President, the Secretary, or the Board of Directors, unless the notice specifies a later time for the effectiveness of such resignation; provided, however, that no director may resign except upon notice to the Office of the Attorney General of the State of California (hereafter the "Attorney General") where the Corporation would then be left without any duly elected director or directors in charge of its affairs. If the resignation is effective at a future time, a successor may be elected to take office when the resignation becomes effective.

Section 5. Removal. The sole member may remove any director at any time, with or without cause.

Section 6. Vacancies. A vacancy in the Board shall be deemed to exist on the occurrence of the death, resignation or removal of any director, or if the authorized number of directors is increased. Such vacancy may be filled by the sole member. Each director so appointed shall hold office until the expiration of the term of the replaced director and until his or her successor has been elected and qualified. No reduction of the authorized number of directors shall have the effect of removing any director prior to the expiration of that director's term of office.

Section 7. Place of Meetings. Meetings of the Board of Directors may be held at any place within or without the State of California which has been designated in the notice of the meeting or, if not stated in the notice or there is no notice, as designated by resolution of the Board.

Section 8. Annual Meetings. The Board of Directors shall hold an annual meeting for the purpose of appointing officers, and all other business as may properly come before the Board. Annual meetings shall be called by the President or any two directors, and shall be noticed in accordance with Section 11 of this article.

Section 9. Regular Meetings. Regular meetings of the Board of Directors may be called by the President or any two directors, and shall be noticed in accordance with Section 11 of this article.

Section 10. Special Meetings. Special meetings of the Board of Directors for any purpose or purposes may be called at any time by the sole member, the President or any two directors, and shall be noticed in accordance with Section 11 of this article.

Section 11. Notice. Notice of the annual meeting and any regular or special meetings of the Board of Directors shall be given to each director at least four days before any such meeting if given by first-class mail or 48 hours before any such meeting if given personally or by telephone (including a voice messaging system), facsimile transmission, or electronic mail, and shall state the date, place, and time of the meeting. A notice need not specify the purpose of any meeting of the Board.

Section 12. Waiver of Notice. The transactions of any meeting of the Board of Directors, however called and noticed or wherever held, shall be valid as though taken at a meeting duly held after regular call and notice if a quorum is present, and if, either before or after the meeting, each of the directors not present signs a written waiver of notice, a consent to holding the meeting, or an approval of the minutes. The waiver of notice or consent need not specify the purpose of the meeting. All waivers, consents and approvals shall be filed with the corporate records or made a part of the minutes of the meeting. Notice of a meeting shall also be deemed given to any director who attends the meeting without protesting the lack of adequate notice before the meeting or at its commencement.

Section 13. Quorum and Action of the Board. A majority of directors authorized in Article III, Section 2 of these Bylaws constitutes a quorum of the Board for the transaction of business, except for purposes of adjournment as provided in Article III, Section 15 of these Bylaws. Unless a greater number is required by law, the Articles of Incorporation or these Bylaws, every action taken or decision made by a majority of the directors present at a meeting duly held at which a quorum is present is the act of the Board; provided, however, that a meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of directors, if any action taken is approved by at least a majority of the required quorum for such meeting.

Section 14. Participation in Meetings by Conference Telephone. Members of the Board of Directors may participate in a meeting through the use of conference telephone, electronic video screen communication, or other communications equipment if all of the following apply: (1) each member participating in the meeting can communicate with all of the other members concurrently, (2) each member is provided the means of participating in all matters before the Board, including the capacity to propose or to interpose an objection to a specific action to be taken by the Corporation, and (3) the Corporation adopts and implements some means of verifying both that (i) a person communicating by telephone, electronic video screen, or other communications equipment is a director entitled to participate in the Board meeting, and (ii) all statements, questions, actions, or votes were made by that director and not by another person not permitted to participate as a director. Participation in a meeting pursuant to this Section 14 constitutes presence in person at such meeting.

Section 15. Adjournment. A majority of the directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned for more than 24 hours, notice of any adjournment to another time or place shall be given prior to the time of the adjourned meeting to the directors who were not present at the time of the adjournment.

Section 16. Action Without Meeting. Any action required or permitted to be taken by the Board of Directors may be taken without a meeting, if all members of the Board shall individually or collectively consent in writing to such action; provided, however, that the preceding provision shall not include the consent of any director who has a material financial interest in a transaction to which the Corporation is a party and who is an "interested director" as defined in Section 5233 of the California Nonprofit Public Benefit Corporation Law. Such written consent or consents shall be filed with the minutes of the proceedings of the Board and shall have the same force and effect as the unanimous vote of such directors.

ARTICLE IV

COMMITTEES

Section 1. Board Committees. The Board of Directors may, by resolution adopted by a majority of the number of directors then in office, provided a quorum is present, create one or more committees, each consisting of two or more directors, to serve at the pleasure of the Board. Appointments to such committees shall be by a majority vote of the directors then in office. Board Committees may be given all the authority of the Board, except with respect to:

- (a) The approval of any action for which approval is required of the members or a majority of all members by the California Nonprofit Public Benefit Corporation Law;
- (b) The filling of vacancies on the Board or in any Board committee;
- (c) The fixing of compensation of the directors for serving on the Board or in any Board Committee;
- (d) The amendment or repeal of the Articles of Incorporation of the Corporation;
- (e) The amendment or repeal of these Bylaws or the adoption of new Bylaws;
- (f) The amendment or repeal of any resolution of the Board which by its express terms is not so amendable or repealable;
- (g) The creation of Board Committees or the appointment of members thereof;
- (h) The expenditure of corporate funds to support a nominee for director after there are more people nominated for director than can be elected;
- (i) The approval of any self-dealing transaction, as defined in Section 5233(a) of the California Nonprofit Public Benefit Corporation Law;
- (j) The removal of any director without cause; or

- (k) The approval of any merger, reorganization, voluntary dissolution, or disposition of substantially all of the assets of the Corporation.

Section 2. Advisory Committees. The Board of Directors may establish one or more Advisory Committees to the Board. The members of any Advisory Committee may consist of directors or non-directors and may be appointed as the Board determines.

Section 3. Meetings and Actions of Committees.

(a) Board Committees. Meetings and actions of Board Committees shall be governed by the provisions of Article III applicable to meetings and actions of the Board, with such changes in the content of these Bylaws as are necessary to substitute the Board Committee and its members for the Board of Directors and its members. Board Committees shall have such authority to act on behalf of the Board as is delegated to them by the resolution, duly adopted, of the Board. Minutes shall be kept of each meeting of any Board Committee and shall be filed with the corporate records.

(b) Advisory Committees. Advisory Committees shall determine their own meeting rules and whether minutes shall be kept. Advisory Committees shall not have the authority to act on behalf of the Board.

The Board of Directors may adopt rules for the governance of any Board or Advisory Committee not inconsistent with the provisions of these Bylaws.

ARTICLE V

OFFICERS

Section 1. Officers. The officers of the Corporation shall be a President, a Secretary, and a Chief Financial Officer, and may include a Chair of the Board. The Corporation also may have, at the discretion of the Board, one or more Vice Presidents, one or more Assistant Secretaries, one or more Assistant Chief Financial Officers, and such other officers as may be elected or appointed in accordance with the provisions of Section 3 of this Article. Any number of offices may be held by the same person except that neither the Secretary nor the Chief Financial Officer may serve concurrently as President or Chair of the Board.

Section 2. Election. The officers of the Corporation (except such officers as may be elected or appointed in accordance with the provisions of Section 3 or 5 of this Article), shall be chosen annually by, and shall serve at the pleasure of the Board, and shall hold their respective offices until their resignation, removal, or other disqualification from service and until their respective successors are elected and qualify.

Section 3. Subordinate Officers. The Board may elect, and may empower the President to appoint such other officers as the business of the Corporation may require, each of whom shall hold office for such period, have such authority, and perform such duties as are provided in these Bylaws or as the Board from time to time may determine.

Section 4. Removal and Resignation. Any officer may be removed with or without cause by the Board of Directors at any time or, in the case of an officer not chosen by the Board, by any officer upon whom such power of removal may be conferred by the Board. Any such removal shall be without prejudice to the rights, if any, of the officer under any contract of employment.

Any officer may resign at any time by giving written notice to the Corporation without prejudice to the rights, if any, of the Corporation under any contract to which the officer is a party. Any such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein.

Section 5. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification, or any other cause shall be filled in the manner prescribed in these Bylaws for regular election or appointment to such office, provided that such vacancies shall be filled as they occur and not on an annual basis.

Section 6. Chair of the Board. The Chair of the Board, if any, shall preside at all meetings of the Board of Directors and exercise and perform such other powers and duties as may be assigned from time to time by the Board.

Section 7. President. Subject to such powers as may be given by the Board to the Chair of the Board, if any, the President is the general manager and chief executive officer of the Corporation and, subject to the control of the Board of Directors, shall be responsible for the general supervision, direction, and control of the business and officers of the Corporation. In the absence of the Chair of the Board, or if there is none, the President shall preside at all meetings of the Board. The President has the general powers and duties of management usually vested in the office of president and general manager of a corporation and such other powers and duties as may be prescribed by the Board.

Section 8. Vice President(s). In the absence or disability of the President, the Vice President(s), if any are appointed, in order of their rank as fixed by the Board of Directors or, if not ranked, the Vice President designated by the Board, shall perform all the duties of the President and, when so acting, shall have all the powers of, and be subject to all the restrictions upon, the President. The Vice President(s) shall have such other powers and perform such other duties as from time to time may be prescribed for them respectively by the Board.

Section 9. Secretary. The Secretary shall keep or cause to be kept, at the principal office of the Corporation or such other place as the Board of Directors may order, a book of minutes of all meetings of the Board and its committees. The minutes shall include the time and place of meetings, whether regular or special, and if special, how authorized, the notice thereof given, the names of those present at Board and committee meetings, and the proceedings thereof. The Secretary shall keep, or cause to be kept, at the principal office of the Corporation in the State of California the original or a copy of the Corporation's Articles of Incorporation and Bylaws, as amended to date.

The Secretary shall give, or cause to be given, notice of all meetings of the Board and its committees required by law or by these Bylaws to be given, shall keep the seal of the

Corporation in safe custody, and shall have such other powers and perform such other duties as may be prescribed by the Board.

Section 10. Chief Financial Officer. The Chief Financial Officer shall also be known as the Treasurer. He or she shall keep and maintain, or cause to be kept and maintained, adequate and correct books and accounts of the properties and business transactions of the Corporation. The books of account shall be open at all reasonable times to inspection by any director.

The Chief Financial Officer shall deposit, or cause to be deposited, all money and other valuables in the name and to the credit of the Corporation with such depositaries as may be designated by the Board. The Chief Financial Officer shall disburse the funds of the Corporation as may be ordered by the Board, shall render to the President and the directors, whenever requested, an account of all transactions as Treasurer and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as may be prescribed by the Board.

ARTICLE VI

PROHIBITED TRANSACTIONS

Section 1. Loans. The Corporation shall not make any loan of money or property to, or guarantee the obligation of, any director or officer; provided, however, that this Corporation may advance money to a director or officer of this Corporation or any subsidiary for expenses reasonably anticipated to be incurred in the performance of the duties of such officer or director so long as such individual would be entitled to be reimbursed for such expenses absent that advance.

Section 2. Self-Dealing Transactions. Except as provided in Section 3 of this Article, the Board of Directors shall not approve or permit the Corporation to engage in any self-dealing transactions. A self-dealing transaction is a transaction to which this Corporation is a party and in which one or more of its directors has a material financial interest, unless the transaction comes within Section 5233(b) of the California Nonprofit Public Benefit Corporation Law.

Section 3. Approval. This Corporation may engage in a self-dealing transaction if the transaction is approved by a court or by the Attorney General. This Corporation may also engage in a self-dealing transaction if the Board determines, before the transaction, that (1) this Corporation is entering into the transaction for its own benefit; (2) the transaction is fair and reasonable to this Corporation at the time; (3) prior to consummating the transaction or any part thereof, the Board authorizes or approves the transaction in good faith by a vote of a majority of the directors then in office without counting the vote of the interested director or director, and with knowledge of the material facts concerning the transaction and the director's interest in the transaction; and (4) prior to authorizing or approving the transaction and after reasonable investigation under the circumstances, the Board determines that it could not have obtained a more advantageous arrangement with reasonable effort under the circumstances.

