

# EXHIBIT 1

**CDCR ESTIMATED CURRENT CONTRACT PROCESSING TIMELINES  
FORMAL MEDICAL BID CONTRACTS  
(with DVBE Exemption)**

PROCESS	RESPONSIBILITY	INDIVIDUAL CONTRACT OBS: Established Time Frames: 183 Total Days or 6 Months 124 Business Days) Starts with No. #3	STATEWIDE/REGIONAL CONTRACT OBS: Established Time Frames: (274 Total Days or 9 Months 186 Business days) Starts with No. #3	Area's That Processing Time can be Reduced by Additional Staff Resources
PROCESS	RESPONSIBILITY	AVERAGE PROCESSING TIME FRAMES (BUSINESS DAYS)	AVERAGE PROCESSING TIME FRAMES (BUSINESS DAYS)	
1. PRE-BID PROCESS	INSTRUCTION	5	5	
2. PRE-BID PROCESS Create/Edit Scope of Work	DCHCS	15	15	Additional SME's and Analytical Staff Streamline Approval Process
3. OBS EVALUATE/CREATE RECORD FOLDER	OBS	3	3	
4. BID PACKAGE DEVELOPMENT	OBS	3	10	
5. PROGRAM REVIEW/APPROVAL	DCHCS	7	14	
6. REVISIONS TO BID PACKAGE	OBS	2	2	
7. FINALIZATION OF BID PACKAGE	OBS/DCHCS	2	2	
8. OBS PRELIMINARY REVIEW	OBS	3	3	
9. ADVERTISING PROCESS	DGS	10	10	
10. BID OPENING & REVIEW	OBS	2	11	
11. PROGRAM REVIEW & APPROVE BIDS/RATES	DCHCS	0	10	
12. PROTEST PROCESS	OBS/DCHCS/DGS	45	45	
13. SPB UNION CHALLENGE	OBS/DCHCS/SPB	20	20	
14. AWARD PROCESS	OBS	4	14	
15. CONTRACT PREPARATION	OBS	3	10	
16. OBS PRELIMINARY REVIEW & PREPARE SIGNATURE LETTER	OBS	3	4	
17. MAIL TIME TO CONTRACTOR	CONTRACTOR	3	3	
18. CONTRACTOR SIGNATURE & REQUIRED DOCUMENTS	CONTRACTOR	10	10	
19. MAIL TIME FROM CONTRACTOR	CONTRACTOR	3	3	
20. REVIEW PACKAGE/ DOCUMENTS; REQUEST MISSING DOCUMENTS	OBS	2	12	

**CDCR ESTIMATED CURRENT CONTRACT PROCESSING TIMELINES  
FORMAL MEDICAL BID CONTRACTS  
(with DVBE Exemption)**

PROCESS	RESPONSIBILITY	INDIVIDUAL CONTRACT	STATEWIDE/REGIONAL CONTRACT	Area's That Processing Time can be Reduced by Additional Staff Resources
		OBS Established Time Frames 18 Total Days or 6 Months 124 Business Days Starts with No. #3	OBS Established Time Frames (274 Total Days or 9 Months 186 Business Days) Starts with No. #3	
		AVERAGE PROCESSING TIME FRAMES (BUSINESS DAYS)	AVERAGE PROCESSING TIME FRAMES (BUSINESS DAYS)	
21. ORIM CONTRACT APPROVAL	DGS	2	2	
22. RAO ENCUMBRANCE	RAO	2	2	
23. OBS MANAGER APPROVAL	OBS	3	4	
24. DGS APPROVAL (>\$75K)	DGS	10	10	
25. DISTRIBUTION	OBS	2	2	
<b>PROGRAM PROCESSING TIME (PRE-OBS)</b>		20	20	
OBS PROCESSING TIME		124	186	
SPB PROCESSING TIME				
<b>TOTAL BUSINESS DAYS</b>		144	206	

Specific timeframes are best case scenarios, and assume no corrections or errors occur; no changes to document are requested by Contractor, and Contractor submits all required documents/licenses/certifications timely.

In an attempt to meet/accomplish the processing timeframes, IMCS requires the additional seven staff that were originally requested but denied, in the 2005/06 Budget Act. As a result, existing staff have had to absorb this workload. Vacancy rates have also affect the workload and can impact meeting the processing timelines; as IMCS receives an average of 500-600 contracts/NTP requests per quarter.

# Description of Contract Processes

## Formal Medical Bid Contract Process

No.	PROCESS	RESPONSIBLE PARTY	PROCESS DESCRIPTION	ISSUES
1	Pre-Bid Process	INSTITUTION	<ul style="list-style-type: none"> <li>Create Bidders List, SOW, (if applicable) and all necessary documents (i.e. CDCR886B, GC 19130, etc);</li> </ul>	<ul style="list-style-type: none"> <li>Difficult to locate viable bidders who are interested in bidding</li> <li>Lack of contract training provided at institutions</li> <li>Institution contract staff (ICA) vacancies and turnovers</li> </ul>
2	Pre-Bid Process	DCHCS	<ul style="list-style-type: none"> <li>If required, DCHCS will provide rate sheet and SOW approval; CDCR Legal Input, and determine if services are required</li> </ul>	<ul style="list-style-type: none"> <li>Lack of Subject Matter Experts to assist in scope creation/editing delays completion.</li> <li>Supervisory and Management review adds significant time to completion.</li> </ul>
3	OBS Evaluate/Create Record Folder	OBS	<ul style="list-style-type: none"> <li>Review bid package documents for estimated contract amount, contract terms, authorized signatures, etc.</li> <li>Contact DCHCS or Institution to obtain missing documents and clarify incorrect information. IMCS will allow 2-5 days for updated document or information, or bid package will be returned unprocessed</li> <li>Search Access for pre-existing contracts (i.e. like services and providers) to avoid duplication; determine possible participation in master agreement</li> <li>Assign to analyst based on workload and pending contracts for like services</li> <li>Complete Contract Request Assignment Sheet and Contract Request Submittal Checklist</li> <li>Create contract file and number by entering all necessary contract information into Access database</li> <li>Print out and fax Confirmation Form to ICA</li> <li>Distribute new contract file and documents to appropriate analyst</li> </ul>	<ul style="list-style-type: none"> <li>Lack of refresher contract training for ICAs continues to result in the receipt of incomplete bid packages</li> <li>DCHCS and Institution continue to submit bid packages with missing signatures, estimated contract amount, term of contracts exceeding established timeframes, and incomplete or missing DCHCS rate sheet and/or SOW approval, etc.</li> <li>IMCS analysts utilize contract processing time to provide ongoing training to the ICAs via telephone/email/fax on contract processing and the use/types of CDCR forms</li> <li>IMCS receive late bid packages which do not allow sufficient time for contracts to be processed/approved. Note that bid services cannot commence prior to execution of bid contract</li> <li>Review of ACCESS to determine existing services/provider and entry of data into Access is time consuming</li> <li>Intake forms are generated manually, such as Contract Request Assignment Sheet and Contract Request Submittal Checklist</li> </ul>
4	Bid Package Development	OBS	<ul style="list-style-type: none"> <li>Develop bid package and applicable documents/exhibits, such as: Invitation for Bid, Bid Submittal Checklist, STD 213 Standard Agreement, SOW, Budget &amp; Payment Provisions, Bid Proposal, Rate Sheet (One Institution, Multiple or Statewide), CDCR GTC, Additional Provisions, Definitions, HIPAA, List of Participating Institutions, RAO Locations, Institutions Map, Contracted Hospitals, STD 204 – Payee Data Record, Subcontractor/Consultant List and CDCR 1786 – DVBE Participation in Exempt Contracts.</li> </ul>	<ul style="list-style-type: none"> <li>IMCS analyst to call DCHCS or Institution to request missing information, such as location of where services are provided, on-site/off-site, participating hospital, etc.</li> <li>Clarification of rate sheet</li> <li>Route Slip and Service Checklist are generated manually</li> <li>Network issues impacts workload processing time</li> </ul>
5	Program Review/Approval	DCHCS/ INSTITUTION	<ul style="list-style-type: none"> <li>Forward SOW and rate sheet to Institution and/or DCHCS for review and approval</li> </ul>	<ul style="list-style-type: none"> <li>Delays can occur receiving approved SOW and Rate Sheet</li> </ul>
6	Revisions To Bid Package	OBS	<ul style="list-style-type: none"> <li>Process revisions to bid package; reissue to Institution and/or DCHCS for review and approval, if required.</li> </ul>	

# Description of Contract Processes

## Formal Medical Bid Contract Process

No.	PROCESS	RESPONSIBLE PARTY	PROCESS DESCRIPTION	ISSUES
7	Finalization Of Bid Package	OBS/DCHCS	<ul style="list-style-type: none"> <li>Forward documents to Institution and/or DCHCS for review and approval</li> <li>Review bid package for content, format and applicable exhibits</li> <li>Review contract against documents provided by DCHCS and/or institution to ensure accuracy and completeness; such as contract term, funding amount and rate sheet information.</li> </ul>	<ul style="list-style-type: none"> <li>Delays can occur receiving approved SOW and Rate Sheet</li> <li>High turnover at management level impact the timely review and approval of contracts</li> <li>Lack of seasoned managers impact the training of new analysts due to limited contract processing knowledge</li> <li>Review and approval of contracts, and staff training are only provided by a small number of staff</li> </ul>
8	OBS Preliminary Review	OBS	<ul style="list-style-type: none"> <li>Upload all applicable bid documents into DGS Contracts Register Website. DGS requires 3 days to publish advertisement</li> <li>Advertisement runs for a minimum of 10 business days at the DGS Contracts Register Website</li> <li>Verify receipt of all bid packages from mailroom</li> <li>Obtain witness, open packages and declare the apparent lowest bidder</li> <li>Analyst to review all bid packages for possible alterations, completeness of requested licenses/certificate and insurance documents</li> <li>Request missing documents from bidder or reject bid</li> <li>Perform analysis on rates to determine accuracy</li> <li>Request Rate approval on bids received, if required.</li> </ul>	<ul style="list-style-type: none"> <li>Timely receipt of bid packages from mailroom</li> <li>Lack of sufficient or any bid packages</li> <li>Re-bid can occur due to alteration of bid package occurs; or no bids received, unqualified bidders or unacceptable rates, etc.</li> </ul> <p>Analysis of rates is time consuming for individual and statewide bids as rates are tracked in Excel to determine hierarchy.</p> <ul style="list-style-type: none"> <li>Required analysis of rates causes delays.</li> <li>Delays can occur receiving rate approval may indicate rates are too high and request a re-bid.</li> <li>Protests can delay award of contract for up to 2 months until decision is made by DGS.</li> </ul>
9	Advertising	OBS/DGS	<ul style="list-style-type: none"> <li>Verify receipt of all bid packages from mailroom</li> <li>Obtain witness, open packages and declare the apparent lowest bidder</li> <li>Analyst to review all bid packages for possible alterations, completeness of requested licenses/certificate and insurance documents</li> <li>Request missing documents from bidder or reject bid</li> <li>Perform analysis on rates to determine accuracy</li> <li>Request Rate approval on bids received, if required.</li> </ul>	
10	Bid Opening & Review	OBS	<ul style="list-style-type: none"> <li>Request Rate approval on bids received, if required.</li> <li>If protest notice is received from DGS, IMCS responds with supporting documentation and letter to DGS and awaits DGS final decision</li> <li>If letter is received from State Personnel Board, IMCS responds with supporting documentation and letter to SPB and awaits SPB final decision</li> <li>Process and distribute Award Notices</li> <li>Processing and typing of contract document</li> </ul>	
11	Program Review & Approve Bids/Rates	DCHCS		
12	Protest Process	OBS/DCHCS/DGS		
13	SPB Union Challenge	OBS/DCHCS/SPB		
14	Award Process	OBS		
15	Contract Preparation	OBS		

