IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA , et al.,

Plaintiffs

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants,

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

EXHIBITS FOR RECEIVER'S FOURTH BI-MONTHLY REPORT

APPENDIX OF EXHIBITS

Exhibit #'s

1. Doctor's Salary Adjustments.
2. Glenn Johnson Curriculum Vitae.
3. Matthew Keith Curriculum Vitae.
4. Dick Cason Curriculum Vitae.
5. Melanie Roberts Curriculum Vitae.
6. Richard Pollard Curriculum Vitae.
7. Marjory Pulvino Curriculum Vitae.
8. Kaye Cloutier Curriculum Vitae.
9. CDCR Pharmacy Improvement Project Org Chart.
10. Maxor Report, "Maxor's First Ninety Days" January 1, 2007.
11. Maxor Report, "An Analysis of the Crisis in the California Prison Pharmacy System Including a Road Map from Despair to Excellence." June 2006.
12. Maxor Report, "Monthly Progress Report to the California Prison Health Care Receivership" January 2007.
13. Maxor Report, "Monthly Progress Report to the California Prison Health Care Receivership" February 2007.
14. Status Tracking Charts re San Quentin Projects.
15. March 15, 2007 Letter to Chief of Staff John Hagar from Maxor Project Manager, Glenn Johnson.
16. March 16, 2007 Letter to Maxor Project Manager Glenn Johnson from Kathleen Yates, DGS Senior Staff Counsel.
17. March 1, 2007 Letter to Jayne Russell, CPR Health Care Project Officer (A) from Charles Antonen, Deputy Attorney General.
18. California Health Care Receivership Corp. Balance Sheet as of January 31, 2007.

EXHIBIT 1

Exhibit 1.

Position	Qualification	New Salary/Year	Previous Salary/ Year
Physician and Surgeon (clinic line doctor)	Non-Board Cert. Lifetime Board Cert. Time-limited Board Cert.	$180,000 $189,996 $200,004	$168,360
Chief Physician and Surgeon (first level institution supervisor)	Non-Board Cert. Lifetime Board Cert. Time-limited Board Cert.	$189,996 $200,004 $210,000	$ 174,696
Chief Medical Officer (top level institution supervisor and some positions in headquarters)	Non-Board Cert. Lifetime Board Cert. Time-limited Board Cert.	$200,004 $210,000 $219,996	$ 184,596
Chief Deputy Clinical Services (includes Regional Medical Directors)	Non-Board Cert. Lifetime Board Cert. Time-limited Board Cert.	$210,000 $219,996 $230,004	$185,000
Statewide Medical Director	Non-Board Cert. Lifetime Board Cert. Time-limited Board Cert.	$219,996 $231,000 $242,544	$185,000

EXHIBIT 2

CURRICULUM VITAE

GLENN GARRETT JOHNSON, M.D.
22510 Felicia Drive
Spicewood, Texas 78669
(512) 264-2810
FAX (512) 264-1445
ggjohn@austintx.com

Personal Information

Date and Place of Birth: August 30, 1954 - Lynchburg, Virginia

Education

College of William and Mary, Williamsburg, Virginia - 1972 - 1976 / B.S. Biology, 1976

Medical College of Virginia, Richmond, Virginia - 1977 - 1981 / Doctor of Medicine, 1981

Residency: University of Texas Health Science Center - Houston, Department of Family Practice, Houston, Texas / 1981 - 1984 -- Residency in Family Practice

Licenses: Texas (Flex 1981), Mississippi, Oklahoma, Michigan, Florida, North Carolina, California, Virginia, New York

Professional Society Membership: American Academy of Family Practice, American Medical Association, Texas Academy Family Practice, Texas Medical Association, Travis County Medical Association, Society of Correctional Physicians, American Correctional Health Services Association, Academy of Correctional Health Professionals

Certification: American Academy of Family Practice - Board Certification(initial)1984 / Re-certified 1991,1997, 2004
Fellow American Academy of Family Practice - October 1986
Certified Correctional Health Professional - 1991 (initial) / re-certified 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005
Certified Correctional Health Professional, Advanced - 1999 (initial), 2000, 2001, 2002, 2003, 2004, 2005

Teaching Appointments: University of Texas Medical School - Houston Department of Family Practice - Clinical Preceptor 1985, 1986, 1988, 1989

Employment

July 1984 - August 1994 Texas Department of Criminal Justice/Institutional Division

(TDCJ-ID, or former Texas Department Corrections, TDC)

POSTS ASSUMED

1984-1987	Unit Health Authorities Ramsey 2, Ramsey 1, Jester 3 Units, TDC
1986-1987	Southern Region Coordinating Physician, TDC
1987-1988	Central Region Coordinating Physician, TDC
1988-1993	Chief of Professional Services, TDCJ-ID
1993-1994	Deputy Director for Health Services, TDCJ-ID

SPECIAL APPOINTMENTS SERVED

1984-1986	Member, Pharmacy and Therapeutics Committee, TDC
1985-1989	Chairman, Physician Peer Review Committee, TDC
1986-1988	Tuberculosis Control Physician, TDC

August 1994 - December 1997	Private Practice Consulting, Correctional Health Care Physician Auditor, National Commission on Correctional Health Care Consultant, National Institute of Corrections - Alaska, South Carolina
January 1998 - present	President, Briarcliff Medical Associates, Inc. Consulting, Correctional Health Care
June 1999-present	Corporate Medical Director, The GEO Group, Inc.

SPECIAL COMMITTEE MEMBERSHIPS

1990-1994	Texas Board of Criminal Justice Health Care Committee, Member
1991-1994	Texas Board of Criminal Justice Substance Abuse Treatment Committee, Member
1992-1994	Texas Department of Health, Tuberculosis Advisory Committee
1992-1994	Texas Commission on Alcohol and Drug Abuse, Criminal Justice Committee, Member
1990-1993	Health Care Review Board, TDCJ-ID and University of Texas Medical Branch, Galveston , Chairman
1988-1993	TDCJ-University of Texas Medical Branch, Galveston Joint Peer Review/Utilization Committee, Co-chairman

Awards Received

1982 - Donald Dalquist M.D. Memorial -- "Outstanding Resident in Emergency Medicine"
University of Texas Health Science Center - Houston, Family Practice Department

1984 - Harold T. Pruessner, M.D. -- "Outstanding Teaching of Family Practice"
University of Texas Health Science Center - Houston, Family Practice Department

1984 - Cardiovascular Surgery of Houston -- "Resident of the Year"
University of Texas Health Science Center - Houston, Family Practice Department

Special Activities

1990 - Graduate of the State of Texas - Governor's Executive Development Class (Class VIII)

1991 - Consultant, Missouri Attorney General Office, Correctional Health Care

1993 - National Institute of Corrections sponsored consultant, Alaska Department of Corrections, Tuberculosis Control

1993-1994 - Supervised and assisted in the development of the Texas Department of Criminal Justice Sex Offender Treatment Program (SOTP), a program offering behavioral cognitive therapy to 100 volunteer offenders at a facility in Sugarland, Texas (Central Unit)

1994 - National Institute of Corrections sponsored consultant, Alaska Department of Corrections, Pharmacy Delivery

1995 and 1999 - National Institute of Corrections sponsored consultant, South Carolina Department of Corrections, Health Care Delivery and Quality Assurance

1991 until present - Physician Surveyor, National Commission on Correctional Health Care, Prison, Jails and Juvenile Facilities
Physician mentor for training, 1998 until present

1998 until present - Death Reviews, Department of Corrections - State of Missouri and Pendleton County, Washington

1997-1999 - Physician Consultant - Wackenhut Corrections Corporation

1999 until 2001 B Trustee, Certified Correctional Health Care Professional program, National Commission on Correctional Health Care

1999 until 2006 B Chairman, Survey Advisory Committee, National Commission on Correctional Health Care

(Special Activities continued)

June 2000 until 2001 B Chairman, Physician Guidelines Initiative, National Commission on Correctional Health Care

1999-2002 B Member, National Commission on Correctional Health Care, Jails/Prisons Standards Revision Committee

2002-2003BNIC/NCCHCBComprehensive Assessment of Medical Care in the Wisconsin State Prison SystemBPrinciple Expert

Special Interests

Quality Delivery of Institutional Health Care

Communicable Disease Treatment and Control in Correctional Settings

Cost Containment in Institutional Health Care

Utilization Management in Correctional Health Care

February 2006

EXHIBIT 3

CURRICULUM VITAE

Matthew R. Keith, RPh, BCPS, FASHP

August 2005

PRESENT POSITION

Inpatient Pharmacy Manager
Alaska Native Medical Center

WORK ADDRESS

4315 Diplomacy Drive
Anchorage, AK 99508
Phone (907)729-2155
Fax (907) 729-2135
Email MRKeith@ANMC.org

BIOGRAPHICAL

Date of Birth: June 24, 1959
Home Address: 23642 Chandelle Drive
Chugiak, AK 99567
(907) 688-2261

PROFESSIONAL EDUCATION & TRAINING

1984	B.S. Pharmacy The University of Texas College of Pharmacy Austin, Texas
1985	General Residency Accredited by The American Society of Hospital Pharmacists (ASHP) Focus: Drug Information/Clinical Skills The University of Texas Medical Branch Galveston, Texas
1997	Physical Assessment Course Baylor College of Medicine Family Medicine Department & Texas Society of Health-Systems Pharmacists

Other Training

2005	Baldridge National Quality Excellence Training
2005	Balanced Score Care Training
2005	Institute for Health Care Improvement 100K Lives Initiative Training
2003	IHS Commissioned Officer Training Academy Basic Orientation Course
2004	Root Cause Analysis
2003	Failure Mode and Effects Analysis

CURRENT POSITION RESPONSIBILITIES

The managerial duties of the inpatient pharmacy include all aspects of operations, finances, regulatory compliance, personnel, recruitment, quality improvement, professional development and interdepartmental activities. The inpatient pharmacy includes specialty care for adult and pediatric intensive care patients and well as a formal pharmacokinetics and parenteral nutrition service. The 150 bed facility serves as the tertiary referral care center for the natives of Alaska. As a result, the acuity, complexity and geographical concerns are similar to those seen in larger medical centers. Other responsibilities include management of the home infusion and chemotherapy services. I was also part of the initial team that developed and implemented the use of a balanced score care to foster integrated improvement of organizational goals for the ANMC campus and am currently the Balanced Score Care Coordinator for Pharmacy, Radiology, Pathology, Dietary, Physical Therapy and Lab. I have also implemented multiple formal quality improvement and initiatives within and outside pharmacy. I am a member of the ANMC Policy and Procedure Committee, contribute to the Pharmacy and Therapeutics Committee and recently completed a 3 year term on the Health Records Committee. I also serve on the Medication Reconciliation initiative task force. I have served as the Drug Information preceptor for our ASAP Accredited residency and continue to serve a mentor for residents related to major projects, posters and presentation. I was responsible for redesign related to USP 797 and currently working on redesign plans for extending inpatient hours and adding services.

IMMEDIATE PAST POSITION **3/00-3/02**

Director of Pharmacy & Residency Program Director
UTMB/TDCJ Correctional Managed Care,
Adjunct Clinical Assistant Professor of Pharmacy Practice
Department of Clinical Sciences & Administration
University of Houston College of Pharmacy

Primary duties include management and finance for a pharmacy department of 95 staff members serving 150,000 correctional patients from three separate agencies at over 140 clinic sites. The department dispenses over 250,000 medication orders per month. Other duties include management of clinical services including formulary management, disease management guideline development, decision analysis and outcome assessment, nonformulary request consultation and pharmacist operated chronic care clinics. Educational activities include direction of the accredited pharmacy residency program and lecturing for pharmacy and medical students. Other activity of note includes testifying in front of the Texas Legislature and State Board of Pharmacy in matters related to budget, health care utilization and pharmacy practice. Direct patient care activities include practice as a clinical pharmacy specialist in HIV. Committee responsibilities are provided below.

PROJECT ACCOMPLISHMENTS

- Development of a night cabinet system for after-hours nursing access.
- Redesign related to USP 797 Sterile Compounding requirements.
- Implemented a pharmacist first-dose review program to assure medication therapy and orders for inpatients are reviewed by a clinical pharmacist prior to administration to the patient.