ARTICLE VII

INDEMNIFICATION, INSURANCE AND DIRECTOR LIABILITY

Section 1. Right of Indemnity. In addition to the mandatory indemnification of agents provided in Section 5238(d) of the California Nonprofit Public Benefit Corporation Law, this Corporation shall indemnify and advance expenses to its indemnitees, in connection with any proceeding, and in accordance with Section 5238, to the fullest extent allowed by Section 5238 of the California Nonprofit Public Benefit Corporation Law. For purposes of this Article, "indemnitee" shall mean any current director, officer, or employee of this Corporation; "agent" shall have the same meaning as in Section 5238(a), including directors, officers, employees, other agents, and persons formerly occupying such positions; "proceeding" shall have the same meaning as in Section 5238(a), including any threatened action or investigation under Section 5233 or brought by the Attorney General; and "expenses" shall have the same meaning as in Section 5238(a), including reasonable attorneys' fees.

Section 2. Approval of Indemnity. On written request to the Board of Directors in each specific case by any agent seeking indemnification, to the extent that the agent has been successful on the merits, the Board shall promptly authorize indemnification in accordance with Section 5238(b) of the California Nonprofit Public Benefit Corporation Law. Otherwise, the Board shall promptly determine, by a majority vote of a quorum consisting of directors who are not parties to the proceeding, whether, in the specific case, the indemnitee has met the applicable standard of conduct stated in Section 5238(b) or Section 5238(c), and, if so, shall authorize indemnification in accordance with Section 5238(e).

Section 3. Advancing Expenses. To the fullest extent allowed by Section 5238 of the California Nonprofit Public Benefit Corporation Law, and except as otherwise determined by the Board of Directors in specific instances, the Board shall authorize the advance of expenses incurred by or on behalf of an indemnitee of this Corporation in defending any proceeding prior to final disposition, if the Board finds that:

(a) the requested advances are reasonable in amount under the circumstances;
and

(b) before any advance is made, the indemnitee will submit a written undertaking satisfactory to the Board to repay the advance unless it is ultimately determined that the indemnitee is entitled to indemnification for the expenses under this Article.

Unless the Board finds compelling reasons to do otherwise, the undertaking shall be unsecured, and no interest shall be charged on the obligation created thereby.

Section 4. Insurance. The Board of Directors may adopt a resolution authorizing the purchase of insurance on behalf of any agent against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, and such insurance may provide for coverage against liabilities beyond this Corporation's power to indemnify the agent under law.

ARTICLE VIII

MISCELLANEOUS

Section 1. Fiscal Year. The fiscal year of the Corporation shall be the calendar year or such other period as may be fixed by the Board of Directors.

Section 2. Corporate Seal. The corporate seal shall be circular in form, shall have the name of the Corporation inscribed thereon and shall contain the words "Corporate Seal" and "California" and the year the Corporation was formed in the center, or shall be in such form as may be approved from time to time by the Board of Directors.

Section 3. Checks, Notes and Contracts. The Board of Directors shall determine who shall be authorized from time to time on the Corporation's behalf to sign checks, drafts, or other orders for payment of money; to sign acceptances, notes, or other evidences of indebtedness; to enter into contracts; or to execute and deliver other documents and instruments.

Section 4. Amendment of Bylaws. The Bylaws of the Corporation may be adopted, amended or repealed in whole or in part by majority vote of the directors then in office.

Section 5. Governing Law. In all matters not specified in these Bylaws, or in the event these Bylaws shall not comply with applicable law, the California Nonprofit Public Benefit Corporation Law as then in effect shall apply.

OFFICER'S CERTIFICATE

I, Lori Estrada-Kirn, the Secretary of California Prison Healthcare Receivership Corporation, formed and existing under the laws of the State of California, do hereby certify that the foregoing is a true and complete copy of the Bylaws of this nonprofit public benefit corporation as submitted and read to, and adopted by, the Board of Directors on April 26, 2006.

IN WITNESS WHEREOF, I have hereunder subscribed my name on this 26 day of April, 2006.



LORI ESTRADA-KIRN
Secretary

EXHIBIT 4

Office of the *California Prison Receivership*

Letter from the Receiver, Vol. I, Number 1.
17 April 2006

Greetings to all on day one of the Federal Court mandated Receivership of the California Department of Corrections and Rehabilitation (CDCR) prison medical care system. This communication serves as the first in an ongoing series to all CDCR staff to inform you of key visions, plans and activities of the Receivership and the CDCR Health Services Division. It is important that you keep abreast of our activities, help inform them and provide input -- critical or supportive -- in order that all of us, together, will improve the medical care our patients receive. All activities of the Receivership have one bottom line in mind: ***To create a system where custody and health care staff together guarantee that access to care and quality of medical services in California prisons meet constitutional standards.***

The challenge is immense, the opportunity unique and failure is not an option. The factors leading to the creation of the Receivership have been in play for decades and although the turn-around will not be completed overnight, actions toward that end will be swift to address the most critical issues and shortcomings.

While we are "fighting fires" to rid our system of the most egregious abuses we will, at the same time, engage in a methodical and organized approach to institute changes in the State prisons that will establish California as a national leader in quality medical systems of which all CDCR employees can be proud.

I understand fully that the local clinical environment is where the most important interactions occur. I assure you I will focus my efforts in this area and, working with you and the Court, will take the steps necessary to make the changes needed.

One of my key challenges and responsibilities is to provide the resources necessary to make positive change. Inhumane working conditions lend themselves to unacceptable behaviors. Shamefully inadequate health care salaries create recruitment and retention barriers to high quality care. My commitment is to work with custody and health care personnel together to, at a minimum, provide adequate clinical space, supplies, equipment, staff, training, education and support. My expectation is that you are competent, caring, compassionate and willing to participate in positive change. Nothing less is acceptable.

There is exhaustive documentation of horrid working conditions, substandard care, preventable patient morbidity and mortality, significant staff indifference and incompetence and a broken system which is unethical, immoral and illegal. No more evidence is required. Documentation of the State's inability and/or unwillingness to take effective action is, in fact, the reason the Court has removed the prison medical system from State control. We will now proceed to make the changes necessary to guarantee our patients their right to constitutionally adequate medical care. We start today.

I look forward to working with you.

Sincerely,



Robert Sillen, Receiver

Upcoming letter topics:

- The Receivership – What is it? Who is the Receiver and what is he doing here? Why did he come?
- The vision – What, how, when?
- Priorities – Everything can't be done at once. Why not? Where is the emphasis and what will happen?
- Systemic change – How? Who will be involved?
- Where do I get meaningful information? How do I communicate with HSD Central Office? The Receiver? Will anybody ever answer me?
- The whole patient. Coordination and integration of other efforts (e.g., mental health, dental).

Distribution:

Honorable Thelton E. Henderson
Honorable Governor, State of California
Honorable Members, California Legislature
All Cabinet Secretaries
All State Department Heads
All Employees, CDCR
All Bargaining Units
Inspector General
All State Constitutional Officers

EXHIBIT 5

Office of the California Prison Receivership

Letter from the Receiver, Vol. I, Number 2
5 May 2006

I would like to thank everyone in the Department of Corrections and Rehabilitation, State Administration and organized labor for the warm welcome they have provided to me in the early days of this endeavor to reform medical care delivery in the state's prison system.

In particular, the Warden and staff of San Quentin were most generous when I toured the facility on my second day on the job, April 18. There, I had the opportunity to see for myself what I had only read about in court documents. It was appalling. I instantly was struck by the dismal physical conditions, overcrowding, disorganization, neglect of the basic equipment and supplies needed for medical care delivery, lack of space and staff, and a host of other problems that add up to bad outcomes for patients.

A few highlights stuck with me. Nurses in the Urgent Care Drop-In Center (TTA), told me they had been waiting four months for a bulk order of 4x4 gauze bandages, with no explanation given them as to why they had not arrived. Outrageous. Upon my instruction, those bandages were delivered the following week. In the X-ray department, staff continues to work with outdated equipment two years after a new X-ray machine was delivered. It remains boxed up on site. Unacceptable. That situation will change, too. Perhaps the most alarming of all was the "clinic" located at the back of a gymnasium where 330 inmates crowd together in bunk after bunk of overflow housing. Those conditions are degrading and unsanitary for both inmate patients, health care professionals and custody staff. They must improve.

It wasn't all bad news, however. I was pleasantly surprised by the good morale and bearing of staff – both health care and custody – who work under these horrid conditions. They were gracious, dedicated and yearning for the chance to do their jobs right. That's just what they're going to get.

The California Prison Receivership is going to put San Quentin under a microscope. Together, the Receiver's staff and the on-site medical and custody personnel will fix urgent on-the-ground problems – such as the lack of timely delivery and installation of equipment and supplies, the cleanliness of clinical space and the archaic state of medical records and data collection. We also will address the systemic problems such as staffing and space shortages that are slowing the pace of improvements taking place there. As well, the relationships between custody and health care staff will be studied and problems fixed. Neither group can do their jobs in a professional manner without high quality interactions.

Why San Quentin? Quite simply, it is the oldest, most decrepit and most notorious prison in California. As such, it is a perfect laboratory for reform. What we learn there about how to proceed will inform our efforts in every other prison going forward. Surely, each institution has its own unique features but at the root of this health care crisis are systemic problems in need of repair. We will start at San Quentin as we simultaneously continue to deal with systemic issues such as pharmacy and clinical service contracts.

Stay tuned for progress reports. We plan to start this month by canvassing health care and custody staff about their suggested solutions to the obstacles they confront in delivering constitutionally adequate care. We will then gather a team together in June to prioritize areas and functions for repair, and get started making a difference. I expect that everyone engaged in medical care delivery -- both health care and custody personnel -- in each institution as well as at Headquarters will assume responsibility and accountability for their role in improving the system.

Please remember, all activities of the Receivership have one bottom line in mind: ***To create a system where custody and health care staff together guarantee that access to care and quality of medical services in California prisons meet constitutional standards.***

I look forward to working with you to achieve that goal.

Sincerely,



Robert Sillen
Receiver

Distribution:

Honorable Thelton E. Henderson
Honorable Governor, State of California
Honorable Members, California Legislature
All Cabinet Secretaries
All State Department Heads
All Employees, CDCR
All Bargaining Units
Inspector General
All State Constitutional Officers
Legislative Analyst's Office

EXHIBIT 6

JOHN HAGAR - Court Appointed Correctional Expert
Marciano Plata et a. v. Arnold Schwartzenegger et al., C-01-01351 T.E.H.

Federal District Courthouse
Law Library 18th Floor
450 Golden Gate Avenue
San Francisco, CA 94102

March 26, 2006

BY E-MAIL (PDF)

MOLLY E. ARNOLD
Chief Counsel, Department of Finance
State Capitol, Room 1145
Sacramento, CA 95814

Re: Funding CDCR Activities Required by the Receiver

Dear Ms. Arnold:

Thank you for arranging the meeting last Friday, and providing the attached proposals. We understand the State's concern: how to proceed forward in full compliance with Judge Henderson's orders and to provide funding for the Receiver, as much as possible, in compliance with California law.

It may be helpful to set forth some of the general concerns I expressed at the 10:00 a.m. and 1:00 p.m. meetings last Friday.

1. An adequate long-term plan for prison health care funding must place the health care budget under the control of the Receiver. Thus, Proposal 1, to the degree that it allocates health care funding to the CDCR Secretary, is not acceptable.
2. An adequate plan for prison health care funding must not require the Receiver to go to the Court, and the Court to go to the Legislature, each and every time the Receiver requires supplemental funds to implement a necessary correction to the health services provided in California prisons. A requirement for repeated requests, and the delays inherent therein, will defeat the very purpose of the Receivership.

In saying this, I do not mean to imply that certain major, long-term funding requests cannot be presented to the Legislative. However, a system must be in place to circumvent this process *whenever* the Receiver perceives it to be necessary. The record in this case is not in dispute, the cumbersome and untimely Budget Change Proposal request process, for whatever reason, has not adequately responded to the CDCR health care crisis.

3. An adequate program for prison health care funding must not involve a process that calls for a reduction to other elements of the CDCR budget whenever the Receiver requests supplemental funding for CDCR health care services.

Given these general concerns, I left last Friday's meetings with the understanding that the State will proceed as follows:

A. A proposal will be prepared, beginning in FY 06/07, to segregate the CDCR health care budget and place it under the Receiver's control. In that regard, Jim Tilton will begin to identify *all* health care, custody, and support staff involved with providing CDCR health care services.

We agreed that an initial cut will require periodic review and correction (I believe the term "calibration" was used at the meeting). Therefore, a process must be established between the Department of Finance and the Office of the Receiver concerning how to effectuate these periodic corrections.