## Description of Contract Processes Formal Medical Bid Contract Process

No.	PROCESS	RESPONSIBLE PARTY	PROCESS DESCRIPTION	ISSUES
16	OBS Manager Preliminary Review & Prepare Signature Letter	OBS	<ul style="list-style-type: none"> <li>Review contract for content, format and applicable exhibits</li> <li>Review contract against bid package documents to ensure accuracy and completeness; such as rates, contract term, funding amount and contractor information.</li> </ul>	<ul style="list-style-type: none"> <li>High turnover at management level impact the timely review and approval of contracts</li> <li>Lack of seasoned managers impact the training of new analysts due to limited contract processing knowledge</li> <li>Review and approval or contracts, and staff training are only provided by a small number of staff</li> <li>Staff vacancies in the support section impact timely mailing to contractors</li> </ul>
17	Mail Time To Contractor	CONTRACTOR	<ul style="list-style-type: none"> <li>IMCS mails bid package to Contractor for signature and required documents</li> </ul>	<ul style="list-style-type: none"> <li>Contractors request boilerplate language/rate changes after contract receipt</li> <li>Contractors incur difficulties obtaining required certificates, licenses and permits</li> </ul>
18	Contractor Signature & Required Documents	CONTRACTOR	<ul style="list-style-type: none"> <li>Contractor to obtain all necessary documents; and signs 4-sets in original signature (STD 213)</li> </ul>	
19	Mail Time From Contractor	CONTRACTOR	<ul style="list-style-type: none"> <li>Contractor mails bid package to IMCS</li> </ul>	
20	Review Package/ Documents; Request Missing Documents	OBS	<ul style="list-style-type: none"> <li>Review package for required certificates, licenses, permits; verify timeframes against contract term</li> <li>Four sets of signed contracts</li> </ul>	<ul style="list-style-type: none"> <li>Contractors return incomplete package or required signatures are in the wrong section of STD 213, or incorrect signing authority</li> <li>Required documents not received, or documents received are unacceptable due to missing language required for insurance, or incorrect dates</li> <li>ORIM may require additional insurance clarification</li> </ul>
21	ORIM Contract Approval	DGS	<ul style="list-style-type: none"> <li>Provide applicable documents, such as STD 213, 215; insurance documents and portions of Exhibit E pertaining to insurance requirements to ORIM for approval</li> </ul>	
22	RAO Encumbrance	RAO	<ul style="list-style-type: none"> <li>Provide STD 213, 215 and CAR to the Regional Accounting Office for signature approval</li> </ul>	
23	OBS Manager Approval	OBS	<ul style="list-style-type: none"> <li>Review contract for format and applicable exhibits</li> <li>Review contract against documents provided by contractor to ensure accuracy and completeness; such as dates of insurance policy, licenses, permits and certificates</li> <li>Verification of ORIM and RAO approval</li> </ul>	<ul style="list-style-type: none"> <li>High turnover at management level impact the timely review and approval of contracts</li> <li>Lack of seasoned managers impact the training of new analysts as new managers have limited contract process knowledge</li> <li>The review/approval/training are only provided by a small number of people</li> </ul>
24	DGS Approval (>\$75k)	DGS	<ul style="list-style-type: none"> <li>Forward contracts to DGS OLS for approval for contracts in excess of \$74,999 or hazardous</li> </ul>	<ul style="list-style-type: none"> <li>Receipt of approved contracts take between 2-3 weeks</li> </ul>
25	Distribution	OBS	<ul style="list-style-type: none"> <li>Update Access to reflect approval date of contract (OBS Manager or DGS OLS (if applicable))</li> <li>Copy approved contract and attached appropriate route slips for each location (Institution, RAO, Contractor, etc)</li> </ul>	<ul style="list-style-type: none"> <li>Staff vacancies in the support section impact timely distribution of approved contracts</li> </ul>

## Description of Contract Processes Formal Medical Bid Contract Process

### IMPACTS TO PROCESSING TIMEFRAMES:

#### Statewide:

Hiring Freeze (October 23, 2001 thru June 30, 2005). See below links to State of California Governor Executive Summaries (may require holding down the CTRL key when clicking on the link)

#### Executive Order S-3-03

[http://www.governor.ca.gov/state/govsite/gov\\_htmldisplay.jsp?BV\\_SessionID=@@&BV\\_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&sCatTitle=Exec+Order&FilePath=/govsite/executive\\_orders/20031119\\_S-3-03.html&Title=Executive+Order+S-3-03&OID=53560](http://www.governor.ca.gov/state/govsite/gov_htmldisplay.jsp?BV_SessionID=@@&BV_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&sCatTitle=Exec+Order&FilePath=/govsite/executive_orders/20031119_S-3-03.html&Title=Executive+Order+S-3-03&OID=53560)

#### Executive order D-71-03

[http://www.governor.ca.gov/state/govsite/gov\\_htmldisplay.jsp?BV\\_SessionID=@@&BV\\_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&sCatTitle=Previous+Administration%2fExec+Order&FilePath=/govsite/executive\\_orders/20030701\\_d\\_71\\_03\\_vacancyelimination.html&Title=Executive+Order+D-71-03&OID=51163](http://www.governor.ca.gov/state/govsite/gov_htmldisplay.jsp?BV_SessionID=@@&BV_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&sCatTitle=Previous+Administration%2fExec+Order&FilePath=/govsite/executive_orders/20030701_d_71_03_vacancyelimination.html&Title=Executive+Order+D-71-03&OID=51163)

#### Executive order D-70-03

[http://www.governor.ca.gov/state/govsite/gov\\_htmldisplay.jsp?BV\\_SessionID=@@&BV\\_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&sCatTitle=Previous+Administration%2fExec+Order&FilePath=/govsite/executive\\_orders/20030701\\_d\\_70\\_03\\_hiringfreeze.html&Title=Executive+Order+D-70-03&OID=51161](http://www.governor.ca.gov/state/govsite/gov_htmldisplay.jsp?BV_SessionID=@@&BV_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&sCatTitle=Previous+Administration%2fExec+Order&FilePath=/govsite/executive_orders/20030701_d_70_03_hiringfreeze.html&Title=Executive+Order+D-70-03&OID=51161)

#### Executive order D-48-01

[http://www.governor.ca.gov/state/govsite/gov\\_htmldisplay.jsp?BV\\_SessionID=@@&BV\\_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&OID=25639&Title=Executive+Order+D-48-01&FilePath=/govsite/executive\\_orders/20011023\\_D\\_48\\_01\\_hiring\\_freeze.html&Title=Previous+Administration/Exec+Order](http://www.governor.ca.gov/state/govsite/gov_htmldisplay.jsp?BV_SessionID=@@&BV_EngineID=ccciaddhmkldmkdcfngcfkmdffidng.0&OID=25639&Title=Executive+Order+D-48-01&FilePath=/govsite/executive_orders/20011023_D_48_01_hiring_freeze.html&Title=Previous+Administration/Exec+Order)

#### SPB:

Union Challenges

#### CDCR:

Reorganization of CDCR commencing (July 1, 2005; Refer to Exhibit A)

Staff Vacancy Rates (Refer to Exhibit B)

Potential relocation to DCHCS (Refer to Page 6, Section C.2.(a) of the Plata Court Order C01-1351 TEH Filed March 30, 2006)

Minimal Contract Process training at Institutions due to budget constraints (Statewide 2002; Southern Institutions 2005)

#### DGS:

Signing of exempt contracts halted June 2004

Release of MM 05-04 January 26, 2005. See below link to the Department of General Services Management Memo 05-04 (may require holding down the CTRL key when clicking on the link)

[http://www.documents.dgs.ca.gov/osp/sam/rmmemos/MM05\\_04.pdf](http://www.documents.dgs.ca.gov/osp/sam/rmmemos/MM05_04.pdf)

#### DCHCS:

DCHCS took over contract request processing June 29, 2004 through May 19, 2005 (Refer to Exhibit C)

Description of Formal Medical Bid Contract Process.doc

# EXHIBIT 2

Division of Correctional Health Care Services  
Effective Medical Services Contract Process  
Project Team Report  
Improved Contract Processes



Project Sponsor: Peter Farber-Szekrenyi, Dr. P.H.  
Project Director: Ted Rauh  
July 26, 2006

DCHCS is conducting a survey of other state and local correctional systems to find out how they manage their contracted health care services. As of the date of this Report, not all survey participants have provided information. For those State agencies that have, New York provides for all of its specialty services through non-bid contracts. New York does bid a few medical services such as dialysis and laboratory services. The State of Nevada utilizes Preferred Provider Organizations for its medical services. Once all the responses are received from survey participants, the Team will provide a summary of the survey results to the Receiver.

C. Current Contracting Processes

The Team presented flow charts and detailed step by step analysis for the current contract processes at the June 16, 2006 Receiver meeting. Table 5 summarizes the average time spent by each organization when processing a contract through one of the current contract processes. These processing times assume a smooth process with general agreement on the SOW, contract terms and rates. Negotiation time on any of these areas can increase the typical time to complete the process. An individual bid contract can take from approximately 4 ½ months to 7 ½ months if it is protested. Within this time CDCR utilizes 63 days to process contracts that are not protested. A statewide bid contract can take from approximately 6 ½ months to 10 months if is protested. Within this time CDCR utilizes 116 days to process contracts that are not protested. Exempt from bid contracts require approximately 6 ½ + months to process. Within this time CDCR utilizes 107 days to process contracts.

TABLE 5  
Summary of Time by Organization and Contract Process Type  
All figures in Business Days

CONTRACT PROCESS TYPE	RAO	INST.	OBS	OBS/DIV.	DIV.	CONT.	DGS	PROTESTS	TOTAL
Individual Bid	2	5	30	2	22	16	22	65	164
Statewide Bid	2	5	75	2	39	16	22	65	226
Exempt Individual	3	5	79	0	20	29	13	0	149
Exempt Statewide	3	5	79	0	20	29	13	0	149

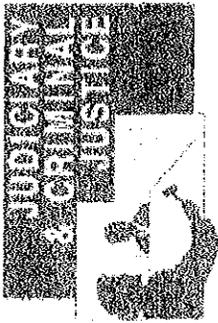
Process descriptions and detailed analysis of each contract process was provided to the Receiver as part of the June 16, Receiver meeting. This analysis included a review of each step – actions taken, reasons for them, and what can be done to reduce/eliminate the actions or the time they take. Key factors driving the times taken to complete each process include: staff vacancies, process inefficiency, lack of adequate staff training, complexity of work/decision processes, contractor delay resulting from failure to respond in a timely fashion at various times in the contract process, delay in the negotiation process due to failure to reach agreement on rates and/or SOW, contractor issues with standard terms, contract management deficiencies (e. g. Failure to identify contract needs until the need for services is urgent), bid – no-bid exemption decision process and, contract approvals delayed by management review levels.

#### D. Lessons Learned

As a result of the Team’s review of current practices 13 areas or “Lessons Learned” were identified. These areas of concern need to be addressed to ensure any changes to improve the health care contracting system are successful. The following briefly describes each area and identifies how and when it should be addressed.

1. Appropriate staffing levels for all contract processing and management functions – Upon acceptance of the proposed contracting system a workload and staffing level analysis should be performed to establish staffing levels.
2. Staff Training – Training for staff involved in the contract process is underway and will be updated once the decision on the new contracting process is made. Training for contract managers (primarily institution health care professionals) needs to be developed and implemented as soon as possible.
3. Dedicated support staff – As part of the workload analysis called for above an evaluation is needed to ensure institution contract managers have the support needed to carry out their responsibilities.
4. Responsibility for bid-non-bid health care contract decisions and contract approvals – a recommendation for legislative action to vest these authorities within DCHCS is made.
5. Increased delegation of contract responsibility to institutions – a recommendation for increased institution contract authority is contained in the recommendations for a new contract process.
6. Who should be responsible for master contracts – a recommendation for how master contracts should be managed is contained in the recommendations for a new contract process.
7. Eliminate the existing NTP process contract amendment workload – a recommendation to remove this workload and manage the fund balances of master agreements was made to the Receiver at the July 16, 2006 meeting and it was accepted. An implementation approach and plan are being developed.
8. IT will play an integral part in improving process efficiency – CDCR’s CIO is leading an effort to develop a contract information system that includes contract tracking, information depositories and system connectivity. The progress on this work effort is reported to the Receiver every two weeks.
9. Establish standard contract terms which cannot be deviated from in negotiations – An initial review of all of CDCR’s contract terms has been conducted and the documents have been substantially reduced in size and complexity. Some requirements will be placed in a document that contractors can refer to as needed. Boilerplate standard terms

# EXHIBIT 3



Legislative Analyst's Office

# Analysis of the 2003-04 Budget Bill

## Department of Corrections (5240)

The California Department of Corrections (CDC) is responsible for the incarceration, training, education, and care of adult felons and nonfelon narcotic addicts. It also supervises and treats parolees released to the community.