- Implemented a STAT order notification system for inpatient nursing and developed a related quality assurance measure.
- Design and implementation of a centralized pharmacy with prototypical robotics serving 150,000 patients in 24-hour turn-around modified mail order model. The operation dispenses over 250,000 medication orders monthly. The process required the completion of an 18-month study and approval by State Board of Pharmacy resulting in the change of 2 practice laws. Savings exceed 2 million dollars annually. Error rate was reduced by 2/3.
- Development and implementation of clinical pharmacy services, formulary management, utilization review, publication of a formulary book and newsletter for a large managed care organization. Resultant savings, 45% reduction in drug costs.
- Implemented personnel policy that reduced leave without pay and tardiness by 80%.
- Development and implementation of the first Accredited Pharmacy Practice Residency in a correctional environment and the first residency approved by the American Society of Health-Systems Pharmacy with, *emphasis in managed care.*
- Development and implementation of an 18-month educational program to retrain staff pharmacists into a clinical practice role.
- Development and ongoing provision of 14 ACPE Accredited 3-hour disease state management modules for staff pharmacists.
- Implementation of pharmacist prospective profile review, with disease management evaluation and clinical interventions with prescribers resulting in a 3 fold increase in clinical interventions.
- Development and implementation of over 30 disease management guidelines, 11 have been reviewed and recognized by the AMA.
- Development and implementation of pharmacist operated chronic care clinics including prescriptive authority.
- Implementation of a pharmacist operated telemedicine clinic in HIV (my clinical practice since 8/1998).

PROFESSIONAL PHARMACY PRACTICE EXPERIENCE

Associate Director of Pharmacy & Residency Director 1/93- 3/00
University of Houston College of Pharmacy
Correctional Managed Care Division services to
The Texas Department of Criminal Justice

Adjunct Associate Professor of Pharmacy Practice/
Associate Clinical Professor 1/91 - 6/00
Department of Clinical Sciences and Administration
University of Houston College of Pharmacy

Associate Managing Consultant 1/91 - 8/93
The University of Houston College of Pharmacy
Houston, Texas 77030

Associate Coordinator of Drug Information Services 9/85 - 1/91
The University of Texas Medical Branch Hospitals
Galveston, Texas 77550

Clinical Instructor 9/87 - 1/91
The University of Texas College of Pharmacy
Austin, Texas 78712

Coordinator of Quality Assurance 4/89 - 1/91
The University of Texas Medical Branch Hospitals
Galveston, Texas 77550

Coordinator for Pharmacist Recruitment 4/89 - 1/91
The University of Texas Medical Branch Hospitals

Relief Pharmacist 9/84 - 12/86
K-Mart Store #3402
Galveston, Texas 77551

LICENSURE and CERTIFICATION INFORMATION

Registered Pharmacist	Texas State Board of Pharmacy. License # 28197, Expiration June 2007. Alaska Board of Pharmacy License # 1396, Expiration June 30, 2006.
Specialty Certification	Pharmacotherapy Specialist, Board of Pharmaceutical Specialties. Certificate # 292121 (8/92), Expiration October 2006.

COMMITTEE RESPONSIBILITIES

- IHI 100K Lives Medication Reconciliation Committee 2005 - Present
- ANMC Balanced Score Care Coordinators Group 2005 - Present
- ANMC Medication Safety Committee. 2004 - Present.
- ANMC Health Records Committee, 2002-2005.
- ANMC Policy and Procedure Committee, 2002-Present.
- Texas State Bulk Purchasing Commission, Founding Chairman 2001-2002.
- Alcalde Southwest Leadership Residency Preceptor Conference Advisory Board Member 1998-1999, Board Chairman 1999-2000.
- Texas Department of Criminal Justice Managed Health Care Hepatitis C Policy Task Force - 1999.
- Texas Department of Criminal Justice Managed Health Care HIV / AIDS Policy Task Force - 1997.
- Informatics Committee - University of Texas Medical Branch/Texas Department of Criminal Justice Managed Health Care 1996-1997.
- Clinical Practice Affairs Committee - American College of Clinical Pharmacy 1996, 1997.
- University of Texas Medical Branch/Texas Department of Criminal Justice Managed Health Care Quality Utilization Review Committee, Ex-officio. 1994 - Present.
- Texas Department of Criminal Justice Dialysis Patient Care Committee 1994 - 1995.
- University of Houston College of Pharmacy External Doctor of Pharmacy Program Planning Committee 1994.
- Pharmacy and Therapeutics Committee, Texas Department of Criminal Justice, 1991 - Present.
- Reference Resource Committee, Texas Department of Criminal Justice, 1991 - 1994.
- Psychiatric Issues Subcommittee of the Pharmacy and Therapeutics Committee, Texas Department of Criminal Justice, 1992 - 1993.

- Infection Control Committee, Texas Department of Criminal Justice, 1992 - Present.
- Pharmacy and Therapeutics Committee, The University of Texas Medical Branch at Galveston, 1984 - 1991.
- Antibiotic Subcommittee of the Pharmacy and Therapeutics Committee, The University of Texas Medical Branch at Galveston, 1989 - 1991.
- Drug Utilization Review Subcommittee, The University of Texas Medical Branch at Galveston, 1984 - 1991.

MEMBERSHIP IN SCIENTIFIC SOCIETIES

The American Society of Health-System Pharmacists	1984 - Present
The Texas Society of Health-System Pharmacists	1984 - 2003
The American College of Clinical Pharmacy	1990 – 2003
Alaska Pharmacists Association	2003 - Present

HONORS/AWARDS

- Fellow of the American Society of Health-System Pharmacists, 2002.
- Resolution of Appreciation. Correctional Managed Health Care Advisor Committee. March 7, 2002.
- Certificate of Appreciation, Texas Tech School of Pharmacy February 14, 2002.
- Award of Appreciation for Service. Texas Society of Hospital Pharmacists Research and Education Foundation, April 2002.
- Outstanding effort recognition plaque – Pharmacy Residency Program, UTMB Correctional Managed Health Care December 14, 2000.
- Innovative Collaborative Practice Award. Texas Society of Health-System Pharmacists, 1996.
- Excellence in Research Award. Texas Society of Hospital Pharmacists Research and Education Foundation, 46th Annual Seminar, San Antonio, Texas April, 1994. A clinical training program designed to retool staff pharmacists.
- Outstanding Young Men of America Award, 1988.
- Clinical Pharmacy Outstanding Student Award. University of Texas College of Pharmacy, 1984.
- Vice-President of Pharmacy Counsel, University of Texas College of Pharmacy, 1983.
- Boy Scouts of America, Eagle Scout Award, 1976.

BIBLIOGRAPHY

Publications

Consultant and co-author. Improved purchasing of prescription drugs. E-Texas report from the Office of Texas Comptroller of Public Accounts. January 2003. www.window.state.tx.us/etexas2003/hhs08.html

Keith MR. Student conduct at the personnel placement service. Am J Health-Syst Pharm. 2002;59:1205 (letter).

Roberts MB, **Keith MR.** Implementing a performance evaluation system for a correctional managed care pharmacy. Am J Health-Syst Pharm. 2002;59:1097-104.

Carmenates JC, **Keith, MR**. The impact of automation on pharmacist clinical interventions and medication error rate in a correctional managed health care system. Am J Health-Syst Pharm. 58; 779-83: 2001.

Keith MR. A diabetes disease management plan in a correctional staff model HMO. P & T Journal. 1999;24:227-37.

Keith MR. Televideo technology for patient education and counseling. Am J Health-Syst Pharm. 1999;56:860-1.

Keith MR. Diagnostic and Support Services in the Telemedicine Environment: Pharmacy. Telemedicine: Practicing in the Information Age. Steven F.Viegas, Kimberly Dunn, Eds. Lippincott-Raven Publishers, Philadelphia, 1998.

Wormley KC, **Keith MR**. Stability of refrigerated medications maintained outside the manufacturers product information leaflet recommendations. Micromedex, Inc., Computerized Clinical Information Systems™. Drugdex® Drug Consults, 95th edition 12/97.

Seals TD, **Keith MR**. The impact of written patient education on anticonvulsant compliance in a correctional environment. Am J Health-Syst Pharm. 1997;54:2585-7.

Keith MR. Integrated Pharmacology (Book Review). Am J Health-Syst Pharm. 1997;54:2534

Keith MR, Coffey EL. Clinical training program for distributive pharmacists. Am J Health-Syst Pharm. 1997;54:674-7.

Cassidy IB, **Keith MR**, Coffey EL, Noyes MA. Impact of pharmacist-operated general medicine chronic care refill clinics on practitioner time and quality of care. Ann Pharmacotherapy. 1996;30:745-51.

Keith MR. A tool, not a player. Drug Topics. June 10, 1996;22. Letter.

Coffey EL, **Keith MR**. Evaluation of efficacy and cost reduction following a therapeutic substitution of dihydropyridine calcium channel antagonists in a state correctional environment. Drug Utilization Review. May 1996;71-3.

Cason DM, **Keith MR**. Correctional facilities guidelines. Am J Health-Syst Pharm. 1996;53:320. Letter.

Keith MR, Coffey EL. Efficacy and cost analysis of an ACE inhibitor therapeutic substitution program in a state correctional environment. Drug Utilization Review. October 1995;151-4.

Kistner UA, **Keith MR**, Sergeant KA, Hokanson JA. Accuracy of dispensing in a high-volume, hospital-based pharmacy. Am J Hosp Pharm. 1994;51:2793-7.

Keith MR, Cason DM, Helling DK. An antiulcer agent prescribing program in a state correctional system. Ann Pharmacotherapy. 1994;28:792-96.

Keith MR. A literature review of martial arts injuries: risk and category comparison of competition sparring level, gender, age and use of protective equipment. Chayon-Ryu™ 1st Degree Black Belt Thesis. September 1994.

Herring P, **Keith MR**. TDCJ-ID psychotropic medication dosage guidelines. P & T Peer Rev J Formular Manag. Newsletter Exchange. 1992;17:1777.

Keith MR, Fuchs, Jr.JE. Drug-induced leukemoid reactions. Micromedex, Inc., Computerized Clinical Information Systems™. Drugdex® Drug Consults, 70th edition 9/91.

Keith MR, Bellanger-McCleery RA, Fuchs, Jr. JE. Controversies in adverse reaction reporting. Am J Hosp Pharm. 1990;47:76-7. Letter.

Keith MR, Bellanger-McCleery RA, Fuchs, Jr. JE. A concurrent, multidepartmental adverse drug reaction reporting system. Am J Hosp Pharm. 1989;46:1809-12.

Fuchs JE Jr., **Keith MR**, Galanos F. Probable metolazone induced pancreatitis. Drug Intell Clin Pharm. 1989;23:711.

Hokanson JA, **Keith MR**, Guernsey BG, et al. Potential use of bar codes to implement automated dispensing quality assurance programs. Hosp Pharm. 1985;20:327-37.

Keith MR. Nicardipine. The Texas Society of Hospital Pharmacists Newsletter . 1990;19(3):1-2,7.

Keith MR, Catarau EM. Recent advances in immunoglobulin therapy. Houston-Galveston Area Society of Hospital Pharmacists Newsletter. 1985;9:1-3.

Abstracts

Keith MR, Givens GM. An internal pharmacist PRN service developed at the Alaska Native Medical Center (ANMC) designed to address IHS staff shortages in bush Alaska. ASHP Midyear Clinical Meeting, vol. 37, (DEC), pp. P-601D, 2002

Keith MR. Metamorphosis toward a longitudinal residency structure. Inter Pharm Abstr. 1997;34(21):2265-6.

Coffey EL, **Keith MR.** Evaluation of efficacy following a therapeutic substitution of beta-agonist inhalers in a correctional managed care setting. Inter Pharm Abstr. 1996;33(21):2284.

Hoffman VF, **Keith MR**. Effect of critical care pathways on antihypertensive agent utilization in a correctional managed care setting. Inter Pharm Abstr. 1996;33(21):2231.

Coffey EL, Hoffman VF, **Keith MR**. Evaluation of efficacy and cost reduction following a therapeutic substitution of dihydropyridine calcium channel antagonists in a state correctional environment. 47th Annual Seminar, The Texas Society of Hospital Pharmacists Newsletter. 1995:24;18.

Keith MR, Nunan RA, Coffey EL. Efficacy and cost analysis of an ACE inhibitor therapeutic substitution program in a state correctional environment. 47th Annual Seminar, The Texas Society of Hospital Pharmacists Newsletter 1995:24;14.

Keith MR. A clinical training program designed to retool staff pharmacists. 46th Annual Seminar, The Texas Society of Hospital Pharmacists Newsletter. 1994:23;15.

Coffey EL, **Keith MR**. Implementation of pharmacist operated chronic care refill clinics. 46th Annual Seminar, The Texas Society of Hospital Pharmacists Newsletter. 1994:23;14-5.

Cason DM, Cassidy IB, **Keith MR**. Reengineering pharmacy services. 46th Annual Seminar, The Texas Society of Hospital Pharmacists Newsletter. 1994:23;14.

Keith MR, Cason DM. Clinical skills evaluation in applicant assessment and approving staff privileges. ASHP Midyear Clinical Meeting, vol. 27, (Dec), pp. MCS-126, 1992.