B. A proposal will be prepared that establishes a pool of funds to meet the directives of the Receiver in the event that funding is necessary *above that* already allocated.

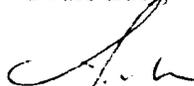
C. A proposal will be prepared concerning recommendations, by the State, for an order and levy against the State's General Fund in the event that proposals A and B do not provide the necessary funding for the Receiver's needs.

These proposals will be presented by April 10, 2006.

In addition, you will meet and confer with other State agencies to determine whether other orders are needed to supplement the Order of February 14, 2006 (to provide specific guidance to State employees concerning how to comply with the Receiver's directives). We look forward to reviewing those proposals also. Again, I understand I will receive suggested supplemental orders by April 10, 2006.

In the interim, if question arise or if an additional meeting is needed, do not hesitate to contact me at (415) 341-6569.

Yours truly,



John Hagar

cc. The Honorable Thelton Henderson (with attachment)
Robert Sillen (with attachment)
Andrea Lynn Hoch (with attachment)

Proposals to Address Funding of Department of Corrections and Rehabilitations Activities Required by the Receiver and Receivership Activities

1. Beginning in FY 06/07, segregate the CDCR Health Care budget and place it within the Receiver's control.

Legal parameters: The Constitution prohibits the appropriation of funds for the purpose or benefit of any institution not under the exclusive management and control of the State. *California Constitution, article XVI, section 3*. The constitutionally permissible path to achieve this objective would be to obtain a separate health care appropriation to CDCR with legislative authorization to expend the appropriation in response to directives of the Receiver, including payments in support of the Receiver's office, and legislative waiver of specific state processes (to be determined).

Practical concerns: *Coleman* (mental health), *Farrell* (juvenile health), *Perez* (dental) etc. will require expenditures from this budget.

2. Seek a specific appropriation to CDCR in the FY 06/07 budget for the purpose of responding to directives of the Plata Receiver, with the authorization and waiver described above.

Amount needs to be determined, and supported in order to obtain legislative approval of the appropriation. May 1 is the deadline for presentation of proposed budget changes to the Legislature.

3. Seek an augmentation of Line Item 9840 in the FY 06/07 budget to create a pool of funds for the specific purpose of augmenting the CDCR appropriation in order to meet the directives of the Plata Receiver, with the authorization and waiver described above.

Amount needs to be determined. The Line Item 9840 process requires periodic notifications to the Legislature re: the use of the line item to augment the CDCR's budget. This process may prove to be more palatable to the Legislature, as it retains legislative control over the augmentation of CDCR's budget.

4. Periodic orders and subsequent levies against the State's General Fund.

The Controller's Office has advised us they will honor a writ of execution against the General Fund.¹

¹ The Controller's Office bases its authority to honor Federal court writs on the Supremacy Clause of the U.S. Constitution. 9.30,

State law requires the levy against an existing appropriation rather than the General Fund to the extent an existing appropriation is available to pay the Federal court order. See *Budget Bill Control Section 9.30(Chapters 38 and 39, Statutes of 2005, Section 9.30)*.

This process requires a writ of execution of an amount certain by the Court. It is unclear how effective this process would be in obtaining additional funds for CDCR Health Care operations, and whether this would require payment to an entity outside of the State government to perform the duties ordered by the court.

EXHIBIT 7



DEPARTMENT OF
FINANCE
OFFICE OF THE DIRECTOR

ARNOLD SCHWARZENEGGER, GOVERNOR
STATE CAPITOL ■ ROOM 1145 ■ SACRAMENTO CA ■ 95814-4998 ■ WWW.DOF.CA.GOV

April 10, 2006

Mr. John Hagar
Court Appointed Correctional Expert
Federal District Courthouse
Law Library 18th Floor
450 Golden Gate Avenue
San Francisco, CA 94102

Dear Mr. Hagar:

Funding CDCR Activities Required by the Receiver

In response to your letter dated March 26, 2006, enclosed is a draft budget item that the Department of Finance (Finance) proposes to present to the California Legislature for consideration. Finance will request the Legislature to adopt this budget item within the fiscal year 2006-07 Budget Act. The dollar amounts reflected in the enclosed draft are expected to change before this budget item is submitted to the Legislature. The total item amount and the schedule amounts are in the final development process taking place between Finance, the California Department of Corrections and Rehabilitation (CDCR), and the Governor's Office.

This proposed budget item segregates the health care component of the CDCR budget from the remainder of the CDCR budget. It provides for use of budgeted funds in response to the Receiver's direction. In addition, it establishes a pool of funds available to augment the budget item in response to the Receiver's direction. We believe that it meets the concerns expressed in your letter.

We have discussed this draft budget item with individual legislators and with legislative staff, and have attempted to address their expressed concerns in this draft. However, as you are aware, this proposal will have to be adopted by the Legislature as part of the Budget Act before it is effective.

In response to your request that we provide recommendations for an order and levy against the state's General Fund in the event funds budgeted to the CDCR health care program are insufficient to meet the Receiver's needs, I have spoken with both the State Controller's Chief Counsel, Rick Chivaro and the State Treasurer's Chief Counsel, Mark Paxon. The State Controller and the State Treasurer are the state officers that perform the duties that must take place in response to any writ of execution for the levy of funds from the state's bank accounts.

Both Mr. Chivaro and Mr. Paxon expressed the willingness of their respective clients to honor a writ of execution for the levy of an identified amount of state funds that is issued by the Court. They both asked that I convey their willingness to discuss the levy process with you further. For

Mr. John Hagar
April 10, 2006
Page 2

your information I have provided you with a copy of the un-codified state statute that pertains to the levy process (Section 9.30 of Chapter 38 of Statutes of 2005).

We look forward to working with the Receiver, and to assisting him in performing his duties in relation to the CDCR health care system.

Sincerely,



MOLLY E. ARNOLD
Chief Counsel

Attachment

cc. Andrea Lynn Hoch, Legal Affairs Secretary, Governor's Office
Rick Chivaro, Chief Counsel, State Controller's Office
Mark Paxon, Chief Counsel, State Treasurer's Office
Jon Wolff, Deputy Attorney General, Attorney General's Office

DRAFT BUDGET BILL LANGUAGE
(Amounts are for display purposes only)

New Item:

5225-002-0001—For support of the Department of Corrections and Rehabilitation.....1,270,000,000

Schedule:

- (1) 10-Corrections and Rehabilitation Administration.....20,000,000
- (2) 25.01-Adult Corrections and Rehabilitation Operations.....40,000,000
- (3) 25.02-Adult Corrections and Rehabilitation Operations-Distributed.....40,000,000
- (4) 50-Correctional Health Care Services.....1,000,000,000
- (5) 97- Unallocated.....250,000,000

Provisions:

1. On February 14, 2006, the U.S. District Court in the case of *Plata v. Schwarzenegger* (No. C01-1351 THE) suspended the exercise by the Secretary of the California Department of Corrections and Rehabilitation of all powers related to the administration, control, management, operation, and financing of the California prison medical health care system. The court ordered that all such powers vested in the Secretary of the California Department of Corrections and Rehabilitation were to be performed by a Receiver appointed by the Court, commencing April 17, 2006, until further order of the Court. The Director of the Division of Health Care Services is to administer this item to the extent directed by the Receiver.
2. Notwithstanding any other provision of law, the Director of Finance may authorize the augmentation of the amount available for expenditure in any schedule in this item of appropriation, or any schedule in any other item of appropriation in Section 2.00 of this Act, by making a transfer from Schedule (5) of this item of appropriation for the purpose of funding costs, including capital outlay costs, for the Department of Corrections and Rehabilitation or any other state agency or department, in order to respond to directions of the Receiver or orders of the U.S. District court in *Plata v. Schwarzenegger* . The Director shall not approve any transfer under this provision unless the approval is made in writing and filed with the Chairperson of the Joint Legislative Budget Committee and the chairperson of the committee in each house that considers appropriations not later than 30 days prior to the effective date of the approval, or prior to whatever lesser time the chairperson of the joint committee, or his or her designee, may determine. The notification to the Legislature shall include information regarding the purpose of the expenditures and the expected outcome of those expenditures.
3. Notwithstanding any other provision of law, the Department of Corrections and Rehabilitation is not required to competitively bid for health services contracts in cases where contracting experience or history indicates that only one qualified bid will be received.
4. Notwithstanding Government Code section 13324 or Section 32.00 of Chapter 38, Statutes of 2005, no State employee shall be held personally liable for any expenditure or the creation of any indebtedness in excess of the amounts appropriated therefore as a result of complying with the directions of the Receiver or orders of the U.S. District court in *Plata v. Schwarzenegger*.

SEC. 9.30. In the event that federal courts issue writs of execution for the levy of state funds and such writs are executed, the State Controller shall so notify the Department of Finance. The Department of Finance shall then notify the State Controller of the specific appropriation or fund to be charged. Federal writs of execution for the levy of state funds may only be charged against appropriations or funds having a direct programmatic link to the circumstances under which the federal writ was issued. If the appropriate department or agency no longer exists, or no linkage can be identified, the federal writ shall be charged to the unappropriated surplus of the General Fund. In the event that an appropriation in the act would have insufficient funding by such a charge, funding augmentations must follow the regular budget processes.

EXHIBIT 8



April 20, 2006

Honorable Wesley Chesbro, Chair
Senate Budget and Fiscal Review Committee

Attention: Mr. Danny Alvarez, Staff Director (2)

Honorable John Laird, Chair
Assembly Budget Committee

Attention: Mr. Christopher W. Woods, Chief Consultant (2)

As you know, Mr. Robert Sillen began his tenure as the Federal Court Receiver of the California Department of Corrections and Rehabilitation's (CDCR) medical care program under the *Plata v. Schwarzenegger* case on April 17, 2006. Many questions have been raised about what relationship the Administration will have with the Receiver, particularly in the fiscal arena. Our immediate plan is to develop a good working relationship with the Receiver so that we can help guide his decisions on fiscal matters. In the long term, it is our expectation that by assisting the Receiver in restoring constitutionally adequate health care in our state prisons and achieving long-term efficiencies in how these health care services are provided, the Federal Court will eventually determine that an ongoing receivership is not necessary.

As we begin this relationship, there are several basic issues that have been raised by the court and Receiver with which we concur. First, as was evidenced by the settlement agreement in this case, we agree with the court that there are longstanding, persistent, and severe deficiencies in the provision of medical services in CDCR. Second, we agree with the court that a more effective health care system that is better managed and more automated would cost less, not more, in the long run. Finally, we agree with the Receiver that in the short run, it will be necessary to spend more money to put these systems in place and address basic shortfalls in the current health care programs in order to achieve the desired long-term results.

As we work with the Receiver towards resolving these issues, it is the Administration's desire to make the fiscal process as efficient as possible so that the State can quickly respond to the fiscal needs of the Receiver. Therefore, we will be proposing to create a stand-alone budget item for the CDCR Health Care Program that will include provisions allowing for expedited revision of the level of funding needed for the Receiver. The proposed budget structure and provisional language are attached. We are still in the process of compiling the necessary fiscal information for this item and will be updating this information in the May Revision.

This stand-alone budget item will also include provisional language specifying that the Administration will provide the Legislature with information regarding goals and performance. We will be working with CDCR and the Receiver to develop guidelines for performance measurements and how we can compare our performance to those measures in order to gauge whether we are providing the appropriate level of care.

In addition to the issues of medical care for which the Receiver is responsible under the *Plata v. Schwarzenegger* case, the CDCR Health Care Program also encompasses the provision of mental health care and dental care to inmates, which are subject to other federal court jurisdiction as a result of *Coleman v. Schwarzenegger* and *Perez v. Hickman*, respectively. Due to the potential overlap in management systems, activities, and efficiencies that these programs have with the provision of medical care to inmates, the Administration is working with the courts to coordinate the various cases in order to determine what will work best from an operational standpoint.

Lastly, the attached Finance Letter requests specific augmentations to the proposed budget for CDCR in order to ensure that they begin fiscal year 2006-07 with adequate resources to meet the provisions of various court orders and to address a significant base shortfall identified in the level of funding needed for the medical contract and medical guarding costs that the Department is currently experiencing. You will be receiving a separate letter identifying the current year health care shortfall and the level of funding necessary to cover those costs.

I look forward to continuing to work with you and the other members of the Legislature as we address the fiscal needs of the Receiver and work towards achieving an adequate and efficient health care system in California's prisons.