The department operates 33 institutions, including a central medical facility, a treatment center for narcotic addicts under civil commitment, and a substance abuse treatment facility for incarcerated felons. The CDC system also operates 11 reception centers to process newly committed prisoners; 16 community correctional facilities; 38 fire and conservation camps; the Richard A. McGee Correctional Training Center; 32 community reentry programs; a restitution and a drug treatment program; 136 parole offices; and 4 outpatient psychiatric services clinics.

### Budget Proposal

The budget proposes total expenditures of \$5.3 billion for CDC in 2003-04. This is \$40.2 million, or about 0.8 percent, above the revised estimate for current-year expenditures. The primary causes of this increase are a projected rise in the inmate population and a proposed increase in funding for worker compensation expenses.

**General Fund Expenditures.** Proposed General Fund expenditures for the budget year total \$5.1 billion, an increase of \$53.1 million, or 1 percent, above the revised current-year estimate.

**Federal Fund Expenditures.** The Governor's budget assumes that the state will receive about \$154.5 million from the federal government during 2003-04 as partial reimbursement of CDC's costs (estimated to be \$556 million in the budget year) for incarcerating inmates in prison and supervising felons on parole who are illegally in the United States and have committed crimes in California. The federal funds are not included in CDC's budget display, but instead are scheduled as "offsets" to its total state General Fund expenditures.

## Overview of the Inmate Population

Who Is in Prison?

## Caseload May Require Further Adjustment

**We withhold recommendation on the 2003-04 budget request for caseload funding. Recent data indicate that the population is trending slightly lower than the department's projections. As a result, inmate population may be slightly overstated in the current and budget years. We will continue to monitor the caseload and recommend further changes, if necessary, following review of the May Revision.**

**Actual Inmate Count Is Slightly Lower Than Fall Projection.** The fall 2002 projection anticipated that the prison population would increase by about 1,800 inmates during the first half of 2002-03 relative to the prior year. Instead, it increased by about 1,500. According to the CDC, this lower than anticipated population increase is attributable to a lower than anticipated number of parolees returned to custody, and more inmate releases from conservation camps due to the recently implemented doubling of work credits pursuant to Chapter 1124, Statutes of 2002 (AB 3000, Committee on Budget).

**Current-Year Effect.** Based on the inmate population as of the end of December 2002, we estimate that the average daily population of the prison system in 2002-03 will be about 630 inmates below the caseload assumed in the Governor's budget plan. We further estimate that the average daily parole population will be about 624 parolees lower than the caseload assumed in the Governor's budget plan. The net effect of these two changes would be a decrease in current-year costs of about \$8.7 million.

**Budget-Year Effect.** The CDC forecast assumes that inmate population will increase by 378 between the current and budget years. Although the recent data suggest inmate population may be stable in the budget year, there is uncertainty as to how much Proposition 36 diversions will be affected by recently adopted CDC/BPT referral procedures for moving parolees into county drug assessment centers. Furthermore, at this time, we are unable to gauge the effect that increased work credits for conservation camp inmates is likely to have on average daily population.

The CDC will issue updated population projections in spring 2003 that form the basis of the department's May Revision proposal. At that time, we will review whether adjustments to CDC's funding for inmate and parole caseloads are warranted.

**Analyst's Recommendation.** We withhold recommendation on the 2003-04 caseload funding request. We will continue to monitor CDC population, and make recommendations as appropriate at the time of the May Revision.

## Early Release of Elderly Inmates

**The California Department of Corrections currently has approximately 6,400 inmates over the age of 55. Elderly inmates are costly to care for, yet research indicates that many of these older inmates represent a relatively low risk of reoffending and show high rates of parole success. Given the state's current fiscal condition, we believe the Legislature should adopt budget trailer bill language requiring early discharge to parole for nonviolent older inmates. We estimate that such a policy would result in state savings of approximately \$9 million in the budget year, and significantly more in the out-years without jeopardizing public safety. (Reduce Item 5240-001-0001 by \$9 million.)**

**Background.** Inmates 55 years of age and older are becoming a larger part of the CDC's institutional population. Currently, approximately

3,509 inmates are between age 55 and age 59, 1,621 inmates are between age 60 and 64 years of age, and 1,267 inmates are 65 years or older. Because older inmates tend to have more significant medical problems, the graying of CDC's population has serious long- and short-term General Fund implications. Last year, we discussed releasing nonviolent, elderly inmates to parole as one of the Legislature's options for addressing the state's fiscal problem. This analysis provides additional information on the cost of housing older inmates in California prisons, and discusses research related to elderly inmates and their likelihood to reoffend.

**Elderly Inmates Two to Three Times More Expensive.** While CDC agrees that housing elderly inmates in California prisons is more costly than housing younger prisoners, it could not provide specific information on how much it costs to house elderly inmates. This is because the department does not collect data on this specific group of inmates. However, our review of correctional operations in other states, as well as other research on this topic, indicates that elderly inmates cost as much as two to three times the amount required to house younger inmates. New York, for example, estimates an average annual cost to house elderly inmates of \$50,000 to \$75,000, which was twice that state's average for a younger prisoner. Although no figures were available, in 1997, the Texas Criminal Justice Policy Council concluded that Texas paid nearly three times as much to provide health care to elderly inmates as it paid for the general prison population. Finally, the National Center of Institutions and Alternatives estimates the national average yearly cost of confining elderly inmates is approximately \$69,000, over three times the national average of \$22,000 to incarcerate ordinary inmates.

**Why Are Elderly Inmates Expensive?** As one might expect, the higher cost of housing elderly inmates is driven by the special needs brought about by age, similar to the needs of many aging adults in society. These special needs range from the need for eye glasses and hearing aids to the need to address more frequent health care episodes, and treatment for chronic disease and fatal illness. Elderly inmates also require special facilities accommodations, such as special commodes and showers with handrails. Many elderly inmates will ultimately require constant bed care and intensive medical supervision.

In addition to the special needs that generally come with aging, there are some unique factors about prison that make housing elderly inmates potentially more costly. First, inmate demographics and prior life styles probably result in a concentration of individuals more prone to certain health conditions such as diabetes, heart disease, and hepatitis. Second, the full cost of prison health care services is borne by the state, rather than shared as in an insurance program. Third, the cost of prison health care services is accompanied by the cost of guarding the inmate while services are delivered. This is particularly an issue when the inmates need to be transported to an outside facility for medical treatment. Fourth, CDC is not equipped to effectively manage the health care needs of elderly inmates. For example, the department does not have a chronic care management program for elderly inmates that might allow it to prevent some inmates from requiring expensive medical treatment.

**Are California Prisons Equipped to Handle Elderly Inmates?** Nationwide, most correctional institutions are poorly positioned to cope with the health and housing needs of aging and geriatric prisoners. For example, California, like most other states, generally does not have facilities specifically designed or operated to meet the needs of elderly inmates. Moreover, California, like other states, relies on a sick-call system originally conceived to treat common illnesses like flu, wherein correctional officers who, except for medical technical assistants (MTAs), typically have little or no medical training, are generally the first to take note of an aging inmate's medical problems. Then, doctors and nurses—many with little training or experience in treating age-related illness—must handle dozens of these and other cases with very limited time per patient.

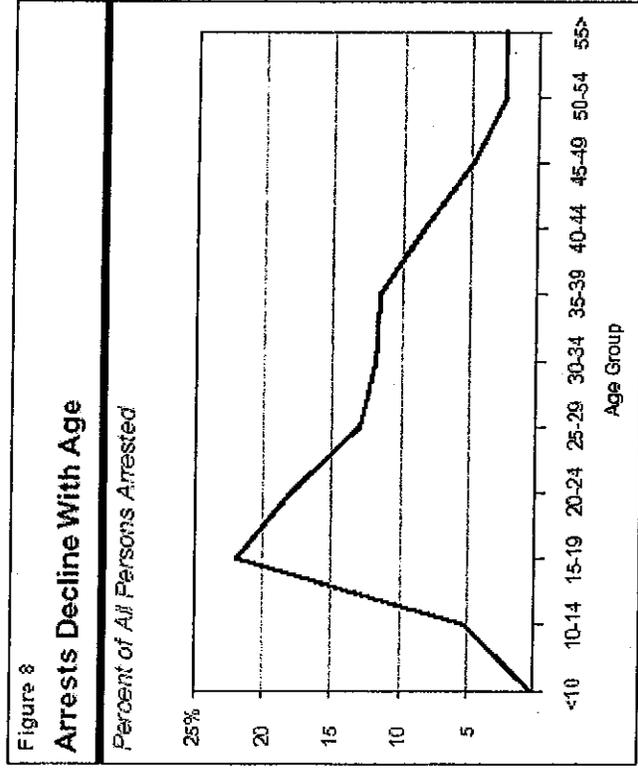
Another problem for California is it, like most other states and the Federal Bureau of Prisons, has no official inmate classification based on age. From a budgetary perspective, the classification system's failure to track prisoners by age precludes the kind of analysis that would flag spikes in the costs to care for elderly inmates or suggest alternative management strategies such as relocation to reduce transportation costs

or dedicated housing to take advantage of economies of scale.

By 2022, we estimate the elderly inmate population will be approximately 30,200, or 16 percent of the total CDC population. Preparing California's prison system for this number of elderly inmates will likely be extremely costly. This is because, it would likely involve facility renovations, as well as a change in the manner in which health care is delivered, and potentially expensive treatments for such age-related illnesses as cancer and heart disease.

**Criminal Behavior Declines With Age.** Criminologists have long known that the propensity to commit crimes declines with age regardless of sex, race, ethnicity, or offense. Figure 8 shows that nationwide, arrests in 1999 peaked between the ages of 15 to 25, dropped dramatically for offenders 25 to 40, and were fewer than 5 percent among individuals 50 years of age and older. If reducing crime is the goal, the data suggest that imprisoning a 55-year old will have much less of an effect than imprisoning a 20-year old.

Perhaps the most important consideration related to early release of an elderly inmate is the possibility that he or she will commit additional crimes in the future. According to one federal study, 45 percent of inmates released from prison between the ages of 18 and 49 were likely to commit another crime and end up back in prison. By comparison, only 3.2 percent of those released over the age of 55 got in trouble with the law. In addition, a 1995 U.S. Department of Justice study tracked a cohort of parolees released in 1991. As Figure 9 shows, the study found that recidivism varies sharply by age group. In particular, this study indicated that older parolees are reincarcerated very infrequently, as only 1.4 percent of parolees 55 years and older recidivated.



# EXHIBIT 4

**CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION  
OFFICE OF THE RECEIVER**

**REQUEST FOR QUALIFICATIONS  
FOR PROGRAM MANAGEMENT SERVICES FOR  
THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION  
ADULT PRISON FACILITIES**

**January 24, 2007**

**Statements of Qualifications DUE: 2:00 p.m. February 16, 2007**

**CONTACT: JARED GOLDMAN, STAFF ATTORNEY  
1731 Technology Drive, Suite 700  
San Jose, CA 95110  
jared.goldman@cprinc.org**

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## **I. REQUEST**

The Receiver of the California Department of Corrections and Rehabilitation's ("CDCR") prison medical system is requesting Statements of Qualification for Program Management Services. The selected Program Manager ("PM") will be engaged to advise and consult with the Receiver and to provide capital facilities development expertise for the renovation of existing facilities and the design, construction, and commissioning of new facilities. The awarded contract will be a service agreement with the Receiver through the California Prison Health Care Receivership Corporation ("CPR").

## **II. BACKGROUND**

As a result of the State of California's ongoing failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California has established a Receivership to assume the executive management of the California prison medical system and raise the level of care up to constitutional standards. On February 14, 2006, the Court appointed Robert Sillen to serve as the Receiver and granted him, among other powers, the authority to exercise all powers vested by law in the Secretary of the CDCR as they relate to the administration, control, management, operation, and financing of the California prison medical health care system.

The Court's actions stem from the case of *Plata v. Schwarzenegger* -- a class action law suit brought on behalf of the CDCR's adult inmates. Applicants should refer to the Court's October 3, 2005 "Findings of Fact and Conclusions of Law Re Appointment of Receiver" and the Court's February 14, 2006 "Order Appointing Receiver" for further information regarding the conditions underlying the Receivership and the powers and responsibilities of the Receiver. These and other relevant documents can be found on CPR's website at: <http://www.cprinc.org/materials.htm>.