Sergeant, K, **Keith MR**. Formalized drug information training in North American Colleges of Pharmacy. ASHP Midyear Clinical Meeting, vol. 25, (Dec), pp. P-37R, 1990.

Keith MR, Sergeant KA. Design and implementation of a multidisciplinary, health care team member approach to adverse drug reaction reporting. Int Pharm Abstr. 1990;27:279. Abstract.

Sergeant KA, **Keith MR**, Blackwell LJ. Development and implementation of a drug information training course for staff pharmacists. Int Pharm Abstr. 1990;27:361. Abstract.

Andel MM, Sergeant KA, **Keith MR**. Pharmacists interventions in physician prescribing habits in an ambulatory care setting to prevent pharmacologic duplication and significant drug-drug interactions. Int Pharm Abstr. 1989;26:1601. Abstract.

Keith MR, Bellanger-McCleery RA, Fuchs, Jr. JE. A concurrent, multidepartmental adverse drug reaction reporting system. Int Pharm Abstr. 1989;26:488. Abstract.

Presentations (National, State, Regional)

Zen and the art of leadership. Alaska Pharmacists Association Annual Meeting, February 2005.

Formulary Management & Clinical Practice Guidelines in Correction. American Correctional Association Meeting, San Antonio, TX. January 2002.

Advanced Clinical Pharmacy Services in Corrections. American Correctional Association Meeting, San Antonio, TX. January 2002.

Antiretroviral Drugs: Interactions, adverse effects and adherence counseling. UTMB HIV Minifellowship for Correctional Healthcare Providers. Galveston, TX . October 16, 2000, April 2001, May 2001, August 2001.

Automation Solutions in Pharmacy: Texas Correctional Managed Care. Public Hospital Pharmacy Coalition, 35th ASHP Midyear Clinical Meeting, Las Vegas, NV., December 3, 2000,

Telepharmacy: A pharmacist-patient clinical encounter model using televideo technology. Gulf Coast Society of Health-Systems Pharmacist Annual Seminar, Galveston, TX. October 2000.

Managing HIV in the Correctional Setting. A Series of CME Accredited Conference Calls. *Education and Counseling for Inmates*. November 2 & 17, 1999. *Adherence Challenges*. November 3 & 18, 1999. *Drug Side Effects and Co-morbidity's*. November 4 & 16, 1999.

Drug Interactions in HIV Care. Considerations in care planning. National Conference on Correctional Health Care, 23rd National Conference, Fort Lauderdale, FL, November 8, 1999.

Correctional Pharmacy Services and Clinical Care Idiosyncrasies. University of Texas Medical Branch Preventive Medicine Department Introduction to Correctional Health Symposium. Galveston, Texas. July 5-9, 1999.

Keith MR, Cason DM. Reengineering pharmacy services: Quality improvement with significant cost reduction. 21st National Conference on Correctional Health Care. San Antonio, Texas. November 10-12, 1997.

Keith MR, Coffey EL. Hyperlipidemia facilitated disease management workshop. University of Houston College of Pharmacy, Houston, Texas. November 1, 1997. Approved for 0.3 CEU by ACPE.

HIV treatment pathway design: science, common sense or blind hope? Alaska Pharmaceutical Association. Anchorage, Alaska May 22, 1997. Approved for 0.1 CEU by ACPE.

Disease management planning. Pharmacotherapeutics - HIV care and monitoring. Pharmacoeconomics - Optimizing care and resources. Alaska Department of Corrections Annual Health Care Education Program. Anchorage, Alaska. May 21 & 22, 1997.

Reengineering pharmacy informatics. First annual UTMB telemedicine seminar. Galveston, Texas April 23-26, 1997.

HIV treatment pathway design: science, common sense or blind hope? Gulf Coast Society of Health-System Pharmacists. February 20, 1997. Approved for 0.1 CEU by ACPE.

Various clinical and administrative topics. Thirty minute presentations at each UTMB Managed Care Physicians' Quarterly Meeting from August 1995 to present. Program Approved for Medical and Nursing CE.

Team specific pharmacoeconomic consultations as part of a multifaceted program to reduce costs in a capitated correctional staff model HMO. Texas Society of Health-System Pharmacists 48th Annual Seminar. Corpus Christi, Texas April 12-15, 1996. Platform Presentation.

Hoffman VH, **Keith MR**. Impact of clinical pharmacists as nonformulary approving agents in a correctional managed care setting. Texas Society of Health-System Pharmacists 48th Annual Seminar. Corpus Christi, Texas April 12-15, 1996. Platform Presentation.

Seals TD, **Keith MR**. The impact of written patient education on compliance in a correctional environment. Alcalde X, Southwest leadership conference for pharmacy residents, fellows and preceptors. San Antonio, Texas March 14-16, 1996.

Cost reduction in a correctional managed care setting through clinical pharmacist nonformulary consultations. 30th Annual ASHP Midyear Clinical Meeting, Managed Care Pearls Session. Las Vegas, NV., December 3-7, 1995.

Pharmacoeconomic strategies. University of Texas Medical Branch/Texas Department of Criminal Justice Managed Care Quarterly Continuing Education Meeting. Huntsville, Texas August 17, 1995. Program approved for CE by the American Medical Association.

Formulary management update and cost reduction strategies. Presented to the Texas Tech University Correction Care Division Quarterly Continuing Education Meeting. Lubbock, TX., May, 18, 1995. Program approved for CE by the American Medical Association.

Patient care idiosyncrasies in correction health care. Presented to the Internal Medicine Division of The University of Texas Medical Branch, Galveston, Texas, March 24 and August 25, 1995. Program approved for CE by the American Medical Association.

Pharmacy cost containment strategies for correctional care in the Texas prison system. University of Texas Medical Branch/Texas Department of Criminal Justice Managed Care Quarterly Continuing Education Meeting. Galveston, Texas January 19, 1995. Program approved for CE by the American Medical Association.

Team specific pharmacoeconomic consultations as part of a multifaceted program to reduce costs in a capitated correctional staff model HMO. Texas Society of Health-System Pharmacists 48th Annual Seminar. Corpus Christi, Texas April 12-15, 1996. Platform Presentation.

Cassidy IB, **Keith MR**, Coffey EL. Outcome analysis of pharmacist operated general medicine chronic care refill clinics. Alcalde Southwest Leadership Conference, San Antonio, TX., March 24-26, 1994.

Infectious diseases practice clinical pearls. Brazos Valley Pharmaceutical Association meeting. Bryan, TX., December 9, 1993. ACPE approved 0.1 CEU.

A clinical training program designed to retool staff pharmacists. 28th Annual ASHP Midyear Clinical Meeting, Clinical Pearls Session. Atlanta, GA., December 5-9, 1993.

Keith MR, Cason DM. Clinical skills evaluation in applicant assessment and approving staff privileges. 27th Annual ASHP Midyear Clinical Meeting. Orlando, FL., December 6-10, 1992.

Formulary management in a correctional care environment. 16th Annual Conference on Correctional Health Care. Chicago, Ill., September 24, 1992.

Computerized clinical information systems. Texas Department of Criminal Justice Central Regional Staff. Huntsville, Tx., September 14 and 15, 1992. CME category 2 approved.

Sergeant KA, **Keith MR**. Implementation of an antibiotic order form. 44th Annual Seminar, The Texas Society of Hospital Pharmacists. Fort Worth, Tx., April 12-15, 1992. Platform Presentation.

Update on psychotherapeutic agents 1992. Texas Department of Criminal Justice Psychiatric Health Care Staff Annual Continuing Education Meeting, Huntsville, Tx., March 6, 1992. CME category 1 approved.

Update and review of generic and brand drug names; Review of medical terminology; Drug effects on body systems; Factors affecting drug actions. Texas Department of Criminal Justice Certified Medication Aide Retraining Seminar, Huntsville, Tx., December 17, 1991.

Drug use evaluation process and results from the TDCJ-ID histamine receptor antagonist review. Texas Department of Criminal Justice Physician Quarterly Continuing Education Meeting, Huntsville, TX., October 24, 1991. CME category 1 approved.

A concurrent, multidepartmental adverse drug reaction reporting system. Highlights of the 23rd Annual ASHP Midyear Clinical Meeting, Audio Abstracts. Dallas, Tx., December 4-8, 1988.

Controversies and considerations in parenteral drug therapy administration. Glaxo District Educational Seminar, Galveston, Tx., May 1990.

Meinssen UA, Sergeant KA, **Keith MR**. A drug usage evaluation of omeprazole. Alcalde Resident Preceptor Conference, Dallas, Tx., March 29-31, 1990.

Sergeant KA, **Keith MR**, Blackwell LJ. Development and implementation of a drug information training course for staff pharmacists. 24th ASHP Midyear Clinical Meeting, Atlanta, Ga., December 3-7, 1989.

Formulary issues in histamine-2 receptor antagonist therapy: A critical approach. Presented to the physicians of the Fayette County Hospital, LaGrange, Texas November 2, 1988.

Zepeda SZ, **Keith MR**. Repackaging quality assurance system. 32nd Annual ASHP Midyear Clinical Meeting, Atlanta, GA., December 7-12, 1997.

Guest Expert on Houston Channel 11 Health Series Health Watch - Topics: Generic drug substitution. August 1987, Mail order pharmacy. November 1988.

Poster Presentations

Keith MR, Herring D. Use of an electronic, stoplight design unit audit tool to foster awareness and understanding of medication control, security and safety requirements. 39th ASHP Midyear Clinical Meeting, Orlando, FL. December 5-9, 2004.

Goroski DT, **Keith MR**. Development and implementation of home infusion pharmacy services for Alaska Natives. 39th ASHP Midyear Clinical Meeting, Orlando, FL. December 5-9, 2004.

Keith MR, Givens GM. Strategies to meet JCAHO first-dose review requirements in a medical center without twenty-four hour pharmacy services. 38th ASHP Midyear Clinical Meeting, New Orleans, LA. December 7-11, 2003.

Herring DL, **Keith MR**. Development of a telepharmacy network to serve rural Alaska. 38th ASHP Midyear Clinical Meeting, New Orleans, LA. December 7-11, 2003.

Jorgenson GA, Schilling BD, **Keith MR**. Optimizing Compliance With Treatment Guidelines for the Use of Oral Anticoagulation in Alaska Natives With Chronic Atrial Fibrillation. 38th ASHP Midyear Clinical Meeting, New Orleans, LA. December 7-11, 2003.

Keith MR, Givens GM. An internal pharmacist PRN service developed at the Alaska Native Medical Center (ANMC) designed to address IHS staff shortages in bush Alaska. 37th ASHP Midyear Clinical Meeting, Atlanta, GA. December 8-12, 2002.

Manning MG, **Keith MR.** A pharmacy clinical interventions database designed to meet specific needs in a correctional managed care environment. The 54th Texas Society of Hospital Pharmacists. Galveston, TX., April 12-16, 1999

Roberts MB, **Keith MR**. An analysis of adherence with hepatitis C therapy in a correctional managed care setting. 53rd Annual Seminar. The Texas Society of Hospital Pharmacists. Austin, TX., March 31-April 4, 2001.

Roberts MB, **Keith MR.** A Departmental operational performance system (OPES) for a correctional managed care pharmacy. 35th ASHP Midyear Clinical Meeting, Las Vegas, NV. December 3-7, 2000.

Keith MR. A descriptive report of a pharmacist operated HIV clinic using televideo technology. 51st Annual Seminar. The Texas Society of Hospital Pharmacists. Dallas, TX., April 15-18, 1999.

Carmenates J, **Keith MR**. A training program to meet continuing education requirements for certified medication aide recertification in a correctional managed care environment. 51st Annual Seminar. The Texas Society of Hospital Pharmacists. Dallas, TX., April 15-18, 1999.

Keith MR, Zepeda S. Telepharmacy services in a correctional managed health care system. Telemedicine World 1999 Conference and Trade Show. Galveston, TX., April 6-9, 1999.

Carmenates J, **Keith MR**. The impact of automation on error rate and pharmacist clinical interventions in a managed care correctional facility. 33nd Annual ASHP Midyear Clinical Meeting, Las Vegas, NV., December 6-10, 1998.
Curriculum Vitae

Keith MR, Coffey, Jr. EL. Disease management intervention training in a correctional managed care setting. 50th Annual Seminar, The Texas Society of Hospital Pharmacists. Houston, TX., April 2-5, 1998.

Keith MR. Metamorphosis toward a longitudinal residency structure. 32nd Annual ASHP Midyear Clinical Meeting, Atlanta, GA., December 7-12, 1997.

Keith MR. Metamorphosis toward a longitudinal residency structure. 32nd ASHP Midyear Clinical Meeting, New Orleans, LA., December 7-11, 1997.