Sincerely,



MICHAEL C. GENEST
Director

Attachment

cc: Honorable Kevin Murray, Chair, Senate Appropriations Committee
Attention: Mr. Bob Franzoia, Staff Director
Honorable Dennis Hollingsworth, Vice Chair, Senate Budget and Fiscal Review Committee
Attention: Mr. Jeff Bell, Staff Director
Honorable Judy Chu, Chair, Assembly Appropriations Committee
Attention: Mr. Geoff Long, Chief Consultant
Honorable Rick Keene, Vice Chair, Assembly Budget Committee
Attention: Mr. Peter Schaafsma, Staff Director
Honorable Michael Machado, Chair, Senate Budget and Fiscal Review Subcommittee No. 4
Honorable Rudy Bermúdez, Chair, Assembly Budget Subcommittee No. 4
Ms. Elizabeth Hill, Legislative Analyst (4)
Ms. Diane Cummins, Senate President pro Tempore's Office
Mr. Craig Cornett, Assembly Speaker's Office (2)
Mr. David Harper, Deputy Chief of Staff, Assembly Republican Leader's Office
Ms. Jeanne Woodford, Secretary, Department of Corrections and Rehabilitation
Ms. Sandra Duveneck, Director, Administration, Department of Corrections and Rehabilitation
Dr. Peter Farber-Szekrenyi, Director, Division of Correctional Health Care Services,
Department of Corrections and Rehabilitation
Mr. Robert Sillen, Receiver

DRAFT BUDGET BILL LANGUAGE

New Item:

5225-002-0001—For support of the Department of Corrections and Rehabilitation.....x,xxx,xxx,xxx

Schedule:

- (1) 10-Corrections and Rehabilitation
Administration.....xx,xxx,xxx
- (2) 25.01-Adult Corrections and Rehabilitation
Operations.....xx,xxx,xxx
- (3) 25.02-Adult Corrections and Rehabilitation
Operations-Distributed.....-xx,xxx,xxx
- (4) 50-Correctional Health Care Services.....x,xxx,xxx,xxx
- (5) 97- Unallocated.....0

Provisions:

1. On February 14, 2006, the U.S. District Court in the case of *Plata v. Schwarzenegger* (No. C01-1351 THE) suspended the exercise by the Secretary of the California Department of Corrections and Rehabilitation of all powers related to the administration, control, management, operation, and financing of the California prison medical health care system. The court ordered that all such powers vested in the Secretary of the California Department of Corrections and Rehabilitation were to be performed by a Receiver appointed by the Court, commencing April 17, 2006, until further order of the Court. The Director of the Division of Health Care Services is to administer this item to the extent directed by the Receiver.
2. Notwithstanding any other provision of law, the Director of Finance may authorize an augmentation of the amount available for expenditure in Schedule (5) of this item, for the purpose of funding costs for the Department of Corrections and Rehabilitation and any other state agency or department, including the costs of capital projects, resulting from actions by the Receiver or the court in *Plata v. Schwarzenegger*. Augmentations pursuant to this authority may not exceed \$250 million, in aggregate, during the 2006-07 fiscal year. From any amount available in Schedule (5), the Director of Finance may authorize the transfer of funds from Schedule (5) of this item of appropriation for the purpose of augmenting the amount available for expenditure in any other schedule in this item of appropriation, or in any other appropriation in Section 2.00 of this Act. The Director shall not approve any augmentation or transfer under this provision unless the approval is made in writing and filed with the Chairperson of the Joint Legislative Budget Committee and the chairperson of the committee in each house that considers appropriations not later than 30 days prior to the effective date of the approval, or prior to whatever lesser time the chairperson of the joint committee, or his or her designee, may determine. The notification to the Legislature shall include information regarding the purpose of the expenditures and the expected outcome of those expenditures.
3. No later than March 1, 2007, the Department of Corrections and Rehabilitation shall submit a report to the Legislature that provides the guidelines for the goals and performance measures of the delivery of health care services and how the Department will compare their performance to those measures to determine whether they are providing the appropriate level of care.
4. Notwithstanding any other provision of law, the Department of Corrections and Rehabilitation is not required to competitively bid for health services contracts in cases where contracting experience or history indicates that only one qualified bid will be received.
5. Notwithstanding Government Code section 13324 or Section 32.00 of this Act, no State employee shall be held personally liable for any expenditure or the creation of any indebtedness in excess of the amounts appropriated therefore as a result of complying with the directions of the Receiver or orders of the U.S. District court in *Plata v. Schwarzenegger*.

EXHIBIT 9

Office of the California Prison Receivership

May 30, 2006

SENT VIA EMAIL

Molly E. Arnold
Chief Counsel, Department of Finance
State Capitol, Room 1145
Sacramento, CA 95814

Dear Ms. Arnold:

Thank you for meeting with us on May 19th. We appreciate your taking the time to discuss the proposed 2006-07 Budget Bill Item for the California Department of Corrections and Rehabilitation (CDCR) health care system. For your reference, I have attached the proposed Budget Bill Item and the proposed amendment to Paragraph 4 of the Budget Bill Item you provided us.

We wish to confirm the mutual understanding our offices reached on the following issues:

1. Proposed Budget Bill Item 5225-002-001, if adopted by the Legislature, will be used solely to support the prison medical, mental health and dental health care system. Funds for the prison *medical* health care system will be subject to the control of the Receiver.
2. In addition to the \$1,419,673,000 appropriated by the proposed Budget Bill Item, the Director of Finance will, at the request of the Receiver and after 30 days notice to the Legislature, augment Schedule (5) of the Budget Bill Item in an amount up to \$250 million. Schedule (5) will be used as directed by the Receiver, which may include funding the Office of the Receiver. You agreed to advise us of the individual we should contact to request augmentations of Schedule (5).
3. Paragraph 2 of the proposed Budget Bill Item states that the Director of Finance "may" authorize an augmentation of Schedule (5). The word "may" is being used to denote the grant of authority from the Legislature to the Director. But it is understood that, by operation of the Court's February 14, 2006 Order Appointing Receiver, augmentations of Schedule (5) requested by the Receiver will be mandatory after 30 days notice to the Legislature.
4. The written notification to the Legislature required by Paragraph 2 of the proposed Budget Bill Item will not be in the form of a "Budget Change Proposal." Rather, it will consist of a brief, general statement of the purpose of the expenditure and the expected outcome.

5. The Order Appointing Receiver requires that the Receiver "arrange with Defendants a system for regularly replenishing the Receiver's Office Fund Account." Prior to the adoption of the 2006-07 Budget Act, the Office of the Receiver may replenish its account from funds appropriated to the CDCR. Our contact for obtaining such funding will be Dr. Peter Farber-Szekrenyi or Acting Secretary Tilton.

6. At this time, the Receiver has no basis for determining the financial needs of the prison medical system. Thus, the Receiver does not necessarily agree with the amounts appropriated in the proposed Budget Bill Item. If the funds appropriated are insufficient for financing the prison medical system, the Receiver will obtain a writ of execution for the levy of additional state funds to finance the prison medical system.

7. A levy of state funds by the Receiver will not be charged against an appropriation or funds with a direct programmatic link to the prison health care system. At our meeting, we discussed whether section 9.30 of the proposed Budget Act would require that a levy of state funds be charged against the CDCR. You agreed to review section 9.30 and consider whether an amendment to the proposed Budget Act is necessary.

8. The Court's February 14, 2006 Order Appointing Receiver requires that the Receiver, within 180-210 calendar days, develop a plan of action, which includes a proposed time line for all actions and set of metrics by which to evaluate the Receiver's progress and success. This report will be made available to the State. The Receiver will not create, or allow resources under his control to be used to create, a second set of goals and performance measures. Thus, to the extent that the State wishes to satisfy Paragraph 3 of the proposed Budget Bill Item (which requires the CDCR to submit a report to the Legislature regarding goals and performance measures) by submitting a report other than the Receiver's report to the Court, the State will not use financial or personnel resources under the control of the Receiver, including DCHCS funds or personnel.

9. The amended Paragraph 4 of the Proposed Budget Bill grants the "Secretary" authority to approve contracts for health care services and health care-related equipment, and exempt health care-related equipment contracts from competitive bidding requirements. This authority will, in fact, reside with the Receiver by operation of the court's February 14, 2006 order, which requires that the Receiver exercise all powers vested by law in the Secretary relating to the prison medical system.

10. Our offices will work together during the coming fiscal year to "calibrate" the 2006-07 CDCR medical system budget as we reach a better understanding of the conditions and needs of the prison medical system. The Office of the Receiver should work with Todd Jerue in your office as an initial contact for this purpose.

Letter to Molly Arnold

May 30, 2006

Page 3 of 3

11. Beginning with Fiscal Year 2007-08, the Receiver will establish the CDCR medical health care system budget. Our offices will work together to assist the Receiver in submitting future budgets in accordance with State practice.

Please let me know of your understanding of the above issues differs in any respect. And again, thank you for your cooperation. We look forward to continuing to work with the Department of Finance on raising the level of medical care in the prisons up to constitutionally adequate standards. We will contact you soon to arrange our next meeting.

Sincerely,



Jared Goldman
Staff Attorney

c: Robert Sillen, Receiver
John Hagar, Chief of Staff, Office of the Receiver
Michael Genest, Director, Department of Finance
Todd Jerue, Assistant Program Budget Manager, Department of Finance
Dr. Peter Farber-Szekrenyi, Director, Division of Correctional Health Care Services
Bruce Slavin, General Counsel, Department of Corrections and Rehabilitation

Attachments (1)

Proposed Budget Bill Item

New Item:

5225-002-0001—For support of the Department of Corrections and Rehabilitation.....1,419,673,000

Schedule:

(1) 10-Corrections and Rehabilitation
Administration.....8,283,000
(2) 25.01-Adult Corrections and Rehabilitation
Operations.....65,256,000
(3) 25.02-Adult Corrections and Rehabilitation
Operations-Distributed.....-65,256,000
(4) 50-Correctional Health Care Services.....1,413,483,000
(5) 97- Unallocated.....0
(6) Reimbursements.....-2,093,000

Provisions:

1. On February 14, 2006, the U.S. District Court in the case of *Plata v. Schwarzenegger* (No. C01-1351 THE) suspended the exercise by the Secretary of the California Department of Corrections and Rehabilitation of all powers related to the administration, control, management, operation, and financing of the California prison medical health care system. The court ordered that all such powers vested in the Secretary of the California Department of Corrections and Rehabilitation were to be performed by a Receiver appointed by the Court, commencing April 17, 2006, until further order of the Court. The Director of the Division of Health Care Services is to administer this item to the extent directed by the Receiver.
2. Notwithstanding any other provision of law, the Director of Finance may authorize an augmentation of the amount available for expenditure in Schedule (5) of this item, for the purpose of funding costs for the Department of Corrections and Rehabilitation and any other state agency or department, including the costs of capital projects, resulting from actions by the Receiver or the court in *Plata v. Schwarzenegger*. Augmentations pursuant to this authority may not exceed \$250 million, in aggregate, during the 2006-07 fiscal year. From any amount available in Schedule (5), the Director of Finance may authorize the transfer of funds from Schedule (5) of this item of appropriation for the purpose of augmenting the amount available for expenditure in any other schedule in this item of appropriation, or in any other appropriation in Section 2.00 of this Act. The Director shall not approve any augmentation or transfer under this provision unless the approval is made in writing and filed with the Chairperson of the Joint Legislative Budget Committee and the chairperson of the committee in each house that considers appropriations not later than 30 days prior to the effective date of the approval, or prior to whatever lesser time the chairperson of the joint committee, or his or her designee, may determine. The notification to the Legislature shall include information regarding the purpose of the expenditures and the expected outcome of those expenditures.
3. No later than March 1, 2007, the Department of Corrections and Rehabilitation shall submit a report to the Legislature that provides the guidelines for the goals and performance measures of the delivery of health care services and how the Department will compare their performance to those measures to determine whether they are providing the appropriate level of care.
4. Notwithstanding any other provision of law, the Department of Corrections and Rehabilitation is not required to competitively bid for health services contracts in cases where contracting experience or history indicates that only one qualified bid will be received.
5. Notwithstanding Government Code section 13324 or Section 32.00 of this Act, no State employee shall be held personally liable for any expenditure or the creation of any indebtedness in excess of the amounts appropriated therefore as a result of complying with the directions of the Receiver or orders of the U.S. District court in *Plata v. Schwarzenegger*.