While the problems identified by the Court and the Receiver reach into almost every element of the medical care system, it is without question that the physical facilities currently in operation at CDCR's prison sites are inadequate to meet the needs of the confined adult population. See Findings of Fact at p. 21-22. CPR has no facilities development infrastructure — neither staff nor systems nor expertise. The PM will be expected to provide appropriate systems and expertise, and to act as the Receiver's trusted advisor in putting systems in place, hiring other professional consultants, and accomplishing the goals of the program in the most expeditious and cost-effective manner.

### **III. ANTICIPATED SCOPE OF SERVICES**

#### **A. General Scope of Services**

The Receiver anticipates that among other needed improvements, the program will require design and construction of multiple sub-acute care housing units at CDCR facilities located throughout the state. Preliminary estimates suggest that the number of beds could be in the range of 5,000 to 10,000. It is anticipated that these would be spread at multiple facilities, with no single location having more than 1,500 new beds constructed. The Receiver's timeline goal -- from concept through completion -- is three years. Note that OSHPD will not be involved in the approval of these facilities.

This new construction is in addition to renovation or reconstruction of other non-housing components of the CDCR medical health care system. Absent in-house staff or expertise, the Receiver requires a broad range of overall professional management and technical assistance in implementing these improvements in the most timely and cost-effective manner.

The Receiver has been appointed by the Court to undertake all activities related to medical care that would otherwise be in the purview of the Director of CDCR. In addition, the Receiver has, among other powers, the power to acquire, dispose of, modernize and repair property as necessary to fulfill his duties. The Receiver and CDCR have not yet finalized a plan for direct management and oversight of design and construction of the anticipated capital improvements. It is at the Receiver's discretion how to engage CDCR resources in this effort. It is anticipated that the selected PM would assist the Receiver and the other engaged professionals in developing a plan for dividing responsibilities among internal and external CDCR resources as appropriate, the PM, and the architectural/engineering/construction professionals that will be selected separately. It is not the Receiver's intention that the PM would provide design, construction, or construction management services.

The overall mission of the PM is to act as a management resource to CPR and to provide broad coordination of the full range of technical resources and management processes necessary to identify and implement the planned capital improvements. The PM will be responsible for assisting the Receiver and other directly engaged professionals in quantifying the capital resource needs and providing overall management of the Receiver's Facilities Improvement Program. Since the Receiver has no existing standards, policies and procedures for the design and implementation of capital projects, it is anticipated that the PM will be responsible for facilitating the development of appropriate standards, policies and procedures.

The nature of the individual improvements, and the delivery and procurement methods may vary significantly among and within the CDCR locations and facilities throughout the state. Therefore, the Receiver requires a PM with statewide reach that is highly flexible, knowledgeable, experienced, responsive, able to anticipate changing needs, and is comfortable with innovative project delivery practices.

***It is the Receiver's intention that its engaged professionals be independent from any staff or consultants that may be engaged directly by CDCR or any other State department or agency in connection with the same program scope. This is to ensure that the PM and other professionals will provide the Receiver independent direction and oversight concerning all aspects of the assessment, design, development, construction, and commissioning processes.***

#### **B. Detailed Scope of Services**

**The PM shall be prepared to provide the following core services at the request of the Receiver:**

- 1. Program Management.** Provide overall management support for the anticipated capital programs at CDCR's health care facilities, serving to advance and expedite capital programs and projects, assess and balance diverse stakeholder requirements, and assist as requested in resolving issues among other consultant resources and with CDCR and its separate representatives.
- 2. Management Policies and Procedures.** In conjunction with the Receiver's staff and consultants, facilitate and assist in developing, documenting and disseminating policies and procedures to ensure the safe, cost-effective and coordinated implementation of capital projects and programs, with due consideration of cost and schedule controls, design standards, operational requirements and construction safety, and conformity with environmental and financial requirements. Assist in exploring potential division of responsibilities between and among Receiver and his staff and consultant resources and CDCR and its staff and consultant resources.
- 3. Project Technical Liaison.** At the discretion of the Receiver, certain projects or project components may be undertaken by others (i.e., directly by CDCR or other agencies). On these projects, the PM may be required to provide technical liaison and oversight services on behalf of the Receiver, to identify issues related to operational, financial, contractual or other concerns, and advise the Receiver regarding technical or other solutions.

4. **Document Management.** Facilitate the implementation of a comprehensive document management system, including computer-indexed storage and retrieval capabilities for all internal and external, design and construction-related documents, to be used by all program management, construction management, design and other consultant resources. Facilitate transition of documents to CDCR operation and maintenance staff.
5. **Program Controls.** Develop a systematic approach to tracking critical program and project issues to ensure schedule and budgetary control. Synthesize and evaluate data and analyses prepared by others to identify issues and areas of potential conflict. Review design, procurement, and construction schedules, budgets, and cashflow analyses prepared by others, for internal consistency, logic, technical and financial viability. Identify recommended financial commitments with sufficient notice for Receiver and CDCR approval, as required.
6. **Program Progress Reporting.** Prepare periodic program-level reports for internal management and stakeholder communications, including reports to the Court. Work with other consultants to secure and synthesize necessary information. Provide data, graphics and other materials as required for internal, external and public presentations.
7. **Construction Claims Prevention and Management.** As part of program oversight function, ensure that on-going practice identifies areas of inadequate or ambiguous design information that could lead to construction claims or delays if unresolved. Develop and implement systematic approach(es) to ensure that design integrates cost, quality, schedule, constructability and value analysis as design criteria.
8. **Management Information Systems (MIS) Support.** Provide technical resources as required to support development and deployment of internal program management as well as other MIS requirements consistent with overall program and project delivery needs.
9. **Conferences and Research:** The PM may be required to conduct field research, site visits to other major capital programs, attend technical conferences or other industry functions with representatives of the Receiver and other agencies as may be required in connection with their services.

**At the request of the receiver, the PM may also be asked to assist in the following services:**

10. **Facilities Assessment.** Assist receiver in developing a scope of work and engaging appropriate professionals to conduct an existing facilities audit to determine and document the quantity and quality of existing

facilities currently in use to provide health care services at CDCR locations. Assist in evaluating the accuracy of existing assessments, together with any as-built drawing or other information furnished by CDCR. Provide required assistance to other professionals engaged by the Receiver in conducting the audit and developing appropriate evaluation, analysis, and reporting tools.

11. **Program Definition and Capital Programming.** Provide technical and coordination support to Receiver and other engaged professionals in reviewing facilities assessments and defining capital programs, program phasing, and the sequencing/prioritization of capital projects, drawing upon input from the full range of planning, environmental, financial and operational/user groups. Assist with strategic planning, prioritization of work, financial implications and related issues.
12. **Project Delivery Methodology.** Assist CPR and other consultants in developing project delivery strategy and comparative assessments regarding the optimal means of implementing that strategy on individual projects. Assist as needed in developing and issuing Requests for Qualifications/Proposal for various professional, design and construction related services.
13. **Design Management.** Assist CPR in liaison, coordination, and monitoring support over assigned architectural and engineering consultants retained by the Receiver. PM may be asked to assist in validating and coordinating design work scopes and establishing comprehensive policies and procedures for the use of technology, including BIM, to assist in integrated project delivery and technical coordination. PM may assist in developing design protocols and BIM standards for assigned projects and programs.
14. **Project Management.** Assist CPR in procuring project management services as appropriate to the chosen delivery methods. This may include a combination of PM staff, other consultant staff, CPR in-house staff, and CDCR in-house staff and consultants.
15. **Program Budgeting.** Assist CPR and other consultants in developing conceptual program- and project-level budgets.
16. **Cost Control.** PM may be expected to help identify opportunities for capital, project implementation and life-cycle cost reduction and/or deferral. PM may be asked to facilitate policy and technical decisions by either preparing or directing the preparation of comprehensive decision analyses, identifying and weighting evaluation criteria against project objectives and operational requirements.

**At the request of the receiver, the PM may be asked to assist in procurement and general management oversight of independently engaged consultants to provide the following services, which are specifically excluded from the PM scope of services:**

**Capital Cost Estimating.** Includes conceptual-level cost estimates, sensitivity analyses or check estimates, either based on cost data provided by others or independent cost estimating by consultant. The PM may also review conflicting cost estimates and facilitate reconciliation when necessary.

**Capital Finance Support.** Includes developing program- and project-level budget tracking systems to control all budgeted, committed and actual expenditures, as well as providing projecting project- and program-level cash flow requirements tied to key schedule milestones. Consultant will provide capital cost accounting support by developing, maintaining, and updating capital cost accounting systems, generating reports and analyses, and tracking the availability of funding sources relative to expenditures and commitments. Consultant will support the Receiver in preparation of disbursement requisitions.

**C. Organization and Direction**

The PM will work at the direction of the Receiver or the Receiver's designee. All work of PM's staff will be at the day-to-day direction of a Program Executive or Program Director designated by PM.

**D. Time Frame**

The Receiver intends to enter into a professional services agreement ("the Agreement") with the selected PM promptly upon selection. Prior to commencing the Services, the PM must sign and return the Agreement and provide proof of insurance. The initial engagement is anticipated to be for a period of not more than 90 days. During this period it is anticipated that, in consultation with the Receiver, the PM will 1) develop a scope of work and estimated fee for its services, 2) assist CPR in initiating the existing facility audit, 3) beginning work on management policies and procedures, 4) assist CPR in engaging other consultants, and 5) developing a detailed workplan for the PM services.

Following the initial short term engagement, the Receiver may in his sole discretion enter into a contract with the PM for a duration up to the length of the capital facilities development program. The PM will be expected to commit its personnel for the duration of the contract unless specifically excused at the sole discretion of the Receiver.

#### **IV. DELIVERABLES**

The deliverables required will be stipulated in conjunction with the approved work plan and associated staffing plans and schedules.

**ALL DELIVERABLES CREATED BY PM UNDER THE AGREEMENT, WHETHER OR NOT IDENTIFIED AS CONTRACTUAL DELIVERABLES, WILL BE THE PROPERTY OF THE RECEIVER.**

#### **V. SELECTION PROCESS**

An Evaluation Committee (the "Committee") will review the submitted Statements of Qualification in accordance with submittal requirements and evaluation criteria set forth below and will recommend to the Receiver a short list of firms for further consideration. Upon acceptance of the short list, the Receiver may invite short-listed firms to make oral presentations to the Committee.

If the Receiver elects to conduct oral interviews, the entire proposed Key Staff of any short-listed teams must be available to participate in these interviews. The Committee will then make a final evaluation and submit its recommendation to the Receiver. The Receiver will make a final determination and authorize negotiations with one or more of the firms that have submitted their qualifications and whose responses are most advantageous to the Receiver.

The Receiver reserves the right to seek clarification of information submitted in response to this RFQ and/or request additional information during the evaluation process. The Receiver reserves the right to accept or reject any or all qualifications and selections when it is determined, in the sole discretion of the Receiver, to be in the best interest of the Receiver.

#### **VI. EVALUATION CRITERIA**

The Committee will review the qualifications in accordance with the following criteria:

- A.** Respondent's proven experience, capabilities and resources, at both the corporate and individual levels, in independent, professional program management services for major capital programs in the United States comparable in size, scope of work, and urgency.
- B.** Qualifications, availability and commitment of key staff. Respondents shall clearly identify the key staff that will perform each of the above-described

areas of scope, what role each is anticipated to fulfill in connection with the Program, and what percentage of their time will be devoted exclusively to this Program.

- C. Demonstrated experience, professional and technical competence and organizational structure designed to advance major programs and individual project components in an expedited, streamlined environment, with major overlaps between planning, design, environmental and funding processes.
- D. Proven systems, management techniques, required expertise and resources designed to facilitate timely and effective decision-making and stakeholder coordination.
- E. Demonstrated ability and experience of the proposed team leadership to secure cooperation and timely progress from consultants and client personnel without having direct contractual or organizational authority over them.
- F. Completeness and comprehensiveness of response to this RFQ and compliance with the submittal requirements
- G. Quality of oral interviews including technical analysis and presentation (if requested by the Receiver).
- H. Legal actions that might affect Respondent's ability to perform as contracted.
- I. Absence of any relationship that could constitute a conflict of interest or otherwise impede the ability of the PM to protect the interests of the Receiver.