Wormley KC, **Keith MR**. Development of guidelines for the use or destruction of refrigerated drug products and biologicals when stored outside optimal temperature recommendations. 31st ASHP Midyear Clinical Meeting, New Orleans, LA., December 8-12, 1996.

Coffey EL, **Keith MR.** Evaluation of efficacy following a therapeutic substitution of beta-agonist inhalers in a correctional managed care setting. 31st ASHP Midyear Clinical Meeting, New Orleans, LA., December 8-12, 1996.

Hoffman VF, **Keith MR**. Effect of critical care pathways on antihypertensive agent utilization in a correctional managed care setting. 31st ASHP Midyear Clinical Meeting, New Orleans, LA., December 8-12, 1996.

Seals TD, **Keith MR**. Assessment of medication compliance in a correctional environment. 30th ASHP Midyear Clinical Meeting, Las Vegas, NV., December 3-7, 1995.

Keith MR, Nunan RA, Coffey EL. Efficacy and cost analysis of an ACE inhibitor therapeutic substitution program in a state correctional environment. 47th Annual Seminar, The Texas Society of Hospital Pharmacists. Dallas, TX., April 9-12, 1995.

Coffey EL, Hoffman VF, **Keith MR**. Evaluation of efficacy and cost reduction following a therapeutic substitution of dihydropyridine calcium channel antagonists in a state correctional environment. 47th Annual Seminar, The Texas Society of Hospital Pharmacists. Dallas, TX., April 9-12, 1995.

Keith MR. A clinical training program designed to retool staff pharmacists. 46th Annual Seminar, The Texas Society of Hospital Pharmacists. San Antonio TX., April 24-27, 1994.

Coffey EL, **Keith MR**. Implementation of pharmacist operated chronic care refill clinics. 46th Annual Seminar, The Texas Society of Hospital Pharmacists. San Antonio TX., April 24-27, 1994.

Cason DM, Cassidy IB, **Keith MR**. Reengineering pharmacy services. 46th Annual Seminar, The Texas Society of Hospital Pharmacists. San Antonio TX., April 24-27, 1994.

Gardner VR, **Keith MR**, Lee N. The effects of pharmacist counseling on inmate compliance with theophylline therapy. Annual Meeting of The American Pharmaceutical Association, Seattle, WA., March 22-24, 1994.

Keith MR, Cason DM, Helling DK, McCormick, WC. Implementation of H_2 antagonist prescribing limits in a correctional care environment. 44th Annual Seminar, The Texas Society of Hospital Pharmacists. Fort Worth, Tx., April 12-15, 1992.

Sergeant KA, **Keith MR**. Formalized drug information training in north American colleges of pharmacy. 25th ASHP Midyear Clinical Meeting, Las Vegas, NV., December 2-6, 1990.

Sergeant KA, **Keith MR**, Meinssen UA. A calcium channel antagonist drug usage evaluation. 41st Annual Meeting of the Texas Society of Hospital Pharmacists. Corpus Christi, TX., April 8-11.

Keith MR, Sergeant KA. Design and implementation of a multidisciplinary, health care team member approach to adverse drug reaction reporting. 24th ASHP Midyear Clinical Meeting, Atlanta, Ga., December 3-7, 1989.

Andel MM, Sergeant KA, **Keith MR**. Pharmacists interventions in physician prescribing habits in an ambulatory care setting to prevent pharmacologic duplication and significant drug-drug interactions. 46th ASHP Annual Meeting, Nashville, Tenn., June 4-8, 1989.

Wallace JW, Fuchs Jr. JE. **Keith MR**. Probable metolazone induced pancreatitis. Alcalde Regional Residency Conference, Dallas, TX., March, 1989.

Keith MR, Bellanger-McCleery RA, Fuchs Jr. JE. A concurrent, multidepartmental adverse drug reaction reporting system. 23rd Annual ASHP Midyear Clinical Meeting, Dallas, Tx., December 4-8, 1988.

VanBuskirk S, **Keith MR**, Catarau EM. Development of reconstitution standards for a centralized sterile products area. 39th Annual Meeting of The Texas Society of Hospital Pharmacists, Dallas, Tx., March 25-28, 1987.

Keith MR, Bellanger-McCleery RA, Fuchs Jr. JE. Profound leukemoid reaction to beta-lactam antibiotics. A case report. 40th Annual Meeting of The Texas Society of Hospital Pharmacists, Houston, Tx., April 10-13, 1988.

OTHER ACTIVITIES

Consultant-	Texas Comptroller of Public Accounts, Drug Utilization Review Paper
Author -	Draft ASHP Guideline on Telepharmacy Patient-Pharmacist Relationship
Reviewer-	Draft ASHP Guideline on Pharmaceutical Services in Correctional Facilities
Consultant -	Bristol Myers Squibb Correctional Health Care Advisory Board
Consultant-	Glaxowelcome HIV Issues in Corrections
Consultant-	Roche Pharmaceuticals
Editorial Advisor-	HIV Inside, 2000, 2001,2002.
Author/Editor -	Clinical Pharmacy Operations Manual, Residency Manual and Formulary, The Texas Department of Criminal Justice Department of Pharmacy.
Author -	UTMB Pharmacy Residency Manual 1st Edition, The University of Texas Medical Branch, Department of Pharmaceutical services, 1990.
Director -	Texas Society of Health-System Pharmacists Research & Education Foundation Board of Directors 1999-2002.
Reviewer -	*The American Journal of Managed Care.* *The American Journal of Health-System Pharmacists*
Consultant -	National Institute for Corrections (1994).
Editor-	The Pill Pass (published monthly), Texas Department of Criminal Justice Department of Pharmacy newsletter, 1991 - 1999.
Editor-	The Pharmacy Bulletin (published monthly) and UTMB Formulary (published annually), The University of Texas Medical Branch., 1984-91.
Facilitator -	Pharmacist-Patient Consultation Program (PPCP-1 & PPCP-3)
Facilitator -	Pharmacy services in correctional health care settings. 30th Annual ASHP Midyear Clinical Meeting Round table Discussions. Las Vegas, NV, December 3-7, 1995.

Participant - ASHP Invitational Consensus Conference. Pharmacy in Managed Care. Vision for the Future. Dallas, TX., February 27 - March 1, 1998.

Past Program Founder & Director - Pharmacy Practice Residency with an Emphasis in Managed Care.

Participant - ASHP Invitational Conference on Implementing Pharmaceutical Care. San Antonio, TX., March 12-15, 1993.

Writer/Proctor - Board of Pharmaceutical Specialties, Pharmacotherapy Specialist Examination.

Past Reviewer - Contributed posters and case studies, The American Society of Hospital Pharmacists, Annual and Midyear Meetings.
The American Journal of Hospital Pharmacy & Clinical Pharmacy.

Chief Instructor - Chayon-Ryu™ Martial Arts, 4th Degree Black Belt
(www.kimsookarate.com) Chugiak Chayon-Ryu™

Trustee - Faith Lutheran Church, Huntsville, Texas 1997-2001.

Elder - Our Redeemer Lutheran, Chugiak, Alaska 2005 - Present

Facilitator - Adult Bible Study 1997-2004

HOBBIES/INTERESTS

Martial Arts
Mountain Climbing \ Backpacking
Motorcycling
Exotic Wildlife & Domestic Cattle Ranching
Scuba Diving
Hunting \ Fishing

EXHIBIT 4

Dick M. Cason
583 Elkins Lake
Huntsville, Texas 77340
(936) 291-6823
dickcason_2000@yahoo.com

EDUCATION

1975-1977	M.S. Hospital Pharmacy University of Houston College of Pharmacy	Houston, Texas
1975-1977	ASHP General Residency V.A. Medical Center	Houston, Texas
1972-1974	B.S. Pharmacy University of Houston College of Pharmacy	Houston, Texas
1967-1971	B.S. Biology Southern Methodist University	Dallas, Texas

PROFESSIONAL EXPERIENCE

Director of Pharmacy 3/02-present
UTMB-CMC (Correctional Managed Care) Department of Pharmacy
Huntsville, Texas

Primary duties included management and finance for a pharmacy department of 100 staff members serving 170,000 correctional patients from three separate agencies at approximately 150 clinic sites. The department dispensed 3,882,013 medication orders in FY 2006.

- May 2002 – PHS (340B) pricing obtained for UTMB-TDCJ service area of the state.
  - Subsequently expanded to include all UTMB-CMC totally operated units (Texas Youth Commission, Federal Bureau of Prisons and County Jails)
- December 2003 – Changed wholesalers as part of State Bulk Purchasing Committee. Decreased up charge from -2.38% to -3.01%
- April 2003 – Installed Accu-Sort reclamation sorter
- September 2004 – Moved into new pharmacy building. Increased floor space from 9,275 sq. ft. to 20,897 sq. ft.
- February 2005 – New 88-lane Accu-Sort small item sorter installed
- March 2006 – MTS-500 prepacking machine installed
  - Goal to eliminate outsource prepacking – accomplished July 2006
  - Projected savings of over $200,000 per year (after first year when machine is paid off)
- September 2006 – Got DEA and DPS (state/controlled substance) permits for Texas Youth Commission facilities
  - Allows for floor stock controlled substances – less paper work and counting for nursing staff, less potential for diversion and makes it easier for units to conform to a formulary

Director, Pharmacy Information Systems 2/00-3/02
UTMB/TDCJ Managed Health Care Department of Pharmacy
Huntsville, Texas

Responsibilities include helping to integrate an electronic medical record system into the present pharmacy drug distribution process, accounting system and pharmacy intervention documentation.

Director of Pharmacy 9/90-2/00
UTMB/TDCJ Managed Health Care Department of Pharmacy
Huntsville, Texas

Primary duties included management and finance for a pharmacy department of 90 staff members serving 150,000 correctional patients from three separate agencies at over 140 clinic sites. The department dispensed 2,213,330 medication orders in FY 99. Initially I was hired by the University of Houston College of Pharmacy in 1990 to manage the Texas Department of Criminal Justice Pharmacy Department. The College of Pharmacy was brought in to address concerns identified by the Ruiz Court Case. In 1990 there were 44,000 inmates in 30 prison units and 39 pharmacy employees. UTMB Managed Care took over the responsibility of all health care in FY 95 from TDCJ. UTMB Managed Care assumed responsibility for the Pharmacy Department in Feb. 2000.

- Developed model of pharmacy practice for prison system
  - 1990 – Four regional pharmacies, 44,000 inmates – 30 units
  - 1993 – Designed centralized pharmacy – 1 pharmacy for the entire state
- Used "extra FTE's" for clinical program development
- 1992 – Instituted prime vendor purchasing for TDCJ
  - 1991 – 3.2 Inventory turns
  - 1993 – 17.2 Inventory turns
  - Inventory turns exceeded 10 every year thereafter (high of 52.1 turns in FY 2001)
  - 2006 - 15 Inventory turns
- 1992 – Started "spheres of influence for pharmacists" – gave responsibility of certain practice areas to individual staff pharmacists
- 1992 – Started first Airborne delivery of medication to prison units
- Opened new building in 1993
  - Reengineered technician and pharmacist's work flow
    - FY 92 144 medication orders/8hrs/tech, 325 medication orders/8hrs/pharmacist
    - FY 94 170 medication orders/8hrs/tech, 500 medication orders/8hrs/pharmacist
    - FY 99 169 medication orders/8hrs/tech, 531 medication orders/8hrs/pharmacist (first full year after Accu-Sort automation installed
    - FY 2005 254 medication orders/8hrs/tech, 937 medication orders/8hrs/pharmacist
    - FY 2006 232 medication orders/8hrs/tech, 851 medication orders/8hrs/pharmacist
  - Assumed responsibility of warehouse operation
  - Provided controlled substances using a distributor's license
  - Provided discharge prescriptions by getting Texas State Board of Pharmacy (TSBP) to agree to use inpatient orders as continuation orders
- Pharmacy received Innovative Collaborative Practice Award from the Texas Society of Hospital Pharmacy in 1996
- With Accu-Sort distribution system redesigned pharmacy in January 1998 – automated checking of medication orders and sortation of orders
  - First pharmacy in the state to use pilot program by TSBP allowing use of automation if patient care is enhanced (decreased errors by 48%, increased interventions by 172%) - interventions became more therapeutic than procedural
- Began providing care to Federal Bureau of Prison patients at Beaumont in FY 97 and Texas Youth Commission patients in FY 96
- Pharmacy Department was instrumental in decreasing drug costs 17% in FY 95 and 25% in FY 96 through clinical pharmacy programs - prior to multiple drug regimen therapy for HIV positive patients
- Developed training program to help technicians pass the national certification exam
- By FY 2000 – Providing service to 150,000 inmates – 140 units - $40 million budget ($37 million drugs) and 90 employees

Director of Pharmacy 7/83-9/90
Mainland Center Hospital
Texas City, Texas

Responsibilities included overall management of the pharmacy department (drug distribution, clinical services, personnel and purchasing). The pharmacy department provided service from 7am-11pm seven days a week. The hospital was licensed for 310 beds, but had an average census of about 150 during the time that I was there. The hospital was a county supported entity during those years and had an affiliation with The Methodist Hospital in Houston for a period of time.