Proposed BBL

Amendment to Paragraph 4 of 5225-002-0001 (As proposed in May Revise Finance Letter):

Replace paragraph 4 with:

4. Notwithstanding any other provision of law, including Public Contract Code sections 10295, et. seq., the Department of Corrections and Rehabilitation is not required to competitively bid for health care services contracts awarded through June 30, 2007. The Department of Corrections and Rehabilitation is further exempted from the requirement to competitively bid for health care equipment where the Department Secretary has made a determination that the equipment is needed to avoid disruption in the delivery of health care services. Final approval of contracts for health care services and such health care-related equipment entered into by the Department of Corrections and Rehabilitation pursuant to this authority shall reside with the Department Secretary. These contracts shall be subject to audit by the Officer of the Inspector General and the Bureau of State Audits.

EXHIBIT 10



DEPARTMENT OF
FINANCE
OFFICE OF THE DIRECTOR

ARNOLD SCHWARZENEGGER, GOVERNOR

STATE CAPITOL ■ ROOM 1145 ■ SACRAMENTO CA ■ 95814-4998 ■ WWW.DOF.CA.GOV

June 5, 2006

Mr. Jared Goldman
Counsel, Office of the California Prison Receivership
Via e-mail to jaredgoldman@yahoo.com

Dear Mr. Goldman:

Thank you for your thorough summary of our meeting. We believe that, in general, it is an accurate reflection of the discussion between the Department of Finance and the Office of the Receiver.

We wish to remind you, however, that during our discussion we were speaking only for the Department of Finance (Finance), as the budget arm of the Governor's Administration. We are not able to speak for other constitutional officers or the Legislature.

As to certain of the matters raised, the Receiver may benefit from additional discussions with the Legislature. For example, we understand the Receiver's position that the report the Office of the Receiver will prepare for the court should be sufficient to meet any requirement for a report to the Legislature (as currently drafted, due on March 7, 2006). We also understand that the Receiver, exercising his court-appointed authority to act as the Secretary of the Department of Corrections and Rehabilitation (CDCR) over medical health care matters, will not permit the use of CDCR medical health care staff or funds for the preparation of any other report for the Legislature. We cannot speak to the Legislature's willingness to accept that report.

In addition, you may wish to discuss the levy process further with the State Controller or the State Treasurer. For example, it is our understanding that the Controller's Office believes that, as a result of the federal constitution's supremacy clause, a federal court's writ of execution can override the requirement for appropriation in the last sentence of Section 9.30 of the 2005-06 Budget Act, but we cannot speak definitively as to their interpretation.

Additionally, as agreed, we have reviewed Section 9.30 of the 2005-06 Budget Act. Pursuant to that section, Finance is responsible for identifying the specific appropriation or fund to be charged when a writ of execution is received by the State Controller. In that regard, we confirm that, should a writ of execution be issued by the *Plata* court levying funds for a CDCR health care purpose, Finance will identify the CDCR health care budget appropriation as the appropriation having the "direct programmatic link to the circumstances under which the federal writ was issued" and will not identify either the general CDCR budget appropriation or any other State department's budget appropriation.

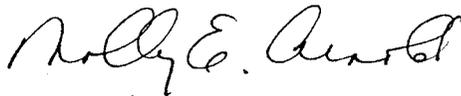
Our review of Section 9.30 suggests that, should a writ of execution issue prior to the depletion of the CDCR health care budget item, the result could be a depletion of funds available to meet the requirements of the *Coleman* or *Perez* courts. It is our understanding that no amendment of Section 9.30 is necessary to permit those courts to obtain funds via the levy process, should a *Plata* court order deplete the CDCR health care budget item.

June 5, 2006
Mr. Jared Goldman
Counsel, Office of the California Prison Receivership
Page 2

As to your question in item number 2, your primary contact for budget items should be the Acting Program Budget Manager responsible for oversight of the California Department of Corrections and Rehabilitations (CDCR) Todd Jerue.

I hope this clarifies a few of the points in your letter. To the extent you have any questions about them, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Molly E. Arnold". The signature is written in black ink and is positioned above the typed name and title.

Molly Arnold
Chief Counsel

EXHIBIT 11



June 19, 2006

Mr. Robert Sillen, Receiver
Office of the California Prison Receivership

Dear Mr. Sillen:

This letter is to inform you of the current status of the 2006-07 budget for the California Department of Corrections and Rehabilitation (CDCR) Health Care Program. The Budget Conference Committee in the Legislature completed its actions on June 10, 2006. For your reference, I have attached the Budget Bill Item for the CDCR Health Care budget as it was approved by the Conference Committee (Attachment I), as well as supplemental reporting language that was approved by the Conference Committee (Attachment II). The following describes the status of a number of budget issues that may be of interest to you.

Budget Bill Item for CDCR Health Care Program and Augmentation Authority

As you know, the Administration proposed a new Budget Bill Item that separately appropriates funds for the CDCR Health Care Program. The Administration's proposal included language that would have allowed the CDCR Health Care budget to be augmented by up to \$250 million for funding costs of providing health care to inmates resulting from actions by the Receiver or the Plata court that exceed the budget item.

The Budget Conference Committee has approved the establishment of the new Budget Bill Item. However, instead of accepting the augmentation language as proposed, the Conference Committee appropriated \$100 million to fund such costs and provided the Director of Finance with authority to transfer these funds to the appropriate program or department that is involved in the provision of health care to California inmates. The Director is required to notify the Legislature of any such transfers made within ten days after the effective date of the transfer, and removed the 30-day waiting period requirement. See Provision 2 of Attachment I for the specific language changes related to the process for transferring these funds.

The Conference Committee also added language requiring the Department of Finance (Finance) to notify the Legislature when expenditures from the \$100 million appropriation are occurring at a rate that would exceed the amount appropriated prior to the end of the fiscal year and requiring that if any of the \$100 million appropriation that is not expended by June 30, 2007 revert to the General Fund. See Provisions 8 and 9 of Attachment I for the specific language changes related to these requirements.

It is our understanding that the Committee's action was intended to provide the Administration with sufficient flexibility to meet the Receiver's needs during times of the year when the Legislature is not in session, while at the same time expressing the Legislature's expectation that appropriations for funding needs that exceed this budgeted amount must be addressed by the Legislature through a supplemental appropriations bill. It is our understanding that it is the

Legislature's intent to take up any supplemental appropriations bill necessary to address your needs on an expedited basis. While the Committee's action does not provide the amount of authority originally requested, we believe that there is still sufficient flexibility provided by this appropriation and language to address your needs. As we go forward, it will be important for Finance to track the need for additional resources based on when actual payments are due, as well as the total or ongoing costs for new activities directed by your office. Finance's intent would be that payments due during the first part of the year when the Legislature is out of session be made from the \$100 million appropriation and that a request be made to the Legislature, as early as possible, for a supplemental bill to address the ongoing or longer-term costs of these activities if they are expected to exceed the existing appropriation.

Proposed Contracting Exemption Language

The language related to contracting for health care services and equipment developed by the Department of General Services in consultation with your office was presented by the Administration to the budget subcommittees in both houses. However, neither house acted to include this language in the budget bill, nor did the budget Conference Committee act to include this language in the budget bill.

Budget Bill Language Regarding the Provision of Telemedicine

The applicable budget subcommittees of each house approved budget bill language proposed by the Legislative Analyst's Office (LAO) requiring CDCR to establish guidelines for the use of telemedicine for special medical care, establish performance targets for medical consultations conducted through telemedicine, and report on meeting these performance targets. See Provision 7 of Attachment I for these requirements. In a meeting with Jared Goldman and John Hagar on May 19, 2006, we learned of your unwillingness to use the resources under your control to create a set of performance measures other than those already required by the court. However, these actions regarding the use of telemedicine consultation had already taken place in both houses, and were not before the Conference Committee, and the Administration was not able to seek any adjustments to this language to address any concerns you might have about establishing telemedicine guidelines and targets, and reporting on them to the Legislature.

Contract Analyst Positions, Conversion from Limited Term to Permanent

On May 19, 2006, John Hagar expressed your position that the newly added contract analyst positions were to be established as permanent rather than limited-term positions. Upon the Administration's request, the Budget Conference Committee took an action on June 1, 2006, that made those positions permanent. It is our expectation that upon final approval of the Budget Act there will be no barrier to hiring contract analysts into these positions on a permanent basis.

Reporting of Performance Measure Indicators

Each year, during the budget approval process, the Legislature establishes an uncodified list of supplemental reports that are of interest to the budget committees. State agencies and departments are expected to make these reports to the LAO. Among the reports established by the Conference Committee this year is a report from the CDCR to the Legislature which is to include specific information about the provision of medical services. See Attachment II for the description of the report expected by the LAO.

Finance staff expressed your unwillingness to use the resources under your control to create a set of performance measures other than those already required by the court to the Legislature during the Conference Committee process and, as a result, the final language approved by the Conference Committee includes a statement to the effect that data related to medical care shall be provided to the extent it is consistent with data collected at the direction of the Receiver. See the third paragraph of Attachment II for this language.

We look forward to continuing to work with you as we go forward into the next fiscal year. If you have any questions about the current status of the budget or the specific details of the Legislature's actions thus far, please feel free to contact Todd Jerue, Program Budget Manager, Corrections and General Government Unit, at (914) 445-8913.

Sincerely,



MOLLY ARNOLD
Chief Counsel

- cc: Mr. John Hagar, Chief of Staff, Office of the California Prison Receivership
Mr. Jared Goldman, Counsel, Office of the California Prison Receivership
Mr. James Tilton, Secretary, Department of Corrections and Rehabilitation
Mr. Peter Farber-Szekrenyi, Director, Division of Correctional Health Care Services,
Department of Corrections and Rehabilitation
Mr. Jonathan Wolff, Deputy Attorney General

ceiver or the court in *Plata v. Schwarzenegger*. ~~Augmentations pursuant to this authority may not exceed \$250,000,000, in aggregate, during the 2006-07 fiscal year.~~ From any amount available in Schedule (5), the Director of Finance may authorize the transfer of funds from Schedule (5) for the purpose of augmenting the amount available for expenditure in any other schedule in this item, or any other appropriation in Section 2.00 of this act to a department or agency that is involved in the provision of health care to California inmates. ~~The Director of Finance shall not approve any augmentation or transfer under this provision unless the approval is made in writing and filed with~~ notify the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the fiscal committees in each house that consider appropriations of the Legislature no later than 30 10 days prior to after the effective date of the approval, or prior to whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine transfer. The notification to the Legislature shall include information regarding the purpose of the expenditures and the expected outcome of those expenditures.

3. No later than March 1, 2007, the Department of Corrections and Rehabilitation shall submit a report to the Legislature that provides the guidelines for the goals and performance measures of the delivery of health care services and how the department will compare their performance to those measures to determine whether they are providing the appropriate level of care.
4. Notwithstanding any other provision of law, the Department of Corrections and Rehabilitation is not required to competitively bid for health services contracts in cases where contracting experience or history indicates that only one qualified bid will be received.
5. Notwithstanding Section 13324 of the Government Code or Section 32.00 of this act, no state employee shall be held personally liable for any expenditure or the creation of any indebtedness in excess of the amounts appropriated therefore as a result of complying with the directions of the Receiver or orders of the United

States District court in Plata v. Schwarzenegger.

6. Of the amount appropriated in Schedule (4), \$21,487,000 is for the purpose of complying with the Perez v. Hickman settlement agreement. Of this amount, \$14,080,000 is appropriated for the purpose of establishing 124 positions, as well as equipment and contract costs, beginning on July 1, 2006. The remaining \$7,407,000 appropriated for the purpose of establishing 202 positions later in the fiscal year shall not be expended until (a) the California Department of Corrections and Rehabilitation provides the Joint Legislative Budget Committee with a copy of the staffing study required under the Perez v. Hickman settlement agreement, and (b) the Department of Finance provides the Joint Legislative Budget Committee with a letter stating the extent to which the staffing levels authorized in this act are consistent with the findings of the staffing study. Within 60 days of the receipt of the study and letter, the Joint Legislative Budget Committee shall notify the California Department of Corrections and Rehabilitation and the Department of Finance whether it finds these expenditures for the positions are consistent with the staffing study. Any funds subject to this provision that are not expended shall revert to the General Fund.
7. On or before January 1, 2007, the Department of Corrections and Rehabilitation shall establish guidelines concerning the conditions under which inmates needing special medical care are provided with a physician consultation through telemedicine rather than an in-person visit at an outside medical facility. The guidelines should take into consideration factors including, but not limited to, whether (a) a telemedicine consultation is medically appropriate, (b) a medical specialist is available to conduct a telemedicine consultation in a timely manner, and (c) the inmate in need of medical specialty services is assigned to a prison that has received telemedicine resources as part of the Plata v. Schwarzenegger rollout. Based on these guidelines, by March 1, 2007, the department shall establish monthly performance targets for prisons with a telemedicine capability

regarding the total number and percentage of medical specialty consultations that are conducted by telemedicine rather than at community medical facilities, and provide a copy of the performance targets to the Joint Legislative Budget Committee. By June 30, 2007, the department shall provide a written report to the Joint Legislative Budget Committee on the extent to which the prisons achieved their performance targets. The report shall include any factors that may have prevented the department from meeting its performance targets, as well as the total estimated savings from using telemedicine.