## VII. SUBMITTAL REQUIREMENTS

### A. RFQ Schedule

Event	Date
RFQ Issued	January 24, 2007
Deadline for questions regarding RFQ	February 2, 2007
Responses to questions	February 9, 2007
Statements of Qualifications due	February 16, 2007
Notification for interviews	February 27, 2007
Interviews	Week of March 5, 2007
Selection announced	March 12, 2007 (estimated)
Estimated project start date	March 26, 2007

**B. Addenda**

Any questions regarding the RFQ should be submitted to CPR in writing. CPR will, at its discretion, respond to questions in an addendum. Any necessary information not included in this RFQ that CPR deems necessary and relevant to responding to the RFQ will also be issued in an addendum. CPR makes no guarantee that all questions submitted will be answered.

Addenda will be sent to all known applicants. If the Respondent did not receive this RFQ directly from CPR, notify CPR in writing of a request to receive any addenda by February 2, 2007.

**C. Format**

The Statement of Qualifications (SOQ) should be clear, concise, complete, well organized and demonstrate both respondent's qualifications and its ability to follow instructions.

8 (eight) bound copies of the SOQ should be provided, with all materials spiral bound into books of approximately 8-1/2" x 11" format, not to exceed forty (40) single-sided pages total length. At least one (1) copy must contain original signatures and be marked ORIGINAL.

Pages must be numbered. We will not count, in the total, the graphic cover sheet, cover letter, table of contents, blank section dividers (tabs), explanations about legal actions, and a maximum of 12 resumes, which may be included in an appendix. The entire SOQ shall also be submitted in electronic (pdf) format on CD, organized in the same manner as the printed submissions.

The SOQ shall be placed in a sealed envelope with the submitting firm's name on the outside of the envelope.

All respondents are requested to follow the order and format specified below. Please tab each section of the submittal to correspond to the numbers/headers shown below.

Respondents are advised to adhere to submittal requirements. Failure to comply with the instructions of this RFQ may be cause for rejection of submittals.

The Receiver reserves the right to waive any informalities in any submittal and/or to reject any or all submittals. The Receiver reserves the right to seek clarification of information submitted in response to this RFQ during the evaluation and selection process. The Committee may solicit relevant information concerning the firm's record of past performance from previous clients or consultants who have worked with the Respondent.

## **D. Contents**

The SOQ must include the following items:

1. A cover letter signed by an officer of the firm submitting the SOQ, or signed by another person with authority to act on behalf of and bind the firm. The cover letter must contain a commitment to provide the required Services described with the personnel specified in the qualification submission. The letter should certify that the information contained in the SOQ is true and correct. Please also indicate the contact person(s) for the selection process along with contact information.
2. **Executive Summary:** The Executive Summary must include a clear description of the primary advantages of contracting with your organization. It should also include a brief explanation of how the Respondent satisfies the evaluation criteria, and a brief statement that demonstrates Respondent's understanding of the desired Services.
3. **Demonstration of the Respondent's Qualifications:** Please provide the following information:
  - a) Your company's name, business address and telephone numbers, including headquarters and local offices.
  - b) A brief description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.
  - c) A description of your company's prior experience related to correctional and healthcare facilities.
  - d) A description of your company's prior experience in California.
  - e) A description of your company's specific areas of technical expertise as they relate to this RFQ.
  - f) A description of your company's project control/management information systems as they relate to this RFQ.
  - g) A description of your company's internal training and quality assurance programs.
4. **Professional references:** Describe previous program management services on no more than three programs of comparable scope and magnitude for which you provided similar types of PM services. Provide complete reference information including project name, location, client, total contract amount (and firm's amount if different), principal-in-charge,

day-to-day technical project director/manager, key staff, date completed, client reference (name, current position and phone number), and a brief narrative of project description for each project identified and described above. **Experience may not be considered if complete reference data is not provided or if named client contact is unavailable or unwilling to share required information.**

5. **Qualifications of Technical Personnel:** Submit current resumes for Key Personnel committed to this Program and a statement regarding their local availability, given the state-wide nature of the Program. Specifically describe previous related experience, its pertinence to this program, and provide references including the name, address and telephone number of a contact person who can verify the information provided. Provide brief description of referenced project(s), as well as any professional certifications, accreditation, special licensing or other qualifications which qualifies the professional to perform in their designated area of responsibility.
6. **Legal action:** Respondent must provide a listing and a brief description of all material legal actions, together with any fines and penalties, for the past five (5) years in which (i) Respondent or any division, subsidiary or parent company of Respondent, or (ii) any member, partner, etc., of Respondent if Respondent is a business entity other than a corporation, has been:
  - a) A debtor in bankruptcy;
  - b) A defendant in a legal action alleging deficient performance under a services contract or in violation of any statute related to professional standards or performance;
  - c) A respondent in an administrative action for deficient performance on a project or in violation of a statute related to professional standards or performance;
  - d) A defendant in any criminal action;
  - e) A principal of a performance or payment bond for which the surety has provided performance or compensation to an obligee of the bond; or
  - f) A defendant or respondent in a governmental inquiry or action regarding accuracy of preparation of financial statements or disclosure documents.
7. **Default Termination:** A disclosure of whether your company has defaulted in its performance on a contract in the last five years, which has led to the termination of a contract

8. **Conflict of Interest:** Identify any existing relationships with CDCR, and explain why those relationships will not constitute a real or perceived conflict of interest.

**E. Confidentiality**

Responses to this RFQ become the exclusive property of the Receiver. Statements of Qualifications (SOQ) will be opened privately to assure confidentiality and avoid disclosure of the contents to competing respondents prior to and during the review, evaluation, and negotiation processes.

Protection from disclosure generally applies to those elements in each submittal which are marked "Trade Secret", "Confidential", or "Proprietary." During the course of the SOQ evaluation and selection process or the course of the Program, the Receiver will accept materials clearly and prominently labeled "Trade Secret", "Confidential" or "Proprietary" by the Respondent or other submitting party. The Receiver will not advise as to the nature of the content of the documents entitled to protection from disclosure, or as to the definition of trade secret, confidential or proprietary information. The Respondent or other submitting party is solely responsible for all such determinations made by it, and for clearly and prominently marking each and every page or sheet of materials with "Trade Secret", "Confidential" or "Proprietary" as it determines to be appropriate.

**F. Modification or Withdrawal of SOQ.**

Prior to the SOQ due date, applicants may modify or withdraw a submitted SOQ. Such modifications or withdrawals must be submitted to CPR in writing. Any modification must be clearly identified as such and must be submitted in the same manner as the original (e.g., appropriate copies, paper size, etc.). No modifications or withdrawals will be allowed after the SOQ due date.

**G. Public Opening**

There will be no public opening of responses to this RFQ. However, after a contract is awarded, and subject to the confidentiality provisions described above, all SOQ's may be available for public review. CPR makes no guarantee that any or all of a SOQ will be kept confidential, even if the SOQ is marked "confidential," "proprietary," etc.

**H. General Rules**

1. Only one SOQ will be accepted from any one person, partnership, corporation or other entity.
2. SOQ's received after the deadline will not be considered.

3. This is an RFQ, not a work order. All costs associated with a response to this RFQ, or negotiating a contract, shall be borne by the applicant.
4. CPR's failure to address errors or omissions in the SOQ's shall not constitute a waiver of any requirement of this RFQ.

#### **I. Reservation of Rights**

CPR reserves the right to do the following at any time, at CPR's discretion:

1. Reject any and all SOQ's, or cancel this RFQ.
2. Waive or correct any minor or inadvertent defect, irregularity or technical error in any SOQ.
3. Request that certain or all candidates supplement or modify all or certain aspects of their respective SOQ's or other materials submitted.
4. Procure any services specified in this RFQ by other means.
5. Modify the specifications or requirements for services in this RFQ, or the contents or format of the SOQ's prior to the due date.
6. Extend the deadlines specified in this RFQ, including the deadline for accepting SOQ's.
7. Negotiate with any or none of the candidates.
8. Terminate negotiations with an applicant without liability, and negotiate with other applicants.
9. Award a contract to any applicant.

**Inquiries in regard to this RFQ should be addressed to:**

Jared Goldman, Staff Attorney  
California Prison Health Care Receivership Corp.  
1731 Technology Drive, Suite 700  
San Jose, CA 95110  
-or-  
jared.goldman@cprinc.org

# EXHIBIT 5

BEFORE THE  
PUBLIC EMPLOYMENT RELATIONS BOARD

In the Matter of:	)	
UNION OF AMERICAN PHYSICIANS & DENTISTS,	)	Case Number: SF-CE-228-S
Charging Party,	)	
v.	)	
STATE OF CALIFORNIA (DEPT. OF CORRECTIONS),	)	
Respondent.	)	

VOLUME II

SEPTEMBER 29, 2005

FRED D'ORAZIO

Administrative Law Judge

PUBLIC EMPLOYMENT RELATIONS BOARD

1031 18th Street

Sacramento, California

Official Transcriber: Karin R. Lewis

1 ADMINISTRATIVE LAW JUDGE D'ORAZIO: Okay. Please  
2 state your name and spell it for us.

3 THE WITNESS: Joe Goldenson, G-O-L-D-E-N-S-O-N.

4 ADMINISTRATIVE LAW JUDGE D'ORAZIO: Okay.

5 DIRECT EXAMINATION

6 BY MR. STRACENER:

7 Q All right. Dr. Goldenson, could you please inform  
8 us of your educational background?

9 A Yes. I graduated from Mt. Sinai School of Medicine  
10 and did a residency in Family Medicine at UC San Francisco.

11 Q And you were appointed as one of the experts in the  
12 Plata case?

13 A Correct.

14 Q Okay. What is your current position?

15 A My current position?

16 Q Right.

17 A In Plata or in general?

18 Q No, no, in general, I meant.

19 A I'm the Director and Medical Director for the Jail  
20 Health Services in San Francisco. I work for the County  
21 Health Department and we're responsible for providing all of  
22 the medical and mental health services to prisoners in the San  
23 Francisco County Jail.

24 Q Okay. And how long have you had that position?

25 A I've been working for about 18 years and I've had  
26 the position of Director, Medical Director for 14 or 15 years.

27 Q Now, as the -- as one of the experts to the court in  
28 the Plata litigation, could you -- could you just explain the

1 nature of your role with respect to the litigation?

2 A We were appointed by the court after the settlement  
3 had been reached, so we weren't part of any of the legal  
4 proceedings that led to the settlement. And then once there  
5 was a settlement, we were appointed as the court experts and  
6 our role evolved over time.

7 Initially, we were going to be going out to the  
8 facilities, checking on the progress of the remedial plan, but  
9 our most important task was going to be once CDC said that  
10 they had reached compliance in certain facilities, we would go  
11 out and verify that.

12 As, very early on, it became clear that things were  
13 even worse than initially suspected so that our role  
14 increased. And we became, the court asked us to become more  
15 involved in both assessing the situation of the different  
16 facilities and working with the state to come up with ways to  
17 address those problems.

18 Q Now, after the -- I mean, , I take that back. The  
19 experts were appointed in 2002, correct?

20 A I think it was 2002.

21 Q Okay. You said that there was a situation in which  
22 CDC was to report back when it had come into compliance. Did  
23 it ever report back that it had come into compliance?

24 A You know, the process was there were these QMAT  
25 audits that had already been described by Dr. Kanan. And once  
26 a facility reached a compliance level of 85 percent with all  
27 of the different indicators that were part of the QMAT audits,  
28 then we would go in and verify that the facility had indeed

1 that was being provided.

2 Q With respect to the second part of your answer in  
3 going out to the facilities yourselves, could you just  
4 generally tell us what you found?

5 A We found a medical system that was totally broken in  
6 almost every aspect. The policies and procedures were not in  
7 effect. There were problems with the laboratory. There was a  
8 problem with x-rays. There was a problem with medical  
9 records, problems with nursing care and problems with the  
10 physician care. Basically, as I said, it was pretty much  
11 totally broken.