PROJECT ACCOMPLISHMENTS

- Developed a medication administration record (MAR) for nurses based upon order entry by pharmacists on computer (this is now done routinely by all inpatient systems-but was novel for the 1980 time period)
- Participated as part of the Methodist Purchasing Program which was developed to serve as it's own GPO
- Limited therapeutic substitution

Inpatient Pharmacy Supervisor 1/80-7/83
V.A. Medical Center
Houston, Texas

Primary responsibilities included supervision of the unit dose, IV admixture and clinical services provided in an 800 bed hospital. Services were provided on a 24 hour basis with a staff of 30 employees.

PROJECT ACCOMPLISHMENTS

- Developed pills on wheels model (pharmacists on floors providing first doses and clinical services)
- Established IV admixture service for the hospital

Relief Pharmacist
Walgreen's Pharmacy
4/01-now
Huntsville, Texas

Relief Pharmacist
Huntsville Memorial Hospital
6/95-4/01
Huntsville, Texas

Relief Pharmacist
Humana Hospital
8/88-9/90
Clear Lake City, Texas

Consultant Pharmacist 1/80-7/83
Bayou Manor Nursing Home
Houston, Texas

Unit Dose Supervisor 3/79-1/80
V.A. Medical Center
Houston, Texas

Staff Pharmacist 9/77-3/79
V.A. Medical Center Houston, Texas

MEMBERSHIP IN SCIENTIFIC SOCIETIES

The American Society of Health System Pharmacists
The Texas Society of Health System Pharmacists
The Gulf Coast Area Society of Health System Pharmacists

OFFICES HELD IN SCIENTIFIC SOCIETIES

Texas Society of Health System Pharmacists	
Student Group Chair	4/94-4/96
Asst. Chairman Professional Affairs Council	4/94-4/95
Chairman Professional Affairs Council	4/92-4/94
Asst. Chairman Professional Affairs Council	4/91-4/92
Seminar Exhibits Co-Chairman	1988
Seminar Co-Chairman	1986
Nomination Committee	1984, 1987-1988
Board of Director's	1981-1983, 1991-1995
Seminar Registration Chairman	1980

Houston-Galveston Area Society of Health System Pharmacists (present name Gulf Coast Area Society of Health System Pharmacists)

Director	1985-1986
Immediate Past President	1983-1984
President	1982-1983
President-Elect	1981-1982
Membership Secretary	1979-1981
Parliamentarian	1978-1979

COMMITTEE RESPONSIBILITIES

Utilization Review Committee,	
UTMB/TDCJ Managed Care	1994-2000
Medical Resource Management,	
UTMB/TDCJ Managed Care	1996-2000
Executive Committee,	
UTMB/TDCJ Managed Care	1994-2000
UTMB-CMC	2002 to present
Strategic Planning Committee,	
Texas Department of Criminal Justice	1993
UTMB-CMC	2005 to present
Pharmacy & Therapeutics Committee,	
Texas Department of Criminal Justice	1990-2000
	2002 to present
Health Care Review Board,	
Texas Department of Criminal Justice	1990-1994
	2002 to present
Pharmacy & Therapeutics Committee,	
Mainland Center Hospital	1983-1990
Pharmacy and Nursing Committee,	
Mainland Center Hospital	1983-1990
Infection Control Committee,	
Mainland Center Hospital	1983-1990
Pharmacy & Nursing Committee,	
V.A. Medical Center, Houston, Texas	1979-1983

LICENSURE AND CERTIFICATION INFORMATION

Registered Pharmacist	Texas State Board of Pharmacy License #21315
Pharmacist Preceptor	Texas State Board of Pharmacy

HONORS/AWARDS

Preceptor of the Year Award: Texas Southern University School of Pharmacy, 1983
RhoChi - Pharmacy Honor Society

Outstanding Alumni Award: University of Houston College of Pharmacy, April 1997, Named one of 50 outstanding Alumni, 50th Anniversary of College

BIBLIOGRAPHY

Publications

Cason, DM, Keith MR. Correctional facilities guidelines.Am J Hosp Pharmacy 1996;53:320 Letter

Haun, WM; Cason, D., Receiving and Transcribing Telephone Orders,Am J Hosp Pharmacy 1986;43:1912-13.

Keith MR, Cason, DM, Helling DK, McCormick WC. An ant ulcer agent prescribing program in a state correctional system. Ann Pharmacotherapy 1994;28:792-96.

Presentations (National, State, Regional)

Cason, DM, "TDCJ/Managed Care Pharmacy and Automation." Accu-Sort Corporate Meeting, Miami, Fl., October 7,2000

Keith MR, Cason DM, "Clinical skills evaluation in applicant assessment and approving staff privileges." 27th Annual ASHP Midyear Clinical Meeting. Orlando, FL., December 6-10, 1992.

Newcomer D, Cason DM. "Selecting a Primary Wholesaler." ASHP Midyear Clinical Meeting, New Orleans, La, December 1985.

Cason DM; Commencement Address, University of Houston College of Pharmacy Graduation, Houston, Texas, May 1985.

Cason DM; "Comparing Mobile Unit Dose to Centralized Pharmacy Drug Distribution." V.A. Medical Center, San Antonio, Texas, February 1981.

Poster Presentations

Cason DM, Cassidy IB, Keith MR. Reengineering pharmacy services. 46th Annual Seminar, The Texas Society of Hospital Pharmacists. San Antonio, Texas, April 24-27, 1994.

Keith MR, Cason DM, Helling, DK, McCormick WC. Implementation of a H_2 Antagonist Prescribing limits in a correctional care environment. 44th Annual Seminar, The Texas Society of Hospital Pharmacists. Ft. Worth, Texas, April 12-15, 1992.

References available upon request.

EXHIBIT 5

MELANIE B. ROBERTS

50 Harbor Run Drive ♦ Coldspring, TX 77331 ♦ (281) 659-5586 ♦ mroberts27@yahoo.com

EDUCATION

ASHP Pharmacy Practice Residency with an Emphasis in Managed Care
University of Texas Medical Branch in Galveston(UTMB)/Texas Department of Criminal Justice(TDCJ). July 2001.

Doctor of Pharmacy
University of Houston, College of Pharmacy – Houston, Texas. May 2000.

PROFESSIONAL EXPERIENCE

Staff Pharmacist
Coldspring Pharmacy – Coldspring, Texas
August 2002 – present

Clinical Pharmacy Practice Specialist
UTMB/TDCJ – Huntsville, Texas
July 2001 – August 2002

- Edited and revised annual TDCJ Drug Formulary
- Edited and wrote articles for monthly prison wide pharmacy newsletter
- Provided pharmacoeconomic reports and consultation to prison units
- Conducted regulatory audits of assigned prison units
- Participated in development and evaluation of Disease Management Guidelines
- Prepared Disease Management Evaluations
- Prepared drug monographs and drug category reviews for TDCJ Pharmacy & Therapeutics Committee
- Provided nonformulary drug consultations and reviews
- Developed database for tracking clinical pharmacist productivity
- Committee member for integrating pharmacy network into the electronic medical record
- Participated in staff development, disease state training and development of continuing education courses
- Organized and carried out annual drug inventory
- Provided HIV specific patient care via telemedicine consultations
- Conducted ambulatory care clinics at assigned prison units
- Prescribed and monitored drug regimens under protocol, performed physical assessment and documented patient encounters in the medical chart

AHSP Pharmacy Practice Residency
UTMB/TDCJ – Huntsville, Texas
July 2000 – July 2001

Rotations included Dialysis Specialty Care, Ambulatory Care, Drug Information and Policy Development, HIV Telemedicine Specialty Care and Pharmacy Management/Systems

- Participated in weekly multidisciplinary team rounds
- Designed, recommended, and monitored patient specific pharmacotherapeutic regimens
- Prescribed medications under protocol, performed physical assessment, and documented patient encounters in the medical chart
- Provided medication-use education to patients and care givers
- Provided in-services to medical staff
- Presented case studies, disease management evaluations and continuing education courses to pharmacy staff
- Prepared drug monographs, drug category reviews, disease management evaluations and disease management guidelines
- Provided formal drug information consultations
- Performed pharmacoeconomic analysis of assigned prison units
- Edited monthly prison wide pharmacy newsletter
- Participated in development and revision of departmental and system wide policy and procedures
- Member of Pharmacy and Therapeutics subcommittees
- Prepared and presented reports to P&T Committee as assigned
- Assisted in ensuring compliance with accreditation, legal, regulatory, and safety requirements: conducted regional and prison unit pharmacy audits.
- Participated in preparation of ASHP residency re-accreditation survey
- Organized and carried out annual drug inventory, prepared monthly drug utilization/expenditure reports, prepared monthly pharmacy productivity reports
- Participated in the development and implementation of Departmental Policies and Procedures and Quality Assurance Programs

PUBLICATIONS AND POSTERS

Roberts MB. Keith MR. A Departmental Operational Performance Evaluation System (OPES) for a Correctional Managed Care Pharmacy. American Society of Health-Systems Pharmacists 35th Annual Midyear Clinical Meeting. Las Vegas, Nevada. December 2000.

Roberts MB. Keith MR. Implementing a performance evaluation system in a correctional managed care pharmacy. *Am J Health-Syst Pharm*. 2002; 59:1097-1104.

HONORS

Graduated Magna Cum Laude. University of Houston, College of Pharmacy. May 2000.
Facts & Comparisons Award for Excellence in Clinical Communication. May 2000.
Texas Society of Health –Systems Pharmacists Annual Scholarship. August 1999.
Rho Chi National Pharmacy Honor Society Member
Dean's Academic Scholarship. August 1998.

LICENSURE/CERTIFICATES

Registered Pharmacist. Texas.
Compounding Techniques. Professional Compounding Centers of America
Aseptic Techniques for Pharmacists. University of Houston, College of Pharmacy

EXHIBIT 6

Richard (Rick) W. Pollard

Over 30 years experience in government and commercial settings with a proven record as an innovative developer and operations manager for outpatient, inpatient, compounding pharmacy operations, distribution, and purchasing. Strong strategic planner, management analyst and administrator, with wide-ranging expertise in automation and logistics. Earned an industry reputation as an efficient and innovative problem-solver noted for achieving successful and cost-effective performance outcomes.

Extensive training and experience in virtually every aspect of pharmacy operations, distribution and management. Successfully served in a myriad of complex and challenging positions and in a variety of organizational structures and operating environments. Demonstrated excellence in difficult and time constrained assignments.

Professional Experience –

Vice President of Operations Support
Maxor National Pharmacy Services Corp., 1992 to present

Duties:

- Consulting, Auditing and Data Analysis: Provide consulting and pharmacy data analysis functions for major PBMs and hospitals
- Information Technology project management
- Pharmaceutical supply management, with extensive knowledge in 340B and Disproportionate Share Hospital (DSH) pricing, DoD pricing, and retail pricing contracts
- Total quality management processes in pharmacy and hospital operations.
- Coordination of benefits

Accomplishments:

- Developed and implemented the following Maxor systems:
  - Interactive Voice Recognition, which is a highly interactive system that allows clients to communicate complex refilling requirements and information to the patients. While IVR systems are fairly commonplace today, Maxor was one of the first non-military pharmacies to routinely use this technology in 1992.
  - Automated audit procedures utilizing data mining techniques to avoid fraud and waste
  - Pharmaceutical purchasing system, which guarantees the "best relative value" routinely reducing cost of goods by over 10% in pharmacies with traditional ordering systems. It also improves inventory management to more than 20 turns/year on average and as high as 40 turns per year.
  - Web-Based Enterprise reporting systems to address rapid communication requirements in pharmacy operations.
  - Innovative free drug tracking system to interface with pharmacy transactions directly

- Computer modeling tool to actuarially predict pharmaceutical costs.
- Management consultation with a Texas hospital where over a million dollars in drug cost savings were identified and achieved.
- Completed a well publicized audit and consulting project for a major hospital in Miami in which over 15 million dollars in over-billing and damages was identified and recovery action initiated.

Senior Non Commissioned Officer
United States Army, 1972 to 1992

Duties:

- Operations manager for inpatient and outpatient pharmacies for various medical and military facilities throughout the world
- Oversaw government and non-governmental pharmaceutical purchasing.
- Pharmaceutical distribution
- Responsible for providing direct supervision for a 350-bed inpatient facility, 11 outpatient pharmacies and 7 troop medical clinic pharmacies.
- Served as the Training Officer for Madigan Army Medical Center. Responsibilities included coordinating both military and medical professional training for over 2000 military and civilian personnel.