8. The Department of Finance shall immediately notify the Joint Legislative Budget Committee and the fiscal committees in each house of the Legislature when expenditures pursuant to Provision 2 are occurring at a rate that would exhaust the level of funding in Schedule (5) prior to the end of the fiscal year.
9. Any funds in Schedule (5) that are not expended by June 30, 2007, shall revert to the General Fund.

EXHIBIT 12

Division of Correctional Health Care Services

Effective Medical Services Contract Process

Project Charter



Project Sponsor: Peter Farber-Szekrenyi, Dr. P.H.

Project Director: Ted Rauh

Approval Date:

Last Updated: 6/20/2006

Version: 6.0

Table of Contents

	<u>Page</u>
Purpose of Project	3
Project Description	3
Project Background	4
Project Goals, Objectives and Expected Results	6
Align with Strategic Plan	7
Project Scope	7
Project Boundaries	11
Project Assumptions	11
Potential Project Constraints and Barriers	11
Assumptions that Require Confirmation	11
Project Approach and Organization	12
High Level Deliverables	12
High Level Milestones	12
Project Approval	13
Stakeholder Identification	13
Project Team Members	14
Group Leaders	15
Document Control – Change Record of approved Charter	15
Reviewers	15
Distribution	16

Purpose of Project

To create an effective contract process within the California Department of Corrections and Rehabilitation (CDCR) and its Division of Correctional Health Care Services (DCHCS), that ensures the timely procurement and reimbursement of medical services contracts. The contract process will achieve processing and invoice payment efficiency goals; satisfy the State of California's responsibility to exercise stewardship over the expenditure of public funds; be transparent and efficiently monitored and evaluated; and, utilize the best practices readily available with regard to contracting efficiency and information technology.

Project Description

This project will evaluate the current CDCR contract and invoice payment processes and propose improvements to the existing processes and/or develop new contracting and invoice payment processes. The existing process involves contract and invoice processing by DCHCS staff at the institutions and in headquarters, CDCR accounting and contract staff, and staff from the Department of General Services (DGS). The new process will focus CDCR resources and responsibility for medical services contract management to create the optimal contracting system for CDRC and will represent the best possible proposal from the State of California. The project will focus on four areas of contract administration. These areas are: 1) The contract bid, negotiation, award, and tracking process; 2) The appropriate use of information technology to manage, track, and provide monitoring of the contract and invoice processes; 3) The invoice review, authorization and payment process; and, 4) The statutory and regulatory requirements, external review and approval, and the legislative intent of those requirements as they provide structure or impediments to an effective contract process. The project will look at the contract and invoice document and approval flows, the information required, the forms used, the methods of information transmittal, and resource allocations and organizational structures needed for an effective contracting system.

There are four performance measures that were suggested by the Receiver for the new contract processing system. These measures are:

- 1) **“Timelines for Execution of Contracts: a.) Non-competitive bid contracts will be executed in 30 days; b.) Competitive bid contracts will be executed in 60 days.**
- 2) **Number of Individuals Preparing, Reviewing and Approving Each Contract: Each contract will be prepared, reviewed and approved by no more than four individuals. For example, the contract may be prepared by a contract analyst, reviewed by a budget analyst, reviewed by an attorney and approved by a director.**
- 3) **Competitive Bidding: Competitive bidding requirements will be streamlined to provide, at a minimum, that contracts for services under \$100,000 will be bid using an informal competitive process. Contract analysts will be**

- permitted to fulfill the informal competitive process by surveying 3 potential providers by phone (with appropriate documentation) or in writing.
- 4) **Timeline for Payment of Providers: Payment of valid provider invoices will be issued within 60 days of receipt of the provider's invoice. Providers will be notified of any disallowed claims within 60 days of invoice receipt of the provider's invoice."**

The project will survey the contract systems and practices of other hospital systems and correctional institutions – state and local – that make similar use of medical service providers to determine what practices they use and which of those may be appropriate to be used at CDCR. The project will also assess the use of contract templates, standardized rates, and other efficiency process methods that will help achieve the performance measures established for the project.

The Team, in conjunction with the Sponsor and the Receiver will monitor the project Charter. As work proceeds, any of these parties can determine a need to change the Charter. When a need to change the Charter is identified, the proposed change shall be made available to the parties in writing. Typically, proposed changes shall be discussed at bi-weekly Receiver briefing meetings before being made.

Project Background

In the federal suit, *Plata vs. Schwarzenegger (Plata)* filed in 2001, *Plata* alleged statewide deficiencies in the medical services delivery system. The *Plata* settlement agreement included the Court's appointment of Mr. Robert Sillen to serve as the Receiver (Receiver) in this action. The Court has also appointed Mr. John Hagar as its Correctional Expert (Expert). The Expert prepared a report on CDCR's medical services contracting and found a number of very serious deficiencies. The Expert found that the current contracting process has significantly contributed to deterioration of the health care services provided to CDCR inmate-patients. Major backlogs in contract invoice payments have lead to delays or withholds of contractor provided medical services. Service provider contracts have expired before replacement contracts were negotiated and in force. The Expert noted that in 2004 the California State Auditor found extensive problems with CDCR's contracting process. The Expert summarizes the audit findings as follows.

"These [2004] audits found numerous serious fiscal problems, including but not limited to failing to competitively bid when appropriate, flawed negotiating practices, agreeing to excessive rates of compensation, failing to ensure discounts, failing to follow CDCR contract manual requirements, failing to secure required approval for exception cases in non-emergency situations, failing to ensure that only valid claims were paid, failing to implement appropriate utilization management policies and procedures, and failing to staff institutions with the appropriate personnel trained to conduct adequate contract negotiations."

The Expert noted that the State agency response to these problems was ineffectual. In addition, changes to bid exemption processes by DGS in response to the audit coupled with the failure of the state to provide adequate resources and training has served to further exacerbate the problem.

The Court issued an Order on March 30, 2006 directing CDCR to, among other things, develop a new contracting process. The specific requirements in the Order pertaining to the contracting process are as follows:

“1. CDCR, working with the Expert under the direction of the Receiver, and the State entities responsible for contract negotiations, management, and payment (including but not limited to DGS, Department of Finance, and the Department of Personnel Administration) shall establish a team of employees/experts (“Team”) who shall develop and institute health care oriented policies and standards to govern CDCR medical contract management. These policies and standards shall consider both the need for timely on-going care and the fiscal concerns of the State, including but not limited to the State Auditor findings of 2004.

2. The Team shall consider the following changes to State policy and procedure:

- (a) Combining the two CDCR units currently responsible for health care contract management and accounting.**
- (b) Development of simplified template contracts applicable to health services providers.**
- (c) Streamlining the exception process for bidding requirements.**
- (d) Evaluating and recommending changes in legislation conducive to cost effective and timely contract services.**
- (e) Developing new and streamlined forms for contract processing.**
- (f) Establishing an information technology sub-group to evaluate and report on the purchase of a computerized state-wide data base to manage all CDCR medical contracts.**

The Team shall also determine whether an outside consultant, skilled in health care contracts, should assist the Team concerning their recommendations.

3. The Team shall approach its task with the goal of implementing new contract policies and procedures, controls, and a training program, within 180 days from the date of this Order. Thereafter, Defendants shall present a plan to the Receiver to end the emergency payment process described in section B (of the Order) above.”

Further direction was provided by the Receiver during a meeting held with CDCR staff on May 3, 2006.

Project Goals, Objectives, and Expected Results

The Goal of this project is to develop and plan the implementation of improvements to the existing contract management and invoice payment systems and/or new contract management and invoice payment processes, which meet or exceed the four established performance measures.

The Objectives of this project are:

Charter Development

Team	5/11 – 5/30
Sponsor	5/15 – 5/31
Receiver	5/18 – 5/19; 5/31 – 6/2

Analysis & Process Building

Current contract practice analysis	6/20
Review of other agency approaches	6/20
Current invoice payment analysis	6/20
CA Contracting law & Reg. review	6/20
Current IT systems analysis	6/20
Team	6/20
Sponsor	6/21 – 6/26
Receiver	6/28 – 6/30
Team/Sponsor response to Receiver	7/5

Identify New/Improved Contract Mgmt. and Invoice Payment Systems Options & Recommendations

Team	7/18
Sponsor	7/19 – 7/24
Receiver	7/26 – 7/28
Team/Sponsor response to Receiver	8/2

Selected Options Policy and Procedure Development

Team	8/28
Sponsor	8/29 – 9/4
Receiver	9/6 – 9/8
Team/Sponsor response to Receiver	9/13

Final report on Contract and Invoice Payment Systems Training & Implementation

Team	9/5
Sponsor	9/6 – 9/11
Receiver	9/20 – 9/22
Team/Sponsor response to Receiver	9/27

Plan to end Emergency Payment Process

Team	9/26
Sponsor	9/27
Receiver	9/27 – 9/29

Team/Sponsor response to Receiver 10/4

The expected results of this project are that the process of medical services contracting, including the approval and payment of invoices, will be effectively run within CDCR with appropriate oversight to ensure that California's objectives for sound, fair, fiscal management are met. Contracts will be processed and managed, and invoices paid in accordance with the performance measures and applicable State contracting and fiscal statutes, regulations, and practices.

Align with Strategic Plan

This project aligns with the following strategies of the CDCR Strategic Plan for delivery of health care.

- Develop and implement a service delivery system to provide accessible, quality, and cost-effective health care across all programs (7.1)
- Develop and implement a comprehensive performance management system to monitor program performance ... and identify opportunities for improvement. (7.2)
- Obtain the necessary resources to support the managed health care system. (7.4)

Project Scope

This project will complete the following non bid contract work:

- An analysis will be made of the types of CDCR medical contracts to determine which types should be non bid contracts. The basis for non bid contract selection shall be responsive to the State of California's responsibility to exercise stewardship over the expenditure of public funds.
- An analysis of the current contracting process for non bid contracts will be performed starting with how needs for services are identified, contract renewal cycles are planned for, and what steps and monitoring processes are needed to assure medical services are in place when they are needed. The analysis will move through each process step culminating in the contract being executed. The analysis will assess each process step, the number of individuals involved, the time taken to complete, obstacles or barriers that are causes for delay, decision points, the reasons for and the effects loops have on the process, and the form of the process (paper, fax or IT). The analysis will review contracts to develop a statistically valid assessment of the current process and the time each step requires.
- An analysis of the current non bid medical services contract and service order processes will be made to determine how best to meet the need for Urgent medical services, i. e. where there is insufficient time to follow normal processes

such as bidding. The dollar amounts, length of agreements, delegation of authority and the processing approaches will be evaluated and a contracting approach that meets this need will be developed.

- An analysis of the current types of non bid medical services contracts will be made to determine what dollar amount(s) should be established for non bid contracts. The analysis will assess the types of services procured, the urgency of services requested, the amount of services procured, the repetitive nature of services, and other factors determined by the analysis to be relevant.
- An analysis of the current types of non bid medical services contracts will be made to determine how standard template(s) can be used to create standard contract documents. The analysis will determine what the minimum contents of the template(s) will be with regard to legal protections, administrative requirements, and statements of work. A two-stage template system will be evaluated. The first stage consists of the legal and administrative standard boilerplate that may be common to all contracts. The second stage is the scope of work that varies in response to the medical needs. In addition, if it is determined that any standard boiler plate language can be waived or altered, the conditions under which the language can be waived or altered and the approval authority for the changes shall be determined and made part of the contract process.
- An analysis of the current types of non bid medical services contracts will be made to determine how a standard fee schedule(s) can be used to create standard contract documents. The analysis will determine what the impact of a standard fee schedule would have on the contracting process, how it would be set and updated, how and who could deviate from the standard rates, whether contracts would include automatic adjustments as the fee schedule changed, how well the schedule would provide or hinder the provision of medical service needs and other issues identified.
- An analysis of the current non bid contract administration system will be performed starting with the identification of a service need and finishing with contract termination and evaluation. The analysis will assess each process step, the number of individuals involved, the time taken to complete, the invoice review/approval process, decision points, obstacles or barriers that are causes for delay, the reasons for and the effects loops have on the process, and the form of the process (paper, fax or IT). The analysis will review contracts to develop a statistically valid assessment of the current process and the time each step requires.
- An improved contracting administrative process for non bid contracts will be developed that achieves the performance and quality goals established in the project charter. In addition, the new process will provide for the State of California's responsibility to exercise stewardship over the expenditure of public funds and will address the systemic problems identified in the State Auditor's findings. Accompanying the improved process will be the policy, procedure, and standards needed to assure the success of the process. In addition, staff training and technical assistance will be developed. A non bid contract monitoring and evaluation program will be developed to assure the program is successfully implemented and ongoing improvements can be made.