12 Q With respect to the physician care, what were the  
13 types of problems you found?

14 A We found numerous episodes where the care was  
15 substandard. Where there was lack of supervision. Where  
16 there were physicians seeing patients who didn't have the  
17 appropriate credentials to be seeing the kind of patients that  
18 they were seeing. That there were just a lot -- just with the  
19 care in general being provided by the physicians was below the  
20 standard of care.

21 Q The standard of care being defined as the community  
22 of CDC or otherwise?

23 A When we use the term standard of care, it's  
24 generally, well, basically, a constitutional level where we  
25 look at the community standard of care as a basis, but  
26 basically, it's a constitutional level that serious medical  
27 problems are being addressed appropriately.

28 Q Did you ever have occasion to look at the Peer

1 Review system used by CDC at the institutional level?

2 A Yes, we did.

3 Q Did you find it adequate?

4 A No, it was not adequate.

5 Q In what manner was it not adequate?

6 A Well, basically, the way Peer Review functions is  
7 that you have qualified physicians reviewing the work of their  
8 peers. And in this system, where at each facility that we  
9 visited, you had physicians who weren't competent reviewing  
10 the work of other physicians who were working at that  
11 facility.

12 In addition, we felt that we -- there was a, sort of  
13 a -- this idea of you take care of your friends and that any  
14 kind of problems that were there were sort of glossed over.  
15 And sort of a buddy system where they weren't going to do  
16 that.

17 I mean, one of the things that was most disturbing  
18 to me was I reviewed a death case at one of the prisons where  
19 the medical care was just totally awful. I mean, this man was  
20 seen over a period of four months, increasingly complaining of  
21 symptoms, physical findings that just jumped out at you as a  
22 clinician that said this guy was really sick. The doctor  
23 actually had written in the chart that he had endocarditis,  
24 which is a severe infection of the valves of the heart, which  
25 require immediate hospitalization and treatment with  
26 intravenous antibiotics.

27 And basically, they didn't do anything, just sent  
28 him back to his housing unit. They would see him again and

1 the man would be complaining of more symptoms. The doctor  
2 sent him back to his housing unit. Eventually, the man was  
3 seen in the Emergency Room. He was in shock. The doctor  
4 refused to send him to the Emergency Room. The nurse was so  
5 upset, she called her supervisor.

6 I mean, it was just an awful situation. The man  
7 didn't get sent to the hospital and within a few hours died in  
8 the facility. Now, that's bad enough, but then what we saw  
9 that when it was sent out for review, the initial doctor from  
10 CDC who reviewed the case basically documented everything that  
11 I just said and said that this was an egregious care.

12 And it then, from that position got sent out to  
13 another physician at CDC who was in the central office, who  
14 reviewed the case and made a determination that since the  
15 doctor who saw -- when the doctor saw the patient in the  
16 Emergency Room, that was again, after about a three or four  
17 month period of time. And the guy was in shock at the time,  
18 that the doctor in the Emergency Room didn't have access to  
19 the medical record.

20 And based on the fact that he didn't have the  
21 medical record at that time, he really couldn't make any  
22 determination as to the quality of the care provided. And,  
23 you know, I felt like this was an incredible cover-up and  
24 wrote a report.

25 And within a week of my report, the doctor was on  
26 administrative leave. I mean, it was just an egregious case,  
27 one of the worst cases I had seen up to that point in all of  
28 my experience. And basically, the doctor responsible for

# EXHIBIT 6

**OFFICE OF THE INSPECTOR GENERAL**

**MATTHEW L. CATE, INSPECTOR GENERAL**



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**SPECIAL REVIEW INTO THE DEATH  
OF CORRECTIONAL OFFICER MANUEL A. GONZALEZ, JR.  
ON JANUARY 10, 2005  
AT THE CALIFORNIA INSTITUTION FOR MEN**

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**MARCH 16, 2005**

**STATE OF CALIFORNIA**

**EXHIBIT 6**

## FINDING 6

**The Office of the Inspector General found that the medical clinic at the California Institution for Men reception center where the victim was taken after the stabbing was poorly equipped and ill-prepared to handle the emergency.**

The reception center clinic where Officer Gonzalez was first taken was not properly equipped, supplied or organized to deal with his medical emergency, nor was the clinic's medical staff prepared to cope with it. The deficiencies may not have contributed to the death of Officer Gonzalez, given the extreme severity of his wounds, but the evidence establishes that the care provided by the clinic staff was very deficient.

*Relationship of reception center clinic to the institution hospital.* Reception Center Central is a large building located several hundred yards south of the institution's hospital. The institution's hospital is a general acute care hospital licensed by the State of California, and its primary purpose is to meet the health and emergency medical needs of inmates. Despite its physical distance from the hospital, the clinic located at the reception center is considered an out-patient facility of the hospital, and has a pharmacy from which medications are dispensed to inmates housed at the reception center. The clinic's primary purpose is to provide medical, psychiatric, and psychological screenings of reception center inmates. Although it typically provides certain health care services not requiring hospital attention, the clinic's staff is sometimes called upon to respond to medical emergencies at the clinic and in other areas of the institution's reception center.

*Medical summary of the stabbing incident.* Officer Gonzalez was stabbed just before 10:57 a.m. in Sycamore Hall. Four correctional officers carried him to the reception center medical clinic and laid him on the floor of the clinic's interview room where medical personnel, including licensed vocational nurses, registered nurses and physicians were present. All of their reports were consistent in describing multiple stab wounds to Officer Gonzalez, accompanied by profuse bleeding.

Clinic staff initially applied direct pressure to the wounds, attached an automated external defibrillator to Officer Gonzalez, began cardiopulmonary resuscitation (CPR), and attempted to establish an airway to begin ventilation. The clinic staff did not defibrillate because the automated external defibrillator initially indicated that CPR should be initiated. Staff did not establish an intravenous line, nor did they administer cardiac medications. A member of the clinic staff called 911 at 11:02 a.m.

At 11:03 a.m., a medic engine from the fire district began its response from approximately 2.5 miles away. At the same time, an ambulance from American Medical Response also initiated its response. The medic engine was first on scene and initiated treatment at 11:10 a.m. by providing ventilation with a bag valve mask. The fire paramedics established an intravenous line at 11:12 a.m. and re-intubated Officer Gonzalez at 11:15 a.m. Paramedics performed defibrillation and at 11:15 a.m., administered medications, including epinephrine, atropine, and lidocaine. At 11:20 a.m.,

a needle thoracostomy<sup>9</sup> was performed, Officer Gonzalez was defibrillated again and additional epinephrine administered. Additional atropine was administered at 11:26 a.m.

The ambulance transporting Officer Gonzalez departed the prison at 11:20 a.m., arriving at Chino Valley Medical Center at 11:30 a.m. Doctors pronounced Officer Gonzalez dead at 11:52 a.m. The San Bernardino County Sheriff's Department homicide investigator's report says that the medical examiner who performed the autopsy determined that the first stab wound penetrated the chest cavity and the heart, causing major bleeding inside the chest cavity.

*The clinic's emergency equipment and supplies are not kept together.* The clinic's equipment and supplies for use in respiratory, cardiac and other medical emergencies includes airway equipment, oxygen, some intravenous access supplies, an automatic external defibrillator, medications, dressings and related material. These items are not kept together for immediate access in an emergency. For example, the advanced airway equipment and drugs are kept in a case in a locked closet down the hall in a different room from the oxygen, an automated external defibrillator, and other emergency first-aid supplies.

While the oxygen, an automated external defibrillator, and first-aid box are available in the same room of the clinic where Officer Gonzalez was initially taken, these items are not kept together. The oxygen tanks are routinely stored behind the main door of the clinic's interview room, while the other equipment is located a short distance away in that room. During its review, the Office of the Inspector General visited the clinic at various times on five different days. On two of those days, the automated external defibrillator, the box of first-aid supplies and an additional container of items were kept together, while on the other days they were sometimes separated and moved to other locations to accommodate other work in cramped quarters. The Office of the Inspector General noted that at times some of this emergency equipment was partially hidden from view by sweaters, snack food, and other items.

The manner in which the equipment and supplies were located and stored in the clinic at the time of the incident involving Officer Gonzalez required clinic personnel to go to different locations to obtain or search for necessary equipment and supplies, wasting valuable time.

Clinic staff suggested to the Office of the Inspector General that the clinic needs a crash cart for providing emergency medical care. The cart would keep all necessary equipment together and could be easily taken to the location of any emergency in the large facility

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<sup>9</sup> Thoracostomy is done to drain fluid, blood, or air from the space around the lungs. Severe injuries to the chest wall can cause bleeding around the lungs. A punctured lung allows air to gather outside the lung, causing its collapse (called a pneumothorax). Chest tube thoracostomy (commonly referred to as "putting in a chest tube") involves placing a hollow plastic tube between the ribs and into the chest to drain fluid or air from around the lungs.

served by the clinic. It would also assure that all necessary equipment would be immediately available should a patient be brought to the clinic.

The institution's *Hospital Policy & Procedure No. C-14*, which provides guidance for assuring crash cart availability in the hospital's emergency room, requires that crash carts be fully equipped with emergency medical equipment, and that they be operational at all times. The policy sets forth an inventory list of equipment and supplies and provides for their security. The clinic does not comply with the policy and there is no alternative policy applicable to the clinic.

***Some equipment and supplies were not in ready-to-use condition.*** Two oxygen tanks are kept in the clinic room where Officer Gonzalez was taken. Both tanks have the required regulators, but only one has attached to it the handle or key necessary to activate the flow of oxygen. There was a delay in providing Officer Gonzalez with oxygen at the time of the incident because the only tank with the required key did not have the necessary "tree" attached to the regulator to allow oxygen tubing to be attached. A member of the clinic staff had to remove the tree from the tank that did not have a key, and attach it to the tank that did have a key before oxygen could be provided to Officer Gonzalez, costing valuable time in a critical situation. Clinic staff told the Office of the Inspector General that an additional delay occurred when staff could not immediately locate a face mask.

***Missing equipment and supplies hampered treatment.*** Clinic medical staff had to abandon efforts to establish intravenous access on Officer Gonzalez when they discovered they did not have the required tubing with which to connect fluid to a catheter. Establishing intravenous access in a trauma victim permits medical staff to infuse a bleeding patient with replacement fluid and to establish a means of delivering medications to that patient. Typical equipment needed to establish intravenous access includes a catheter, an IV start kit, tubing, and fluid solution.

When the Office of the Inspector General inspected equipment and supplies almost a month after the incident, endotracheal tubes were found in a case containing medications. There was no stylet to assist in the intubation of a patient, or a syringe that could be used to inflate the balloon cuff of the endotracheal tube following intubation. Clinic staff told the Office of the Inspector General that a stylet and syringe were not available at the time of Officer Gonzalez' emergency.

At the time of the Office of the Inspector General's inspection there was no device present in the clinic that could be used to prevent an endotracheal tube from being dislodged accidentally following intubation. The Office of the Inspector General's post-incident interviews with clinic staff have determined that the tube used on Officer Gonzalez became dislodged at some point. The Office of the Inspector General did not observe an esophageal detector device, suction device, or suction catheter with the airway equipment during its inspections. Clinic staff told the Office of the Inspector General that such equipment was not available at the time of the incident. The continued absence of these supplies leaves the clinic unprepared should a similar medical emergency occur.

***Other equipment and supplies, though available, are inadequate.*** The emergency supplies set aside in the clinic include a single 20-gauge catheter. A larger supply of catheters is required to enable the clinic staff to establish IV access in patients during medical emergencies. Catheters with a larger bore are also needed for trauma victims. Medical professionals expecting to encounter emergency situations typically equip themselves with a plentiful supply of fluids in large-volume bags, yet only a single 500-ml bag (approximately 16 fluid ounces) of normal saline was in the clinic's emergency supplies at the time of the Office of the Inspector General's tour.

The institution's ambulance stationed at the institution hospital has large-volume bags of normal saline, tubing and start kits, but is not stocked with catheters. Under these circumstances, establishing IV access in a patient at the clinic will be delayed by the necessity of waiting for an ambulance to deliver the additional supplies.

***Some available equipment and supplies were not used.*** The Office of the Inspector General's interviews of clinic staff revealed that an end-tidal CO<sub>2</sub> detector or measuring device was available to provide capnometry or capnography<sup>10</sup> during endotracheal intubation, but was not used on Officer Gonzalez. Such a device assists in confirming that the endotracheal tube has been properly placed and is being maintained while the patient is being ventilated.