Accomplishments:

- Achieved higher standards while enhancing pharmacy operations and pharmaceutical procurement during periods of shrinking budgets.
- Received command recognition for implementing the first U.S. Army European based pharmacy computer system.
- Received a 3M corporate award for innovation for assisting in the development of the diagnostic quality of digitized radiographic images. Developed technology is now commonplace throughout military and civilian medical practices.
- Developed training processes which resulted in fostering the careers of many successful senior commissioned and non-commissioned pharmacy officers. Acknowledged for creating an automated training tracking system.

Other Skills / Education –

- Software engineering
- Unix System Administrator
- System Administrator training (4 different Pharmacy Systems)
- Oracle Master DBA program
- Delphi Programming
- Advanced Non Commissioned Officer Academy
- Combat Medic/EMT/Pharmacy Technician

EXHIBIT 7

CURRICULUM VITAE

MARJORY SUSAN PULVINO, RN,BSN,PhD

UNDERGRADUATE EDUCATION

1966 – 1970	Biology	B.S.	University of New Mexico
1983 – 1985	Nursing	B.S.N.	University of Texas Medical Branch

GRADUATE EDUCATION

1970 – 1974	Medical Sciences (Physiology)	Ph.D.	University of New Mexico School of Medicine Albuquerque, New Mexico
2006	Nurse Refresher		Memorial Hermann Southest

POST GRADUATE EDUCATION

1974 – 1977	Fellowship	Cardiovascular Research Institute University of California San Francisco, California

PROFESSIONAL EXPERIENCE

3/15/06 – present	Staff Nurse : Orthopedics, Med/Surg, Telemetry Woodland Heights Medical Center Lufkin, Texas
8/1/02 – 6/30/2005 (retired)	Director of Clinical Administration Health Services Division Texas Department of Criminal Justice Huntsville, Texas
9/14/01 – 7/31/02	Assistant Director, Health Services Texas Department of Criminal Justice Huntsville, Texas

2/12/96 – 9/14/01	Health Services Liaison Texas Department of Criminal Justice Huntsville, Texas
7/1/95 – 2/11/96	Clinical Managed Care Liaison Texas Department of Criminal Justice Huntsville, Texas
10/1/94 – 6/30/95	Interim Assistant Director for Health Services Texas Department of Criminal Justice Huntsville, Texas
5/30/89 – 9/30/93	Director of Medical Training and Continuing Education Texas Department of Criminal Justice Huntsville, Texas
1987 – 1989	Community Health Nurse, part time Upjohn Health Care Services Huntsville, Texas
1986 – 1987	Director of Nurses Trinity Memorial Hospital Trinity, Texas
1985 – 1986	Charge Nurse, night supervisor Trinity Memorial Hospital Trinity, Texas
1984 - 1985	Instructor, School of Nursing Graduate School University of Texas Medical Branch Galveston, Texas
1981 – 1983	Assistant Professor of Physiology & Biophysics and Medicine University of Texas Medical Branch Galveston, Texas
1979 – 1981	Assistant Professor of Physiology and Internal Medicine University of Texas Health Science Center Dallas, Texas
1978 –1979	Research Scientist Department of Internal Medicine University of Texas Health Science Center Dallas, Texas
1977 – 1978	Assistant Research Physiologist III University of California San Francisco, California

Research Activities

The mechanisms of electrolyte transport, fluid reabsorption and acidification in the mammalian kidney were investigated using the techniques of in vivo microperfusion, pH and PCO_2 microelectrodes and microcalorimetry to measure total CO_2 in nanoliter samples.

Awards and Grants

National Institutes of Health Young Investigator Award, 1983

Tom L. Popejoy Dissertation Award, University of New Mexico, 1976

Bachelor of Science cum laude in General Studies, 1970

Phi Sigma Honor Society for Biologists

Bachelor of Science in Nursing with Highest Honors, 1985

School of Nursing, Dean's Award for Scholarship, 1985

Sigma Theta Tau Honor Society for Nurses

BIBLIOGRAPHY

Articles in Journals

1. Lucci, M. S., H. H. Bengele and S. Solomon. 1975. Suppressive action of prolactin on the renal response to volume expansion. Am. J. Physiol. 229(1): 81-85.

2. Evan, A. P., E. C. Palmer, M. S. Lucci and S. Solomon. 1977. Prolactin induced stimulation of rat renal adenylate cyclase and autoradiographic localization to the distal nephron.

3. Lucci, M. S., D. G. Warnock, and F. C. Rector, Jr. 1979. Carbonic anhydrase dependent bicarbonate reabsorption in the rat proximal tubule. Am. J. Physiol. 236: F58-F65.

4. Lucci, M. S., and D. G. Warnock. 1979. Effects of anion-transport inhibitors on NaCl reabsorption in the rat superficial convoluted tubules. J. Clin. Invest. 64:570-579.

5. DuBose, T. D., L. R. Pucacco, M. S. Lucci and N. W. Carter. 1979. Micropunture determination of pH, PCO_2, and total CO_2 concentration in accessible structures of the rat renal cortex. J. Clin. Invest. 64: 476-482.

6. Cogan, M. G., D. A. Maddox, M. S. Lucci, and F.C. Rector, Jr. 1979 Control of proximal bicarbonate reabsorption in normal and acidotic rats. J. Clin. Invest. 64:1168-1180.

7. Lucci, M. S., T. D. DuBose, L. R. Pucacco, J. P. Kokko and N.W. Carter. 1980. Direct evaluation of acidification by the rat proximal tubule: the role of carbonic anhydrase. Am. J. Physiol. 238:F372-F379.

8. Lucci, M. S., L. R. Pucacco, T. D. DuBose, Jr. , and T. D. DuBose, Jr. 1982. Direct evaluation of the permeability of the rat proximal convoluted tubule to CO_2. Am. J. Physiol. 242:F470-F476.

9. Lucci, M. S., L. R. Pucacco, N. W. Carter and T. D. DuBose, Jr. 1982 Evaluation of bicarbonate transport in rat distal tubule: Effects of acid-base status. Am. J. Physiol. 243:F335-F341.

10. DuBose, T .D., and M. S Lucci. 1982. Effect of carbonic anhydrase inhibition on superficial and deep nephron bicarbonate reabsorption in the rat. J. Clin. Invest. 71:55-65.

11. DuBose, T.D., R. W. Hogg, L. R. Pucacco, J.P. Kokko, and N. W. Carter. 1983. Comparison of parameters in superficial and deep nephrons of the rat. Am. J. Physiol.

12. Lucci, M. S., J. P. Tinker, I. M. Weiner and T. D. DuBose, Jr. 1983. Function of proximal tubule carbonic anhydrase defined by selective inhibition. Am. J. Physiol. 245: F445-F449.

Abstracts

* Denotes presentation at conferences

1. Solomon, S., J. C. Cook and . 1971. Acidification of proximal tubular fluid. Biophysical Soc. Abstr. 11:274a.*

2. Lucci, M. S., H. Bengele and S. Solomon. 1973. Effects of prolactin on the renal response to volume expansion. Physiologist.16:383.*

3. Lucci, M. S., A. P. Evan, H. Bengele and S. Solomon. 1974. Altered effect of saline loading on the lateral intercellular spaces of the proximal tubule during prolactin infusion. Fed. Proc. 33:368.*

4. Solomon, S., M. S. Lucci, A. P. Evan. 1974. Evidence that prolactin regulates renal water and salt excretion in mammals. V, Int. Conf on Physiol. of food and water intake, Jerusalem.*

5. Lucci, M. S., D. G. Warnock, and F. C. Rector, Jr. 1977. Luminal Diamox totally inhibits proximal tubular bicarbonate reabsorption. The Physiologist. August.*

6. Lucci, M. S., D. G. Warnock and F. C. Rector, Jr., 1977. Dual effects of diuretics on volume reabsorption in the superficial proximal tubule. Kidney Int. 12:535a.*

7. Warnock, D. G., M. S. Lucci, and F. C. Rector, Jr.. 1978. Luminal furosemide inhibits NaCl reabsorption in the superficial proximal tubule. Clin. Res. April.*

8. Cogan, M. G., D. A. Maddox, J. M. S. Lucci, and F. C. Rector, Jr. 1978. Glomerular filtration and proximal reabsorption of volume and total CO_2 in hydropenic and euvolemic rats. Clin. Res. April.*

9. Warnock, D. G., and M. S. Lucci. 1978. NaCl transport in the proximal tubule. VII Internation. Conger. of Nephrology, Montreal, Canada, June.*

10. Lucci, M. S., D. G. Warnock, and F. C. Rector, Jr. Proximal bicarbonate reabsorption totally depends upon carbonic anhydrase. VII International Congr. of Nephrology, Montreal, Canada, June.*

11. Maddox, D. A., M. G. Cogan, M. S. Lucci and F. C. Rector, Jr. 1978. Determinants of the distal delivery rate of total CO_2 in normal and acidotic rats. VII Intern. Congr. of Nephrology, Montreal, Canada, June.*

12. DuBose, T .D., R. J. Hogg, L. R. Pucacco, M. S. Lucci, N. W. Carter and J. P. Kokko. 1979. Direct determination of pH and PCO_2 in cortical and medullary nephron segments of the Munich-Wistar rat. Clin. Res. 27:413A.*

13. Lucci, M. S., T. D. DuBose, Jr., L R. Pucacco, J.P. Kokko and N. W. Carter. 1979. Effect of carbonic anhydrase inhibitors of varying permeabilities on proximal tubular pH and total CO_2 reabsorptive rate. Clin. Res. 27:423A.*

14. Warnock, D. G. and M. S. Lucci. 1979. Neutral NaCl transport in the superficial proximal tubule. Clin. Res. 27:433A.*

15. Lucci, M. S., L. R. Pucacco, N. W. Carter, and T. DuBose, Jr. 1979. Inability of the rat proximal tubule to sustain a PCO_2 gradient in vivo. Kidney Int. 16:287.

16. Lucci, M. S., L. R. Pucacco, N. W. Carter and T. D. DuBose, Jr.. 1979. Direct determination of CO_2 permeability in the rat proximal tubule in vivo. Clin. Res. 27:795A.*

17. Lucci, M. S., L. R. Pucacco, N. W. Carter and T. D. DuBose, Jr.. 1980. Evaluation of bicarbonate transport in the rat distal convoluted tubule. Clin. Res. 27:795A.*

18. Lucci, M. S., L. R. Pucacco, N. W. Carter, and T. D. DuBose, Jr. 1980 an <u>in vivo</u> microperfusion evaluation of bicarbonate transport in the rat distal convoluted tubule. Clin. Res. 28.*

19. Lucci, M. S., L. R. Pucacco, N. W. Carter, and T. D. DuBose, Jr. Effect of carbonic anhydrase inhibition on the ability of the rat proximal tubule to sustain a PCO_2 gradient. XXVIII Intern. Congr. Physiological Sciences, Budapest.*

20. Lucci, M. S., L. R. Pucacco, N. W. Carter, and T. D. DuBose, Jr. 1981. Effect of altered acid-base status on bicarbonate reabsorption by the rat distal convoluted tubule. Clin. Res. 29:469.*

21. DuBose, T .D., and M. S. Lucci, 1981. Disparate effects of carbonic anhydrase inhibition on rate superficial and deep nephron bicarbonate reabsorption. Kid. Int. 20:106A.*

22. Lucci, M. S., J. Tinker, I. Weiner, C. Crowther, J. Pulvino and T. D. DuBose, Jr. 1982. Role of luminal carbonic anhydrase in proximal bicarbonate reabsorption: Effects of dextran-based inhibitor. Clin. Res. 30:457A.*

23. DuBose, T. D., and M. S. Lucci. 1982. Comparison of deep Loop of Henle (LOH) and vasa recta (VR) total CO_2 concentration (tCO_2). Abstracts of the American Society of Nephrology.