This project will complete the following bid contract work.

- An analysis of the current contracting process for bid contracts will be performed starting with how needs for services are identified and moving through the contract being executed. The analysis will assess each process step, the number of individuals involved, the time taken to complete, obstacles or barriers that are causes for delay, decision points, the reasons for and the effects loops have on the process, and the form of the process (paper, fax or IT). The analysis will review contracts to develop a statistically valid assessment of the current process and the time each step requires.
- An analysis of the current types of medical services contracts that are bid will be made to determine what bidding procedure(s) should be used. The analysis will assess the types of services procured, the availability of service providers, the urgency of services requested, the amount of services procured, the repetitive nature of services and other factors determined by the analysis to be relevant. The analysis will also look at bid streamlining options including an exception process and how each option would impact the contracting system.
- An analysis of the current types of medical services contracts that are bid will be made to determine how standard template(s) can be used to create standard contract documents. The analysis will determine what the minimum contents of the template(s) will be with regard to legal protections, administrative requirements, and statements of work. A two-stage template system will be evaluated. The first stage consists of the legal and administrative standard boilerplate that may be common to all contracts. The second stage is the scope of work that varies in response to the medical needs. In addition, if it is determined that any standard boiler plate language can be waived or altered, the conditions under which the language can be waived or altered and the approval authority for the changes shall be determined and made part of the contract process.
- An analysis of the current types of medical services contracts that are bid will be made to determine how a standard fee schedule(s) can be used to create standard contract documents. The analysis will determine what the impact of a standard fee schedule would have on the contracting process, how it would be set and updated, what the conditions would be and approval process for any deviations from the standard rates, whether contracts would include automatic adjustments as the fee schedule changed, how well the schedule would provide or hinder the provision of medical service needs and other issues identified.
- An analysis of the current bid contract administration system will be performed starting with the identification of a service need and finishing with contract termination and evaluation. The analysis will assess each process step, the number of individuals involved, the time taken to complete, the invoice review/approval process, decision points, obstacles or barriers that are causes for delay, the reasons for and the effects loops have on the process, and the form of the process (paper, fax or IT). The analysis will review contracts to develop a statistically valid assessment of the current process and the time each step requires.

- An improved contracting administrative process for contracts that are bid will be developed that achieves the performance and quality goals established in the project charter. In addition, the new process will provide for the State of California's responsibility to exercise stewardship over the expenditure of public funds and will address the systemic problems identified in the State Auditor's findings. Accompanying the improved process will be the policy, procedure, and standards needed to assure the success of the process. In addition, staff training and technical assistance will be developed. A bid contract monitoring and evaluation program will be developed to assure the program is successfully implemented and ongoing improvements can be made.

This project will assess the following areas when reviewing the invoice processing system

- An analysis of the current invoice approval and payment system will review each step in the process that is carried out by DCHCS, Regional Accounting Office (RAO) and Office of the State Controller (SCO) to determine work activities and processes that do not materially contribute to the tasks of approving and paying invoices. Roles, work volume, responsibilities, staffing levels, training, and information transfer will be assessed.
- SCO and RAO are reviewing opportunities to use electronic submittals of invoices to SCO and payment by means of electronic fund transfers.
- The Team is evaluating the invoice payment practices of other states and is looking at the internal processes of invoice logging, coding, and the potential for pre-approval of invoices in certain circumstances.

This project will assess the following areas while developing a new contract system

- An analysis of the current contract administration system will be performed to assess staff resource allocations and the placement and functions of organizational units involved in medical services contracting. The analysis will determine the appropriate role, location and resource levels for staff that are responsible for the new contract management and invoice processing systems. A specific assessment and recommendation will be made on the consolidation of the two CDCR units currently responsible for health care contract management and accounting.
- An evaluation will be done of the new contract management and invoice payment systems to determine any changes in state law that are required to facilitate the effective implementation of the new systems.
- The Team shall assess and advise the Receiver of its determination regarding the need to retain outside contract expert(s) to advise and recommend contract management processes, invoice payment processing methods, and/or contract tools or information systems.
- The Team will evaluate and propose an information management system that will facilitate the information flow, processing and tracking of contracts and invoices.

Project Boundaries

The direction of the Court.

Project Assumptions

- The Team will be able to design and develop an implementation plan for a contract management system that meets the intent of the State to manage its fiscal resources in an efficient, fair, and effective manner.
- The project will identify and recommend an effective contract management system and invoice payment system that utilizes resources, approval authority, and information management in the most practical and efficient manner. .
- Contract training on the existing system is planned to begin on June 14, 2006. Training that is being conducted in response to the Court Order will continue, however elements of this training that will conflict with the new process and are not necessary to the efforts to negotiate and process current contracts will be noted in the training and deferred if warranted.

Potential Project Constraints and Barriers

- One or more of the project performance measures cannot be met with a contract management system and/or invoice payment system that will meet the State of California's responsibility to exercise stewardship over the expenditure of public funds. If the Team determines that this situation has the potential to exist it will identify the problem(s) to the Receiver.
- The Team will identify the staff positions located in the institutions, CDCR and/or DCHCS and in other agencies that are needed to implement and carry out all aspects of the new contract management and invoice payment process. Other stakeholder organizations that may have a role in facilitating the hiring of needed staff will be kept advised of the project.
- The contract management and invoice payment processes will initially use existing IT systems that are readily available and can be supported by CDCR. These systems may not satisfy project needs and manual processing systems may initially be required. The Team will identify and recommend the IT system needs for long term contract management and invoice payment support. The Team will involve the other stakeholder organizations that play a role in the design, review, and procurement of IT systems as it develops long term IT recommendations.
- Contract Providers may raise concerns regarding doing business with the State if some of the elements of the contracting approach being considered are implemented. Concerns may be raised regarding the State's use of standardized rates for medical services and standardized contract terms.

Assumptions that Require Confirmation

None identified.

Project Approach and Organization

- This project will be organized into a cross-functional team with representatives from the functional areas impacted by the project from within DCHCS, CDCR, DGS and other state agencies as needed. At each stage in the Project, the State Auditor will be requested to review and comment on the products produced by the Team. Within the Team, four functional working groups are focusing on specific areas of the contract management and invoice payment processes. These groups work both independently and collectively in the Team to evaluate and recommend solutions to the contracting and invoice payment processes problems. These groups are the Invoice/Accounting Group, the Contract Process Management Group, the IT/Contract Data Base Group, and the Legal/Audits Group. Each group and the Team will ensure the new processes are equitable and transparent. Process monitoring and performance evaluation will also be a major component of the new contract management and invoice payment systems. The project will proceed in six phases which are described along with completion dates in the Project Goals, Objectives, and Expected Results section found on page 5.

High Level Deliverables

- Approve Team Charter. 6/2/2006
- Bi weekly reports to the Receiver – every other Friday commencing 5/19/06.
- Report to the Receiver documenting the results of the Team's Analysis and Process Building tasks. 6/28/06
- Report to the Receiver on the contract management and invoice processing systems options and the Team's recommendations. 7/26/06
- Report to the Receiver on the selected options' policy and procedures. 9/6/06
- Final report to the Receiver on the contract management and invoice payment systems training and implementation. 9/20/06
- Report to the Receiver presenting the plan to end the emergency payment process. 9/27/06

High Level Milestones

- Approval of the Project Charter
- Approval of any contract management process component that will not comply with existing state contracting requirements, regulations or laws.
- Agreement on where contracting and accounting resources and responsibilities will reside.
- Agreement on the role of DGS in contract review and approval.
- Completion of Project plan deliverables by the Project Team.

Project Approval

Project Director,

Ted Rauh
Project Director, Division of Correctional Health Care Services



Program Sponsor,

Peter Farber-Szekrenyi, Dr. P.H.
Director, Division of Correctional Health Care Services



Stakeholder Identification

<u>Stakeholder Name</u>	<u>Role/Responsibility</u>
Peter Farber-Szekrenyi, Dr. P.H.	Overall responsibility for project implementation and DCHCS resources
James E. Tilton	Provide input on the development of the program and CDCR resources
CDCR Legal Affairs	Review of legal issues and program before submission to the Receiver
Department of General Services	Provide input on the development of the program
State Office of the Controller	Provide input on the development of the program
California State Auditor	Provide input on the development of the program
Office of the Attorney General	Review of legal issues and program before submission to the Receiver
Department of Finance	Provide input on the development of the program

Project Team Members

<u>Name</u>	<u>Position</u>
Ted Rauh	Project Director
Yulanda Mynhier	Deputy Director, Health Care Administrative & Operations Branch
Denny Sallade	Chief, Fiscal & Business Management Section
Terri Hall	Manager, HCCUP Unit, DCHCS
Delores Carrier	SSM I, HCCUP Unit, DCHCS
David Hale	SSM I, Community Provider Network Program, DCHCS
Debra Crisp	Contract Analyst, DCHCS
Susan Wimberley	Contract Analyst, Pelican Bay State Prison
Gina Gill	Contract Analyst, Central California Women's Facility
Wendy Harris	Contract Analyst, California Medical Facility
Greg Neal	SSM I, Manager, DCHCS Informatics Unit
Zozimo Castro	Information Technology Unit, DCHCS
Kyme Lee	Information Technology Field Support Unit, DCHCS
Allan Gaines	Staff Information Systems Analyst, DCHCS
Larry Smith	DP Manager, CDCR
Leisa Rackelmann	Chief of Governance & Oversight, CDCR
Linda Cabatic	Department of General Services
Richard Kirkland	Deputy Director, Fiscal Services, CDCR
Tim Gilpin	Associate Director (A), Accounting Services, CDCR
Marjul Pawelczyk	Accounting Administrator I, Accounting Services, CDCR
Karen V. Smith	Deputy Director (A), Office of Business Services, CDRC
Susan Lew	Chief, Institutional Medical Contracts Section, CDCR
Lauren Trevathan	Associate Governmental Program Analyst, OBS
Chris Swanberg	Staff Counsel III, CDRC Office of Legal Affairs
Laurie Giberson	Staff Counsel III, DGS Legal Affairs Division
Jon Wolff	Supervising Deputy Attorney General, OAG
Paul Mello	Legal Counsel, Hanson, Bridgett, Marcus, Viahos & Rudy LLP

Group Leaders

Delores Carricr/Tim Gilpin – Invoice Review, Authorization, and Payment Process
Denny Sallade – Contract Bid, Negotiation, Award, and Tracking Process
Greg Neal/Allan Gaines – Use of Information Technology
Chris Swanberg – Statutory and Regulatory Requirements

Document Control – Change Record of Approved Charter

<u>Date</u>	<u>Author</u>	<u>Version</u>	<u>Change Reference</u>
6/20/2006	Ted Rauh	6.0	Final

Reviewers

<u>Name</u>	<u>Position</u>
Peter Farber-Szekrenyi, Dr. P.H.	Director, CDCR, Division of Correctional Health Care Services
Renee Kanan, M.D.	Deputy Director, DCHCS
Yulanda Mynhier	Deputy Director, Health Care Administrative & Operations Branch, DCHCS
Ted Rauh	Project Director, DCHCS
Denny Sallade	Chief, Fiscal and Business Management Section, DCHCS
Tim Gilpin	Associate Director (A), Accounting Services, CDCR
Susan Lew	Chief, Institutional Medical Contracts Section, CDCR
Chris Swanberg	Staff Counsel III, CDRC Office of Legal Affairs
Laurie Giberson	Staff Counsel III, DGS Legal Affairs Division
Richard Kirkland	Deputy Director, Fiscal Services, CDCR
Karen V. Smith	Deputy Director (A), Office of Business Services, CDCR
Jon Wolff	Supervising Attorney General, OAG
Paul Mello	Legal Counsel, Hanson, Bridgett, Marcus, Viahos & Rudy LLP

Distribution

<u>Copy #</u>	<u>Name</u>
1	Peter Farber-Szekrenyi, Dr. P.H.
2	Renee Kanan, M.D.
3	Yulanda Mynhier
4	Ted Rauh
5	Denny Sallade
6	Tim Gilpin
7	Susan Lew
8	Chris Swanberg
9	Laurie Giberson
10	Richard Kirkland
11	Karen V. Smith
12	Jon Wolff
13	Paul Mello

EXHIBIT 13

California Prison Healthcare Receivership Corp.	
Balance Sheet	
As of June 30, 2006	
<i>(Unaudited)</i>	
June 2006	
ASSETS	
Current Assets	
Cash in Bank	\$ 2,072,487
Prepaid Insurance	\$ 41,138
Prepaid Rent/Other Deposits	121,402
Total Current Assets	2,235,027
Property, furniture, and equipment:	
Office Equipment	31,437
Total Property, furniture, and equipment:	31,437
Other Assets:	
Security Deposit	176,222
Total Other Assets	176,222
TOTAL ASSETS	\$ 2,442,686
LIABILITIES AND FUND BALANCES:	
Current Liabilities	
Other Current Liabilities	
Accrued Expenses	39,000
Payroll-Payable	98,274
Total Current Liabilities	137,274
Fund Balances:	
Contributed Capital -Federal Court	2,752,547
Net Expenses	(\$447,135)
Total Fund Balances	2,305,412
TOTAL LIABILITIES AND FUND BALANCES	\$ 2,442,686

California Prison Healthcare Receivership Corp.