Though a pulse oximetry device to measure the level of oxygen in a patient's blood was available, it does not appear to have been utilized to determine that Officer Gonzalez was being properly ventilated. A pulse oximeter can be used whether or not an artificial airway is used and can be used regardless of the type of airway utilized.

Oropharyngeal airways<sup>11</sup> were available to assist in maintaining a patient airway, in the absence of an endotracheal intubation. The Office of the Inspector General's interviews of clinic staff found a substantial probability that staff did not successfully intubate Officer Gonzalez with an endotracheal tube, and did not resort to use of an oropharyngeal airway after encountering problems with achieving proper intubation. Although available, clinic staff did not administer cardiac medications to Officer Gonzalez because of their inability to establish IV access and because they did not know such medications could be administered through a properly placed endotracheal tube.

The very presence of such supplies at the clinic reflects the institution's recognition that their use can be reasonably anticipated. However, the fact that these supplies were not

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<sup>10</sup> Capnography is the continuous analysis and recording of carbon dioxide concentrations in air expelled from the lungs. Although the terms capnography and capnometry are sometimes used synonymously, capnometry suggests measurement or analysis alone without a continuous written record or graph.

<sup>11</sup> Oropharyngeal airways are used to maintain the airway in the unconscious patient during assisted breathing, and do not extend deeply into the trachea ("windpipe") as do endotracheal tubes.

used suggests that staff is not properly trained in their use, which was confirmed through the Office of the Inspector General's interviews with clinic staff.

***The clinic lacks standardized inventory control for emergency supplies and equipment.***

Although such procedures exist for medications, there are no established inventory control procedures for other emergency equipment and supplies at the clinic. The clinic staff is not provided with a written list of supplies that must be included in the first-aid, airway, and IV supplies cases. The Office of the Inspector General learned that even a month after the incident, some of the supplies used on Officer Gonzalez still had not been replaced, and during inspections conducted at that time, no bag valve mask or AMBU bag were included with the emergency medical supplies. Clinic staff were confused as to what supplies were used in treating Officer Gonzalez and just as confused about what should typically be included among the clinic's emergency medical equipment and supplies.

The Office of the Inspector General's inspections noted that the case containing airways, intubation equipment, medications, and many other items was quite disorganized, with most equipment and supplies placed haphazardly in the case, making it difficult for staff to find a particular item rapidly during an emergency.

During the Office of the Inspector General's first inspection of the airway equipment case, there was no security seal on the outside of the case. On the following day, there was a seal on the case, requiring someone from the pharmacy staff to break the seal for a second inspection and reseal it afterwards. During a third inspection, this process was repeated. None of these precautions were exhibited the first time the equipment case was inspected.

Unless improved, the clinic's current practices with respect to inventories will leave it unprepared to address future emergencies. One of the clinic's staff informed the Office of the Inspector General that the clinic treats as many as 20 to 30 stab wounds per month.

The institution's *Hospital Policy & Procedure No. C-14* provides that crash carts be available and operational in the hospital's emergency room, fully equipped with emergency medical equipment and supplies. The policy prescribes an inventory list of equipment and supplies and provides for their security. While this policy does not explicitly apply to the clinic, it can still serve as a valuable guideline until clinic-specific policies are developed.

***Regular inspections of supplies and equipment are not performed.*** The clinic's medical staff has no procedure requiring regular inspections of emergency equipment to ensure that all necessary equipment is available and ready to use when needed. There is no policy requiring re-stocking and replacement of missing and consumed materials when an emergency is over.

While the institution's *Hospital Policy & Procedure No. C-14* requires that emergency equipment and supplies in the hospital's crash cart be audited at the beginning of each

shift, no such requirement exists for the clinic. As a result, missing or inoperable equipment and supplies may not be discovered until needed during an actual emergency.

The absence of policies, training, and supervision in this area is demonstrated by the fact that, at the time of the Office of the Inspector General's review, items consumed in the effort to save Officer Gonzalez had not been replaced, and items unavailable when critically needed had not been added to the emergency supplies. Unless corrected, the absence of a policy requiring regular inspections will contribute to the clinic being unprepared for future emergencies.

***Orientation of new clinic staff is inadequate.*** The Office of the Inspector General's interviews with clinic staff revealed that staff members are not adequately briefed on the location of emergency equipment when first assigned to the clinic. Some staff members believed the only key available to turn on the flow of oxygen is attached to one of the tanks, while others thought the key is kept in a desk drawer. During interviews, a number of staff members were unable to locate basic equipment, such as a bag valve mask, AMBU bag, and airway adjuncts.

In addition to a lack of initial orientation, the institution does not conduct drills or offer periodic in-service training in responding to emergency medical situations to clinic staff. There is evidence that such training existed at one time — a written examination administered to medical staff at the institution in May 2000 tested staff on their knowledge of emergency drills at the institution. The Office of the Inspector General's interviews of clinic staff disclosed confusion and a lack of uniform understanding as to the extent and type of emergency medical services that clinic staff should provide. For example, some of the clinic staff believe it appropriate for them to administer medications to a patient experiencing cardiac arrest, while others believe such medications should be administered at the institution's hospital or by paramedics responding from outside the facility. The clinic staff members are unaware of any guidelines providing clarity or guidance on this issue. Without proper training, the clinic's staff cannot be expected to perform adequately during an emergency.

***Lack of specialized training in emergency medicine.*** The institution does not conduct or otherwise provide sufficient specialized training in emergency medicine for its medical staff. All medical staff who assisted in the attempt to save Officer Gonzalez' life held the appropriate professional licenses. Those requiring certification in cardiopulmonary resuscitation (CPR) were currently certified.<sup>12</sup>

The institution does not currently require that any of its clinic personnel maintain certification in advanced cardiovascular life support. Medical staff interviewed by the Office of the Inspector General stated that advanced cardiovascular life support certification was required for emergency room employees in the past, but that the institution no longer imposes such a requirement. One member of the clinic staff told the

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<sup>12</sup> Physicians are not required to be certified in CPR.

Office of the Inspector General that he had not received any "code blue" training in eight years.

Both physicians present when Officer Gonzalez was brought to the clinic knew that epinephrine, atropine, and lidocaine could benefit a patient experiencing cardiac arrest. But the lack of advanced cardiovascular life support training and certification may explain why one physician did not know, while the other would not state, that epinephrine, atropine, and lidocaine could all be administered through a properly placed endotracheal tube after intubation. These medications and others are included in the case containing the endotracheal tubes and IV fluid. One of these physicians also works shifts in the institution hospital's emergency room where the protocols refer to the use of such medications. The Office of the Inspector General determined during interviews with these physicians that neither has received any specialized training or certification in emergency medicine, although one has continuing education credits in heart failure and coronary syndromes as recently as December 2002. One of the physicians advised the Office of the Inspector General that he had not worked in an emergency room in approximately 25 years, and the other said that the only emergency medical experience he has comes from working shifts in the institution's emergency room.

As an example of the confusion among clinic staff members as to procedures, a nurse with significant administrative responsibilities initially told the Office of the Inspector General that there were no cardiac medications in the clinic's supplies. This nurse later said the medications were intended for use in responding to emergencies involving inmates, but 911 is to be called for medical emergencies involving employees. Still later, this nurse said that use of these medications is to be directed by the physicians.

Clinic staff do not routinely perform some of the skills associated with providing emergency medical services. Intubation is one example. One of the physicians told the Office of the Inspector General that staff members are required to train or demonstrate ability to perform oral intubations on a mannequin every six months, but the institution could not produce evidence of such a practice, nor could other clinic staff members recall such a practice. The nurse who claims to have intubated Officer Gonzalez told the Office of the Inspector General that such periodic training is not required.

The lack of specific training in emergency procedures, supplemented by periodic refresher courses, can result in the delivery of inadequate care during future emergency situations.

***Insufficient direction and leadership during the emergency.*** Several of the Office of the Inspector General's interviews with clinic staff revealed that at least two physicians were present when Officer Gonzalez arrived in the clinic. Some clinic staff stated that physicians failed to provide substantial assistance, direction, and leadership during the attempts to save the officer's life. Interviews of the two physicians reveal they have little, if any, significant training and no substantial experience in dealing with significant medical emergencies.

Without at least one medical staff member providing directions acknowledged by the rest of the staff, there can be a lack of focus and coordination in delivering emergency medical services.

The institution's *Hospital Policy & Procedure C-11* states that the Medical Officer of the Day or other physicians working in the hospital are to direct the medical care team when a "code blue" is called in response to a patient who is not breathing or has no pulse. The fact that this policy statement is directed to hospital operations does not diminish its value in providing guidance to clinic procedures in the absence of policies specific to that area.

***Inadequate documentation of events during the emergency.*** Clinic staff members involved in treating Officer Gonzalez prepared incident reports on California Department of Corrections Form 837 as required. These reports are the only written documentation of emergency medical care that clinic staff prepared, and are inadequate in describing the assessment, care and treatment of Officer Gonzalez.

Based on interviews with the Office of the Inspector General, some clinic staff indicated the belief that standard medical charting is not required for emergency medical treatment provided at the clinic, while others believe that such charting is required only if emergency treatment is provided to inmates.

The institution's *Hospital Policy & Procedure No. C-11* includes by reference a "Cardiopulmonary Resuscitation Form" that must be completed during treatment of a patient experiencing cessation of breathing or pulse. The form requires that hospital staff record pertinent information concerning medical assessment and care, as well as the patient's response to treatment. The clinic staff created no such record concerning Officer Gonzalez.

Additional policies and procedures directly requiring, or indirectly referring to, charting or other documentation of medical care provided in the hospital include *Hospital Policy and Procedures A-10, C-5, C-6, C-15, and E-10*. These policies and procedures require charting as a means of avoiding errors and to aid in diagnosis, treatment, and care of both inmates and employees. Clinic staff complied with none of these policies and procedures in connection with Officer Gonzalez.

Proper documentation minimizes or eliminates ambiguity about what occurred, and who performed particular procedures. Proper charting has the added advantage of providing evidence that appropriate medical care was provided and further assists by improving future medical care and in managing risk.

In contrast with the documentation produced by the institution's clinic staff, the fire and ambulance paramedics did a much more thorough job of providing medical documentation on their standardized patient care reports.

As a result of the clinic staff's failure to document the incident adequately, there remain discrepancies in critical details of Officer Gonzalez' treatment:

- The fire paramedics defibrillated Officer Gonzalez shortly after their arrival because he was experiencing ventricular fibrillation. If clinic staff had pressed the “analyze” control on the automated external defibrillator that they attached earlier to Officer Gonzalez, the device would have recognized such a heart rhythm and recommended defibrillation. However, because clinic staff did not maintain charts of the incident there is no way to tell precisely how long Officer Gonzalez was attached to the clinic’s automated external defibrillator or how frequently someone activated the “analyze” control. Further, there is no way to tell how long Officer Gonzalez had a heart rhythm in need of defibrillation prior to the fire paramedics’ arrival.
- Though the 837 reports record clinic staff’s attempt to establish an intravenous line, there is no mention as to whether the attempt was successful. The Office of the Inspector General learned only during subsequent interviews with clinic staff that the attempt to establish an intravenous line was unsuccessful because supplies to accomplish the task were inadequate. The critical missing item was the tubing for connecting the catheter to fluids. None of the clinic staff’s 837 reports mention the reason an intravenous line could not be established. The necessary intravenous line tubing had still not been added to the intravenous line supplies and other emergency equipment at the clinic a month after the problem was first encountered.
- The Office of the Inspector General’s examination of the 837 reports revealed significant discrepancies in identifying the type of airway used in attempting to ventilate Officer Gonzalez. One registered nurse wrote in his 837 report that he “was able to insert the trach tube.” His oral statement indicated the tube had a balloon cuff. Another nurse wrote in her 837 report that she advised fire paramedics that Officer Gonzalez needed to be re-intubated, suggesting that the clinic staff’s attempts at this procedure were unsuccessful or that the tube had been dislodged while the patient was being moved. The same nurse was clear in stating that she handed a packaged endotracheal tube, equipped with a balloon cuff, to the physicians.