24. Bidani, A., M. S. Lucci, E. Crandall, and T. D. DuBose, Jr. Role of metabolic CO_2 production (MCO_2) and diffusive gas transfer in generation of elevated renal cortical PCO_2. Abstracts of the American Society of Nephrology.*

25. Lucci, M. S., J. Tinker, I. Weiner and T. DuBose, Jr. 1982. Effects of a dextranbound and unbound carbonic anhydrase inhibitor on proximal tubule acidification. Abstracts of the American Society of Nephrology.*

26. DuBose, T .D., and M. S. Lucci. 1983. Acidification parameters in superficial and deep nephron segments of the rat. Clin. Res. 31*

27. DuBose, T .D., C.R. Caflisch, M. S. Lucci and A. Bidani. 1983. Role of metabolic CO_2 production (MCO_2) in generation of renal cortical CO_2. XIX Intern. Congr. Physiological Sciences, Sydney.*

EXHIBIT 8

Kaye Cloutier
2011 Port Royal Drive
Nassau Bay, TX 77058
Home: (281) 333-8363 FAX (281) 335 1304

ACHIEVEMENTS:

Thirty years in healthcare field including a combination of nursing and administrative healthcare experience

Extensive background in accreditation, regulatory and licensing standards and multi-site healthcare management

Participation in the development of a statewide healthcare system for Correctional Healthcare in multiple states

Developed a nationwide Prior Notification / Utilization Management program for Commercial Medicaid / Medicare products in multiple states

Experience with budgeting, contract administration and physician network development

Extensive knowledge of claims adjudication and provider reimbursement

Developed start up programs for Utilization Management, Risk Management, Process Improvement, Case Management, Resource Management and Physician Quality Programs

Experience includes conducting needs assessments, analyzing data, generating reports and developing systems to improve quality and cost efficiency

Graduated Delta Mu Delta (National Honor Society in Business Administration) Our Lady of the Lake University
Speaker at NCCHC National Conference for 7 years
Coordinated over 25 successful JCAHO surveys

EDUCATION:

1999 - **MBA**
Our Lady of the Lake University

1988 - **BSN**
Angelo State University

1976 - **Diploma RN**
Brackenridge Hospital School of Nursing

SUMMARY OF EXPERIENCE:

2004 - 2005 **National Executive Director, Prior Notification**
AmeriChoice Healthcare, Houston, TX
Start-up program for AmeriChoice. Developed a national centralized program for Utilization Management – Prospective Review. This program included the Medicaid product in 12 states and the Medicare product in 6 states. Served as member of Administrative team in each state. Program standardized when possible but designed to meet individual state regulations and codes.

1994 – 2002	**Executive Director, Resource Management and Medical Compliance**, UTMB, Galveston, TX. Administrative member of UTMB Correctional Managed Care team. Responsible for Utilization Management, Case Management, Risk Management and Quality Improvement program development and systems analysis. Developed nursing and physician networks including Telemedicine programs. Developed and implemented Skilled Nursing, Extended Care and Hospice programs in the Texas Department of Criminal Justice System. Served as a consultant for UTMB to the New York Department of Criminal Justice.
1990 – 1994	**Administrator Quality Services**, St. Mary's Hospital, Galveston, TX. Oversight of CQI, Medical Staff Quality, Utilization Review, Risk Management, Workman's Comp, Employee Health, Infection Control and Patient Representative Program
1985 – 1990	**Area Supervisor**, Texas Medical Foundation, San Antonio, TX. Onsite review of 50 regional hospitals for Medical Compliance. Instructor for Physician Advisor certification classes.
1976 – 1990	**RN** ICU, CCU, ER nursing and supervisor positions.

EXHIBIT 9

CDCR Pharmacy Improvement Project

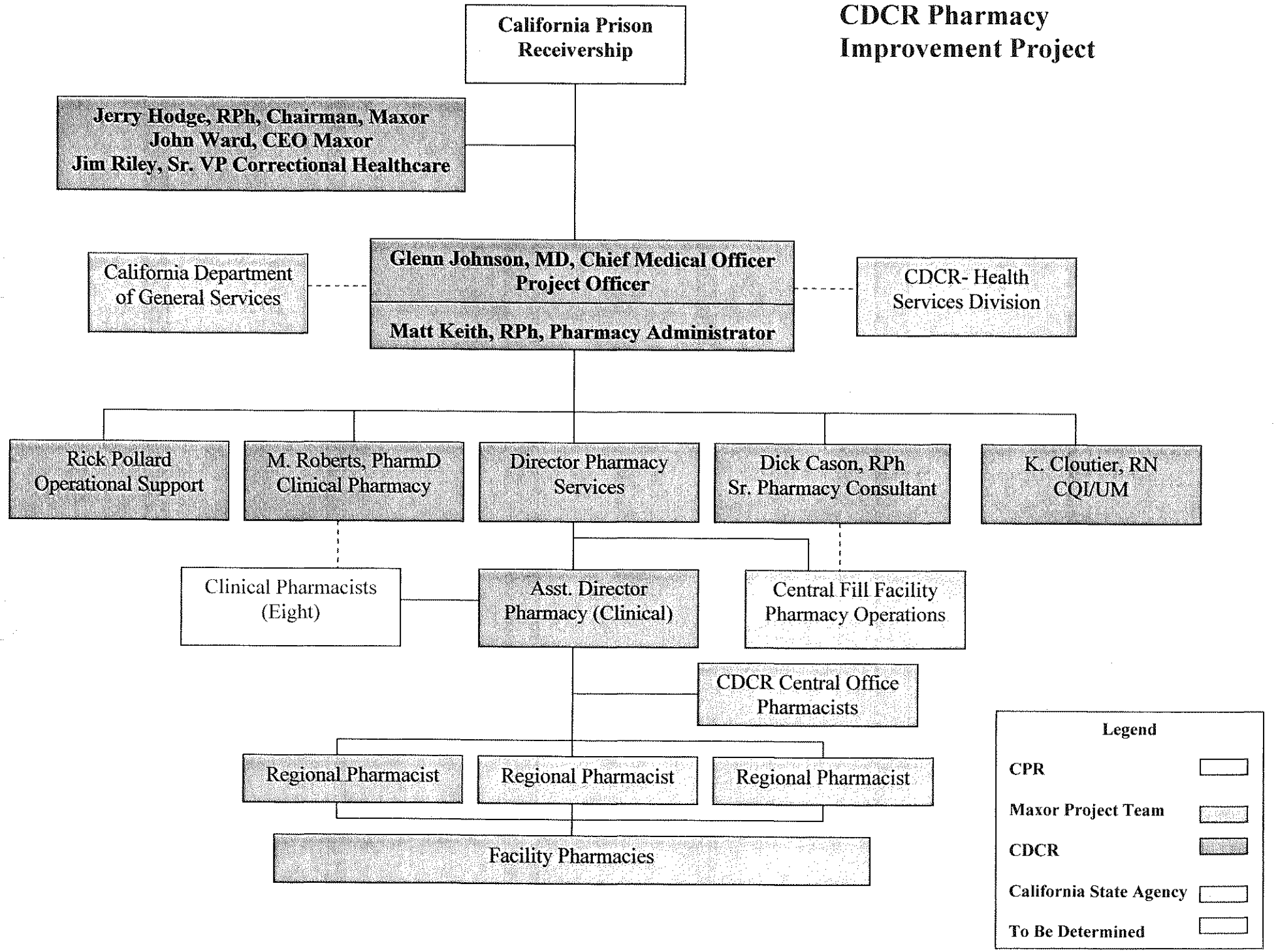

EXHIBIT 10

MAXOR[SM]
National Pharmacy Services Corp.

The Road Map to Excellence
Patient Safety—Evidenced Based Practice—Cost Effective
A California Approach

California Prison Health Care Receivership Corporation
Pharmacy Management Consulting Services

Maxor's First Ninety Days

A Plan

Submitted to the
California Prison Health Care
Receivership Corporation

Effective
January 1, 2007

The Road Map to Excellence
Patient Safety—Evidenced Based Practice—Cost Effective
A California Approach

California Prison Health Care Receivership Corporation
Pharmacy Management Consulting Services

Maxor's First Ninety Days

Introduction

The following planning document is submitted pursuant to the Agreement made effective January 1, 2007, by and between the California Prison Health Care Receivership Corporation ("CPR") and Maxor National Pharmacy Services Corporation ("Maxor") to provide pharmacy management consulting services to CPR. The purpose of this document is to clearly outline the activities that will be ongoing and the milestones that are to be accomplished in the first 90 days of the Agreement. The Agreement incorporates goals, objectives and timelines originally proposed in the *Road Map from Despair to Excellence* and further defined through Maxor's response to the CPR Request for Proposals.

Concept of Operation

The Scope of Work for the above referenced Agreement is outlined in seven key goals. Each goal is supported by a number of objectives outlining necessary tasks to be accomplished to achieve the desired outcome. Each objective is further defined by identifying detailed actions to be taken. This document outlines those actions to be taken in the first 90 days of the contract.

Maxor's CPR Pharmacy Project Team will be structured to ensure that the goals and objectives outlined in the *Road Map* are achieved in an effective manner. Maxor will assign an overall Project Manager from its senior executive ranks to oversee integration of the various goals and objectives and to serve as principal liaison with the Office of the Receiver. Maxor will assign Senior Team Leaders with responsibility for oversight of each goal to ensure tasks are identified and accomplished in a timely manner. The team structure will be flexible to adapt to changing needs and circumstances as the project develops.

The following Maxor personnel will serve as the principal project team:

- Project Manager: Glenn Johnson, MD
- Pharmacy Administrator: Matt Keith, RPh, BCPS, FASHP
- Senior Pharmacy Consultant: Dick Cason, RPh. MS.
- Clinical Pharmacy Consultant: Melanie Roberts, RPh., PharmD
- Pharmacy Information Officer: Rick Pollard
- Pharmacy Nurse Advisor/Liaison: Marjorie Pulvino, RN, PhD (*)
- Pharmacy UM/CQI Consultant: Kaye Cloutier, RN

Note: (*) Subject to approval of Receiver and/or Receiver's Chief of Staff

Summary of 90-Day Priorities

This plan identifies key goals and objectives to be accomplished in some detail in the following pages. Many of these actions are designed to address priority concerns identified by the CPR and the *Road Map*. In general terms, the priority focus of Maxor during the first 90 days of the contract will include:

- Establishing communication and coordination channels through the CPR for managing project activities;
- Assuming management responsibility for oversight and monitoring of the CDCR pharmacy services program;
- Filling critical staff vacancies to ensure adequate pharmacy coverage for all facilities;
- Taking immediate corrective measures to address any identified patient safety issues;
- Developing essential connectivity between pharmacy management and individual facilities to facilitate electronic reporting and monitoring systems; and
- Initiating comprehensive review and reform of the pharmacy policies, procedures, formulary processes and management practices, including the development of performance monitoring systems.

Detailed actions anticipated for each goal and corresponding objective are outlined in the following pages.

Goals, Objectives and Related 90-Day Actions

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

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

Related 90-Day Actions:

- Sacramento Office to be established NLT January 1, 2007.
- Key Project team members to arrive on site for orientation and initial briefings by Project Leader and Corporate Headquarters.
- Lines of communications to be established with CPR and CDCR Health Services office.
- Schedule initial meeting with Receiver and the Receiver's staff to receive initial guidance and project direction.
- In conjunction with the Receiver's staff attorney, develop plans and timelines for implementing centralized oversight, control and monitoring over the CDCR pharmacy services program.
- Establish on site Maxor presence with a Project Manager, Senior Pharmacy administrator, two Pharmacy consultants, the CDCR central office pharmacist, and support staff.
- Commence Recruitment of a Director of Pharmacy Services, Assistant Director and 8 clinical specialists.

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

Related 90-Day Actions:

- With the approval of the Receiver, Schedule and conduct system wide CDCR Pharmacy staff information briefings on the approved Road Map.
- Document and disseminate clear organizational reporting relationships and chains of command and coordination.

- Orient all pharmacy staff to the *Road Map*. Establish a compact: delineate roles, responsibilities and expectations of leadership and staff. Communicate the organizational structure.
- Identify early adopters to participate as active change agents and communicate with pharmacists-in-charge to assure clear understanding and ongoing communication structure.

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

Related 90-Day Actions:

- Establish policy and procedure review team.
- Develop and adopt policy and procedure review process and schedule for standardizing policies and procedures for all institutions and care levels.
- Review existing central policies and procedures.
- Solicit input from institution level policies and procedures to identify best practices.
- Begin to roll out standardized policies and procedures to institutions, with an emphasis on addressing patient safety risk issues on a priority basis.

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

Related 90-Day Actions:

- Identify available information sources and establish data reliability.
- Define operational targets for pharmacy and institution level teams.
- Develop a pharmacy initiative tracking grid (for projects with finite timelines), balanced scorecard (clinical, service, financial and workforce measures), and dashboard (workload measures) to include historical benchmarks, measures, targets and milestones for the program. These documents will serve as a start point for a performance

measure system focusing on outcome data and will continue to be refined throughout the project.

- Create institution level dashboards to provide performance benchmarks and comparisons, and set targets to structure improvement (institution level report card for prescribers and pharmacy).
- Begin process of instituting an organizational culture in which the balanced scorecard and dashboard are central themes in meetings at every level.