Statement of Expenses

For the period ending June 30, 2006

	<i>(Unaudited)</i>			
	<i>(started 4/17/06)</i>			
	Apr 2006	May 2006	June 2006	Total
Operating Expenses				
Salaries & Wages	\$50,429	\$103,108	\$151,441	\$304,978
Payroll Taxes	\$4,996	\$7,954	\$10,041	\$22,991
Legal & Other Professional Fees		\$1,500	\$26,752	\$28,252
Professional Fees - Chief of Staff	\$17,488	\$22,500	\$22,689	\$62,677
Office Expenses	\$63	\$501	\$58	\$621
Rent		\$5,790	\$680	\$6,470
Insurance		\$6,331	\$1,789	\$8,120
Telephone		\$694	\$303	\$997
Travel		\$5,749	\$9,878	\$15,627
Total Operating Expenses	\$72,976	\$154,128	\$223,631	\$450,735
Other Income				
Interest Earned		\$1,057	\$2,542	\$3,599
Total Other Income	\$0	\$1,057	\$2,542	\$3,599
Net Expenses	\$72,976	\$153,071	\$221,089	\$447,136

EXHIBIT 14

California Prison Healthcare Recevnership Corporation
Financial Statement Projections
for the fiscal year ending 6/30/07

INCOME STATEMENT

	July	August	September	October	November	December	January	February	March	April	May	June	Totals
Operating Expense:	225,801	294,619	295,921	467,968	494,870	494,870	494,870	494,870	494,870	494,870	494,870	494,870	5,243,267
Salaries, Wages & related	35,000	35,000	285,000	285,000	285,000	285,000	285,000	285,000	285,000	285,000	285,000	285,000	2,920,000
Contractors	5,400	16,706	16,706	16,706	16,706	16,706	16,706	16,706	16,706	16,706	16,706	16,706	189,166
Rent	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	60,000
Professional Fees	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	36,000
Office Expenses	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	42,000
Telephone	10,000	10,000	10,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	210,000
Travel/ Meals	3,577	3,577	3,577	3,577	3,577	3,577	3,577	3,577	3,577	3,577	3,577	3,577	42,924
Insurance	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	30,000
Miscellaneous													
Net Expenditures	293,778	373,902	625,204	807,251	834,153	834,153	834,153	834,153	834,153	834,153	834,153	834,153	8,773,357

	July	August	September	October	November	December	January	February	March	April	May	June	Totals
BALANCE SHEET													
ASSETS													
CURRENT ASSETS													
Cash	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Other Deposits	99,296												
Prepaid Insurance	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Other current assets(PP Rent)	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
TOTAL CURRENT ASSETS	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
LONG TERM ASSETS													
PP&E, net	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Security deposit	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Other assets	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
TOTAL LONG TERM ASSETS	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
TOTAL ASSETS	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

	July	August	September	October	November	December	January	February	March	April	May	June	Totals
LIABILITIES AND STOCKHOLDERS' EQUITY													
CURRENT LIABILITIES													
Payroll payable	\$112,900	\$147,310	\$147,961	\$233,984	\$247,435	\$247,435	\$247,435	\$247,435	\$247,435	\$247,435	\$247,435	\$247,435	\$2,474,335
Other accrued expenses	16,994	19,821	82,321	84,821	84,821	84,821	84,821	84,821	84,821	84,821	84,821	84,821	84,821
TOTAL CURRENT LIABILITIES	129,895	167,130	230,281	318,805	332,256	332,256	332,256	332,256	332,256	332,256	332,256	332,256	332,256
LONG TERM LIABILITIES													
Capital leases													
Long-term debt													
TOTAL LONG TERM LIABILITIES													
TOTAL LIABILITIES	129,895	167,130	230,281	318,805	332,256	332,256	332,256	332,256	332,256	332,256	332,256	332,256	332,256
Current Year Expenses	(293,778)	(667,680)	(1,292,884)	(2,100,135)	(2,934,288)	(3,768,440)	(4,602,593)	(5,436,746)	(6,270,899)	(7,105,051)	(7,939,204)	(8,773,357)	(8,773,357)
Paid in Capital	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Fund Balance	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
TOTAL LIABILITIES & EQUITY	\$0	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

California Prison Healthcare Recevership Corporation
Financial Statement Projections
for the fiscal year ending 6/30/07

CASH FLOW STATEMENT

	July	August	September	October	November	December	January	February	March	April	May	June
Cash flows from operating activities												
Net earnings (loss)	\$ (293,778)	\$ (373,902)	\$ (625,204)	\$ (807,251)	\$ (834,153)	\$ (834,153)	\$ (834,153)	\$ (834,153)	\$ (834,153)	\$ (834,153)	\$ (834,153)	\$ (834,153)
Adjustments to reconcile net earnings (loss) to net cash (used in) provided by operations:												
Depreciation and amortization	-	-	-	-	-	-	-	-	-	-	-	-
Net change in operating assets and liabilities:												
Security Deposit/PP Rent	#REF!											
Other assets	#REF!											
Payroll payable	#REF!	34,409	651	86,023	13,451	-	-	-	-	-	-	-
Other accrued expenses	#REF!	2,827	62,500	2,500	-	-	-	-	-	-	-	-
TOTAL Balance Sheet Adjustments	#REF!											
Net cash (used in) provided by operations	#REF!											
Cash flows from investing activities												
Sale (purchases) of property and equipment	(268,000)	(36,000)	(56,000)	-	-	-	-	-	-	-	-	-
Proceeds from Equipment Deposits	-	99,296	-	-	-	-	-	-	-	-	-	-
Net cash (used in) provided by investing activities	(268,000)	63,296	(56,000)	-	-	-	-	-	-	-	-	-
Cash flows from financing activities												
Net increase (decrease) in cash	#REF!											
Cash beginning of period	#REF!											
Cash end of period	#REF!											

proof

**California Prison Healthcare Receivability Corporation
Expenditure Worksheet
For the FYE 6/30/07**

	FTE's	July	August	September	October	November	December	January	February	March	April	May	June	Totals
Salaries, Wages, & Related:														
Receiver	1	\$650,000	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$54,167	\$650,000
Special Assist. To Receiver	1	\$131,300	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$10,942	\$131,300
Staff Atty.	1	\$195,000	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$195,000
Staff Atty.	1	\$195,000	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$16,250	\$195,000
Cont. Of Projects & Receivability Activities	1	\$194,000	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$8,667	\$194,000
Director of Facilities Engineering	1	\$234,000	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$19,500	\$234,000
Patent Inmate Relations Manager	1	\$121,860	\$10,140	\$11,267	\$11,267	\$11,267	\$11,267	\$11,267	\$11,267	\$11,267	\$11,267	\$11,267	\$11,267	\$132,950
Chief Financial Officer	1	\$357,500	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$29,792	\$357,500
Chief Medical Information Officer	1	\$357,500	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$465,000
Chief Medical Officer	1	\$465,000	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$37,917	\$465,000
Information Technology Officer	1	\$357,500	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$465,000
Directors Of Custody Support Services	1	\$260,000	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$260,000
Chief Pharmacy Officer	1	\$357,500	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$465,000
Chief Nursing Officer	1	\$357,500	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$21,667	\$465,000
Executive Assistant	4	\$91,000	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$15,167	\$363,333
Administrative Assistant	2	\$45,500	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$181,667
Office Assistant	2	\$45,500	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$3,792	\$181,667
Financial Analyst	2	\$130,000	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$10,833	\$303,333
Accounting Clerk	1	\$58,500	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$4,875	\$117,000
Staff Accountant	1	\$97,000	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$7,583	\$194,000
Sub-total	28	\$195,498	\$255,082	\$256,209	\$405,167	\$428,459	\$428,459	\$428,459	\$428,459	\$428,459	\$428,459	\$428,459	\$428,459	\$4,539,625
Payroll Taxes		\$21,505	\$28,059	\$28,183	\$44,588	\$47,130	\$47,130	\$47,130	\$47,130	\$47,130	\$47,130	\$47,130	\$47,130	\$498,359
Workers Comp		\$4,887	\$6,377	\$6,405	\$10,129	\$10,711	\$10,711	\$10,711	\$10,711	\$10,711	\$10,711	\$10,711	\$10,711	\$113,491
PTO		\$3,910	\$5,102	\$5,124	\$8,103	\$8,589	\$8,589	\$8,589	\$8,589	\$8,589	\$8,589	\$8,589	\$8,589	\$90,793
Total Salaries, Wages & Related		\$225,801	\$294,619	\$295,921	\$467,968	\$494,870	\$494,870	\$494,870	\$494,870	\$494,870	\$494,870	\$494,870	\$494,870	\$5,243,267
Outside Contracts:														
Various	\$300,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$420,000
Chief Of Staff		\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$420,000
Total Contractors		\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$420,000
Rent		\$5,400	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$16,706	\$189,186
Professional Fees		\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$60,000
Travel & Ent.		\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$120,000
Office Supplies		\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$36,000
Insurance		\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$3,577	\$42,924
Phone Expense		\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$42,000
Other Misc. exps.		\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$30,000
Total Projected Operating Expenses		\$293,778	\$373,902	\$375,204	\$607,251	\$634,153	\$634,153	\$634,153	\$634,153	\$634,153	\$634,153	\$634,153	\$634,153	\$8,773,357
Capital Items:														
Information Technology (one time)		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$55,000
Phones (one time)		\$42,000	\$15,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$42,000
Office Equipment (copiers, fax, etc)		\$15,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$21,000	\$30,000
Computers	21	\$3,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$63,000
Furniture		\$190,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$190,000
Total Capital Expenses		\$248,000	\$36,000	\$56,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$360,000

- 1 KATHLEEN KEESHEN
Legal Affairs Division
- 2 California Department of Corrections
P.O. Box 942883
- 3 Sacramento, CA 94283

- 4 RICHARD J. CHIVARO
JOHN CHEN
- 5 State Controller
300 Capitol Mall, Suite 518
- 6 Sacramento, CA 95814

- 7 MOLLY ARNOLD
Chief Counsel, Department of Finance
- 8 State Capitol, Room 1145
Sacramento, CA 95814

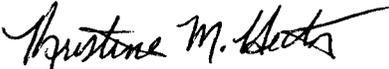
- 9 LAURIE GIBERSON
Staff Counsel
Department of General Services
- 10 707 Third Street, 7th floor, Suite 7-330
West Sacramento, CA 95605

- 11 MATTHEW CATE
Inspector General
Office of the Inspector General
- 12 P.O. Box 348780
Sacramento, CA 95834-8780

- 13 DONNA NEVILLE
Senior Staff Counsel
Bureau of State Audits
- 14 555 Capitol Mall, Suite 300
Sacramento, CA 95814

- 15 WARREN C. (CURT) STRACENER
PAUL M. STARKEY
Labor Relations Counsel
- 16 Department of Personnel Administration
Legal Division
- 17 1515 "S" Street, North Building, Suite 400
Sacramento, CA 95814-7243

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23 I declare under penalty of perjury under the laws of the State of California that the foregoing
is true and correct. Executed on July 5, 2006 at San Francisco, California.

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25 
26 Kristina Hector

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