One of these physicians told the Office of the Inspector General he intubated the patient with an endotracheal tube about six inches long having no balloon cuff, and that he does not know what an oropharyngeal airway is.<sup>13</sup>

Two of the medical technical assistants (MTA’s) directly involved in providing care to Officer Gonzalez stated during their interviews that an endotracheal tube was not used, but that an oropharyngeal airway was. When shown an oropharyngeal airway the same MTA told the Office of the Inspector General that it did not look like the airway used on Officer Gonzalez. Another of the MTA’s described an airway to

<sup>13</sup> The difference between an oropharyngeal airway and an endotracheal tube is significant. The oropharyngeal airway, when properly sized, does not extend past the pharynx when inserted and is rather easily inserted in an unresponsive patient with an absent gag reflex. In contrast, the endotracheal tube is actually inserted in the trachea with great care given to avoid placing it in the esophagus.

which the AMBU bag was attached after insertion. However, there is nothing on an oropharyngeal airway to which an AMBU bag can be attached.

- Only one of the 837 reports suggests any sort of problem with the airway, recording that paramedics were advised of a need to re-intubate Officer Gonzalez. Interviews of clinic staff by the Office of the Inspector General a month later disclosed the airway used on Officer Gonzalez became dislodged at some point. There is no written record as to when or how the airway became dislodged, how long staff took to recognize the airway was dislodged, or how long, if at all, effective ventilation was provided.<sup>14</sup> In fact, there is insufficient evidence to conclude the airway was properly placed.
- There is no documentation discussing the adequacy of the ventilation provided at any time. Interviews of some clinic staff indicate that Officer Gonzalez' chest was observed to rise and fall after intubation and ventilation, which if true suggests tracheal and not esophageal placement of the endotracheal tube. However, the nurse who claims to have performed the intubation said there was no rise and fall of the chest following intubation. There is no written documentation describing Officer Gonzalez' response to ventilation. In addition, clinic staff have offered no testimony, oral or written, regarding any definitive primary or secondary assessments verifying that the endotracheal tube was properly placed in the trachea as opposed to the esophagus. The "Cardiopulmonary Resuscitation Form" used in the California Institution for Men Hospital, but apparently not used at the clinic, calls for such information.

The clinic staff's collective omission of these critical details from official written reports deprives management and staff alike of the ability to conduct an objective critique of the handling of Officer Gonzalez' emergency.

*No staff debriefing or incident critique conducted.* The medical staff was appropriately offered stress debriefing for psychological benefit following the incident. However, there was no attempt to evaluate or debrief the handling of the medical emergency or the adequacy of available equipment and supplies. Some clinic staff indicated in interviews with the Office of the Inspector General that they desired to speak with someone about what had actually happened, because they felt there had been problems and they wanted to contribute to better preparation in the future. Specific incident debriefing is an essential part of quality improvement.

The institution's *Hospital Policy & Procedure No. C-11* requires that a hospital nursing supervisor or lead nurse prepare a written critique after medical services have been provided to a patient experiencing a cessation of breathing or pulse. Several items on that

<sup>14</sup> If an endotracheal tube was actually used, there are no incident reports mentioning whether someone attempted to secure it, even with nothing more than tape, to guard against dislodging. Subsequent interviews, however, revealed there was no attempt to secure the endotracheal tube before lifting the officer to a gurney and wheeling him out of the building.

critique form would apply in this case. For example, one of the questions addresses whether the crash cart was adequately stocked. It appears, however, that clinic staff believe this policy was never intended to apply outside of the hospital.

*Hospital Policy & Procedure No. Q-1* describes a quality assurance program.<sup>15</sup> Its purpose is to systematically monitor and evaluate the quality and appropriateness of nursing care, pursue opportunities to improve nursing care and clinical performance and resolve problems. No such policy and procedure is in place for the clinic, however. One of the questions on a test administered by the institution in May 2000 indicates that all emergency medical responses involving an ambulance shall be reviewed monthly to identify procedural or training issues requiring correction. The institution made no apparent attempt to review the quality of the care provided to Officer Gonzalez until the Office of the Inspector General's inquiry was initiated.

***Key members of the clinic staff provided conflicting information about critical details.*** One of the nurses reported in his 837 report that he personally intubated Officer Gonzalez, and further confirmed this during an interview with the Office of the Inspector General. The nurse's written 837 report that he inserted a "trach tube" into the patient is corroborated by testimony of the other medical staff present during the event, except for one of the physicians who claims that he, and not the nurse, intubated Officer Gonzalez.

This physician who claims to have intubated Officer Gonzalez told the Office of the Inspector General he personally listened to Officer Gonzalez' heart and lung sounds when the officer was first brought to the clinic and that both were absent. However, one of the MTA's in the clinic during the incident reports that Officer Gonzalez' carotid pulse was initially palpable and the chest was seen rising and falling before clinic staff initiated ventilation. At least one member of the clinic staff told the Office of the Inspector General that the physician who claims to have attempted to listen to heart and lung sounds simply opened the officer's uniform and walked away.

The physician claiming to have intubated Officer Gonzalez told the Office of the Inspector General the following:

- He was unable to identify by name the instrument normally used to assist in the intubation of patients.
- He performed a blind intubation without the assistance of a light source. The Office of the Inspector General observed two fully functional disposable laryngoscopes<sup>16</sup> inside the case containing a small supply of endotracheal tubes.
- He could not and did not confirm that the endotracheal tube was in the trachea.

<sup>15</sup> Many health care providers have moved to a quality improvement program instead of a quality assurance program.

<sup>16</sup> This instrument permits visual confirmation that the endotracheal tube been inserted through the vocal cords and into the trachea and not into the esophagus.

- A pulse oximeter was not used and that he does not know what an end-tidal CO<sub>2</sub> monitor is. This physician was not familiar with the terms capnometry or capnography.
- The only way to secure an endotracheal tube after intubation is to either hold the tube in place with the fingers or to inflate the balloon cuff at the distal end of the tube to hold the tube against the interior wall of the trachea. Neither is an adequately reliable method of securing a tracheal tube. The physician confirmed that the endotracheal tube he used did not have a balloon cuff. All of the other endotracheal tubes seen by the Office of the Inspector General on subsequent inspections at the clinic have inflatable balloon cuffs. Typically, only endotracheal tubes for infants and small children have no inflatable balloon cuffs.
- He held the tracheal tube in place with his fingers but could not explain how or when the endotracheal tube became dislodged.
- There was no stylet present among the supplies, or if there was, that he did not see it. He also said there is no suction device available at the clinic and further stated that he did not know how suction might be needed during an intubation procedure.<sup>17</sup>
- He did not know what an oropharyngeal airway was, insisted that the carina<sup>18</sup> was the portion of the anatomy separating the esophagus from the trachea, and was unfamiliar with the Glasgow Coma Scale; terms commonly known to those familiar with performing intubations.
- He personally saw on the small screen of the automated external defibrillator/cardiac monitor four or five ECG waves that changed to a straight line, indicating Officer Gonzalez' heart rhythm was asystole (cardiac standstill). The physician said he administered no cardiac medications, and that the four or five ECG waves he observed were insufficient for him to determine the exact type of heart rhythm before he recognized Officer Gonzalez was asystole.

Nonetheless, this same physician wrote an 837 report failing to mention his having intubated the patient, the method used to provide an airway, how placement of the endotracheal tube was confirmed, and that he read and assessed ECG waves on a cardiac monitor while Officer Gonzalez was in the clinic. This physician's 837 report further describes that he issued various orders to other medical personnel.

***The policies and protocols governing emergency medical procedures lack coordination.*** The policies and protocols governing emergency medical procedures create confusion among staff because they lack coordination. The California Institution for Men has three

<sup>17</sup> Suction is necessary to remove blood and other liquids that can block visual inspection of endotracheal tube placement, or that may be aspirated into the patient's lungs.

<sup>18</sup> The carina trachaea is a projection of the lowest tracheal cartilage, forming a prominent semi lunar ridge running antero posteriorly between the openings of the two bronchi. The carina trachaea is below the portion of the anatomy separating the esophagus from the trachaea.

separate sets of health care protocols. The first are policies and procedures for the medical/surgical unit of its hospital. The second are the hospital's emergency medical policies and procedures. The third are policies and procedures intended only for the clinic and are outpatient protocols concerning the care to be provided inmates.

While the institution's emergency operations plan contains a resource supplement<sup>19</sup> concerning emergency medical treatment, it applies only in the event of a major disturbance and provides guidance for transporting those injured in such disturbances without providing specific treatment protocols. The institution has no written policies and procedures for providing emergency medical care to its employees outside of its hospital.

There are no emergency medical care protocols available to the staff in the clinic. While there are medical protocols located in the institution's hospital, these do not specifically and comprehensively address emergency care to be provided by clinic staff. Some clinic staff believe the hospital protocols do not apply to the clinic, while others do not know whether they apply.

The institution's general practice is to call a private ambulance company to transport seriously ill or injured employees to an outside medical facility. This is the written policy to be applied during a major disturbance. In contrast, inmates experiencing a medical emergency are usually transported by the facility ambulance to the institution's hospital. These policies do not preclude employees from being taken to the institution's hospital or inmates from being transported to outside hospitals.

The same equipment and staff assigned to provide first-response emergency medical services to inmates at the clinic are the same that would be used for employees experiencing an emergency. Neither inmates nor employees will be well served by the state of emergency-preparedness that the Office of the Inspector General observed at the institution's clinic.

***Information in the institution's emergency operations procedures is incorrect.*** The institution's emergency operations procedures list a phone number to an ambulance substation in Chino to contact for emergency medical transportation off institution grounds, but that phone number is no longer in service. The 800 central dispatch number for the ambulance company, however, is valid. Fortunately the clinic staff simply called 911 when seeking assistance for Officer Gonzalez, activating a response by not only American Medical Response, but Chino Valley Fire whose number is not listed in the procedures.

The emergency procedures identify a list of hospitals as providers of emergency medical services, but Loma Linda University Medical Center, the only Level I trauma center in the region, is not listed.

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<sup>19</sup> Resource Supplement Number 17, *Providing Emergency Medical Treatment for All Staff and Inmates.*

Employees and inmates at the institution's central unit are isolated from the traditional 911 community for obvious safety and security reasons. They are also isolated, to some extent, from the services of the facility's ambulance and hospital emergency room, further underscoring the need to plan and prepare clinic staff for medical emergencies in the clinic or at other locations. That planning and preparation is inadequate at this time.

#### **RECOMMENDATIONS**

**While the primary function of the reception center's clinic is to perform inmate medical evaluations, it is also common for clinic staff to provide emergency medical care, and specialized equipment and supplies have been provided to it for that purpose. Indeed, the very environment of the institution provides strong reason for it to be properly prepared to respond to medical emergencies since other alternatives may be delayed or inaccessible due to security concerns.**

**Accordingly, the Office of the Inspector General recommends that the California Institution for Men take the following actions with respect to its central reception center clinic:**

- **Develop comprehensive procedures specific to the clinic that focus on delivery of emergency medical services.**
- **Assess the clinic's needs with respect to emergency medical supplies and equipment and assure that the clinic is adequately stocked with them. The chief medical officer should institute a practice of conducting regular inventories and inspections of these supplies and restock those that have been consumed or lost to spoilage or obsolescence.**
- **Ensure that the emergency supplies are ready to use and are immediately accessible. A crash cart would address this purpose within the clinic, and could also be easily taken to any emergency in the facility served by the clinic.**
- **Provide specialized training in emergency medical procedures for clinic staff and other employees as appropriate. This may include courses leading to advanced cardiovascular life support certification. Further, management should conduct regular emergency drills for clinic staff. Management should provide additional training in medical charting and proper documentation of emergency medical incidents.**
- **The institution's medical staff should engage in thorough debriefing following incidents of medical emergencies. California Evidence Code, section 1157 encourages a frank evaluation of quality of care issues by prohibiting discovery of such information. The California Institution for Men should take full advantage of this statute by engaging in candid and**

**complete self-assessments after significant medical events, whether involving inmates or employees.**

- **The institution should consider retaining the services of a consultant in emergency medicine to provide a comprehensive review of its policies, protocols, procedures, staffing, training, quality assurance/improvement program, supply and equipment requirements and to provide guidance on implementing improvements. The consultant should be knowledgeable and experienced in establishing and maintaining emergency medical clinics outside of a traditional hospital setting.**

**In addition, the Department of Corrections should review the emergency preparedness of its other institutions to ensure that the deficiencies found at the California Institution for Men do not exist elsewhere.**