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

Related 90-Day Actions:

- Initiate rudimentary reports based on available data. More sophisticated reporting will be contingent upon the implementation of a fully integrated pharmacy information management system.
- Use an action plan tracking grid to establish timelines and monitor implementation of the Road Map.
- Establish initial standardized institution audit process to assess adherence to standards of practice and P&P.
- Establish a stoplight grid to post institution audit results with links to detail reports. Post on website or other shared forum to allow comparison between institutions. Discuss at monthly P&T committee meetings.
- Require corrective action plans from institutions not meeting requirements.
- Develop a standardized format for identification of needed disease management guidelines, criteria development, data collection, reporting, monitoring and follow-up.

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

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

Related 90-Day Actions:

- Assess current P&T Committee.
- Within the first 30 days of contract implementation, identify and meet key CPR and CDCR clinical personnel (Medical, Mental Health and Dental).
- Develop an interdisciplinary P&T Committee with membership experienced in formulary management. Include central, regional and institution level participation as appropriate. Provide specific recommendations for the appropriate representation on a newly formed P&T Committee. Staff recommendations with designated clinicians and submit to the Receiver's Office for approval
- In conjunction with CPR's Project Management Office, schedule the initial P&T meeting within 45 days of contract initiation.
- Establish a clear committee charter utilizing principles stated in Objectives A3, A4, and A5.
- Assign committee members responsibility for various functions; assign implementation oversight and ownership to gain accountability from all members.
- Methodically work through the formulary categories and various reports and measures identified under Goal A to implement initiatives as identified.
- Review the entire formulary identifying "quick hits" and any patient safety risks, with P&T Committee action around the overall review as a priority on the meeting agenda.

- Establish a process of routine scheduled review of the entire formulary by therapeutic category through the P&T Committee to assure a sustained up-to-date formulary is maintained.

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

Related 90-Day Actions:

- Establish direct liaison and routine meetings with the CPR Director of Nursing and staff as she may designate to discuss pharmacy management processes and receive input.
- Assess current CQI program and review pharmacy component for existing indicators, the process for identifying opportunities for improvement and the methodology utilized to resolve those issues. Begin the design pharmacy CQI component to fit into existing model when possible.
- Initiate the development of a formal Pharmacy CQI program.
- Establish measurable indicators to monitor physician practice patterns including formulary compliance and prescribing behavior.
- Establish variance reports to review and compare patient outcomes for care delivered outside the approved disease protocol.
- Develop indicators specific to treatment protocols that identify expected and actual outcomes. Identify variances and establish process to monitor and report positive/negative, long/short term effects on a patient's health and functioning which are attributed to care (medication therapy) given. (Begin this process--indicators will be added as new protocols are developed).
- Review current staff development program to assist in the development of a strong communication process.

- Establish a mechanism for a training program for approved protocols that provides educational in-service to health care providers prior to implementation.
- Begin the creation of online training courses and maintain online protocol manual for reference resource.
- Establish protocol for peer review of noncompliant practitioners. Determine if negative outcomes were attributed to noncompliance.
- Assess how to implement a formal CQI process for peer review that meets California state statutes and is incorporated into existing CDCR medical committee structure.

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

Related 90-Day Actions:

- Assess disease treatment guidelines in use.
- Begin process to review, revise or develop formal, evidence-based disease treatment guidelines with consensus of clinical stakeholders (initially for epilepsy, hypertension, asthma, diabetes, hyperlipidemias, HIV disease, Hepatitis C, and mental illness-at a minimum, schizophrenia, bipolar disease and depression) which delineate medication utilization expectations.
- Assess current UM Program for data collection capabilities, available reports and potential resources.
- Initiate development of a formal Pharmacy Utilization Management Program that will effectively monitor progress of patient throughout health care delivery system. Design pharmacy UM component to fit into existing model when possible.
- Develop mechanism(s) to evaluate patient compliance, participation in chronic care clinics, exacerbations of illness, transfers to ER and hospitals, outpatient testing, diagnostic procedures, etc. and relate these occurrences to the expected outcomes of the disease management protocol.

- Determine reports needed to monitor health care outcomes. Develop process to obtain reliable data and format reports to P&T Committee.

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

Related 90-Day Actions:

- Develop and publish a schedule for regular institution operational audits. The audits will encompass all areas of operations, accountability and compliance using the performance benchmarks, measures, protocols and reporting mechanisms developed pursuant to the Road Map.

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

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

Related 90-Day Actions:

- Schedule meetings with the California Department of General Services, CDCR Pharmacy central office staff, and contracted pharmaceutical vendor to discuss *Road Map* and discuss processes for the review, auditing and monitoring of pharmaceutical contracting and procurement processes to ensure cost efficiency in pharmaceutical purchases.
- Download CDCR purchases directly from the wholesaler and audit contract pricing.
    (1) Review purchases for Overcharges
    (2) Review purchases for Contract Maximization and Least Expense of Relative Value
    (3) Rebate analysis and reconciliation

- Meet with Amerisource Bergen and DGS to actively participate in the credit/rebills process and ensure that CDCR is credited in full for any loss in contract pricing or rebates not received.
- Ensure Wholesaler is stocking the contracted items at an appropriate level in each of its local Distribution Centers
- Intercept individual orders for appropriateness
- Review Registry Billing hours
- Collect available CDCR CY 2006 pharmacy data and analyze for trends and projections
- Continually audit CDCR purchases and closely monitor the credit/rebills process.

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

- Conduct system-wide pharmacy inventory to establish baseline.
- Concurrently, Maxor staff member experienced in inventory control will conduct on-site inspections to survey and document deficiencies.
- Establish ongoing liaison with both the Office of Inspector General and the CDCR Internal Affairs Division.
- Establish a written inventory control procedure that compares all purchases vs. all dispenses to identify potential diversion or misuse of CDCR pharmaceuticals.
- Monitor inventory on perpetual basis, with random spot checks of physician orders and medication administration records to validate electronic data during operational audit reviews.
- Report any suspected diversion to the Receiver, Office of the Inspector General and the CDCR internal affairs division and assist in any investigations deemed necessary.

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

Related 90-Day Actions:

- Compare each requirement for replenishment with all available contracts to ensure the best relative value item is purchased.
- Establish process to analyze purchases on a quarterly basis to ensure contract compliance, Prime Vendor availability of the best contracted item and facility adherence to purchasing policies.
- Develop an arrangement mutually agreeable to the Receiver and DGS for the coordination and improvement of pharmaceutical procurement and contracting activities.
- Verify contract compliance by the pharmaceutical manufacturers, collection and reconciliation of all rebate payments, and formulary compliance.
- Establish liaison with the Office of the Receiver, designated California state agencies and CDCR's P&T Committee to obtain contracts, through DGS, with pharmaceutical manufacturers to take maximum advantage of the CDCR's and the State's significant purchasing power in an effort to reduce medication costs.
- Evaluate the effectiveness of DGS contracts and the need for the CDCR to execute pharmaceutical contracts independent of the State.

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

Related 90-Day Actions:

- Maxor's Operation Support team in conjunction with CPR's Chief Medical Information Officer and Chief Information Officer will determine an interim solution to immediately begin capturing uniform dispensing data and improve patient safety. Any solution suggested will require a

discussion on connectivity at each facility, the equipment/hardware requirements, as well as security.

- Once an interim solution is agreed upon, six test sites will be identified to begin implementation and building a baseline model for pharmacy operations.

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

- Identify 340B preferential pricing savings potential.
- Establish work group to explore and evaluate potential contractual arrangements with 340b covered entities that would establish eligibility for CDCR inmate patients.

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

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

Related 90-Day Actions:

- Commence recruitment for a Director and assistant Director of Pharmacy
- Enhance clinical representation on the Maxor Pharmacy Management team.
- Prepare job descriptions for the Pharmacy Director, Assistant Director and Clinical Pharmacists
- In conjunction with the Receiver's Office, determine the organizational placement and supervisory relationship for eight clinical pharmacist positions.

- Commence recruitment of Clinical Pharmacist positions to include consideration of requesting assistance from a California School of Pharmacy.
- In conjunction with the CPR Staff Attorney's Office and CDCR's Human resource Office, develop a meaningful pharmacy human resource program that effectively manages staffing, compensation, job descriptions, competency, performance assessment, discipline, training, and use of the workforce including temporary employees and non pharmacist staff.
- Reevaluate staffing pattern versus workload and interim practice model (prior to full system redesign) to determine appropriate staffing compliment and numbers.
- In coordination with the Office of the Receiver and CDCR, hire employees to fill vacant pharmacy manager (Pharmacist II) positions
- In coordination with the Office of the Receiver and CDCR, hire employees to fill all other vacant positions.
- Train new employees and define methodologies for monitoring and evaluating employee competence and performance.

Objective D.2: **Complete skill set inventory of State and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing employees. Establish new hire orientation checklist and identify annual mandatory training and education series.**

Related 90-Day Actions:

- Identify knowledge deficits in clinical, operational, and fiscal matters.
- Develop and obtain approval of new hire orientation checklist.
- Develop annual in-service training modules.
- Prioritize in-services and develop schedule for conducting training.

- Develop and implement a highly trained and well managed "Drop In" pharmacist team to deploy to institutions requiring high priority assistance. Test the team's responsiveness and capabilities at the San Quentin facility.

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

Related 90-Day Actions:

- Identify key data elements for employee training, education and disciplinary tracking system.
- Develop and begin implementation of comprehensive employee tracking system.

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

Related 90-Day Actions:

- Evaluate current system-wide workload standards for pharmacists and technicians.

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

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

Related 90-Day Actions:

- Initiate a system wide assessment of CDCR institutional pharmacy drug distribution operations and establish a baseline for standardization and revision.
- Identify and develop best practice models for "ambulatory" care distribution model using existing resources and pre-centralization model (correct high risk safety and control issues).
- Identify and develop best practice models for "inpatient" care areas.

Objective E.2: Design, construct and operate a centralized pharmacy facility in coordination with CPR.

Related 90-Day Actions:

- Assess benefits of using and, if appropriate, utilize a third party "Central Fill" facility for limited services, such as packaging, as an interim measure until the centralized facility is built.
- Develop straw model for centralization concept.
- Begin an assessment of potential sites for establishing a centralized pharmacy facility to include as a minimum: Fresno, Stockton and Sacramento. Criteria should include access to lines of transportation (air and ground), location, proximity to pharmaceutical distribution centers, ability to recruit and maintain qualified pharmacy staff and costs.
- In conjunction with CPR, determine general location, survey, real estate and identify a suitable location for the centralized pharmacy facility.
- In conjunction with CPR and/or State, plan ownership (CPR, State or Maxor) of rights in facility and equipment and plan for any transfers, if necessary, of such property following termination of this Agreement.

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

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

Related 90-Day Actions:

- Create a data repository of prescription data from the existing PDTS system and assign an industry standard identifier to all drugs to allow for consistent data accumulation and reporting.
- Provide data input guidance to pharmacies to insure data consistencies are maintained.
- Develop rudimentary utilization management and pharmacy reports based on standard managed care and pharmacy benefit manager practices.
- Provide initial data information to the CPR CMO for analysis.

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

Related 90-Day Actions:

- Survey the pharmacies, conducting on-site visits in all sites to evaluate current connectivity issues and obstacles to achieving connectivity.
- Identify and employ stopgap measures to overcome connectivity issues.
- Establish basic connectivity in all pharmacies.

Objective F.3: **Procure a state-of-the-art pharmacy dispensing system in coordination with the Office of the Receiver.**

Related 90-Day Actions:

- Organize an interdisciplinary team of pharmacy experts with clinical, operational, fiscal, and technological backgrounds to assist in evaluating the requirements for the pharmacy dispensing system.

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

Related 90-Day Actions:

- No action in first 90-days, pending completion of related objectives.

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

Related 90-Day Actions:

- No action in first 90-days, pending completion of related objectives.

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

Related 90-Day Actions:

- Meet with the CPR Chief Medical Information Officer and the CPR Information Office to discuss strategies for the pharmacy interface to the overall medical information system.
- Visit and assess on going data gathering projects such as that in the Pelican Bay institution.

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

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

Related 90-Day Actions:

- No action in first 90-days, pending completion of related objectives.

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

Related 90-Day Actions:

- No action in first 90-days, pending completion of related objectives.

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

Related 90-Day Actions:

- No action in first 90-days, pending completion of related objectives.

Attachments:

A. CDCR Pharmacy Improvement Project Organization Chart
B. Project Team CVs
C. Revised Contract Fiscal Note
D. Supplemental Fiscal Note

EXHIBIT 11

MAXOR
National Pharmacy Services Corp.

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

Prepared and Submitted by
Maxor National Pharmacy Services Corporation

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

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Receiver Bob Sillen
John Hagar, Court Appointed Correctional Expert
Matthew L. Cate, CA Inspector General

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California State Auditor
FOX Systems, Inc.
Office of the Inspector General
Senate Advisory Commission on Cost Control in State Government

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EXECUTIVE SUMMARY

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

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

> *"In recent years, providing adequate health care to inmates has been increasingly problematic for the Department of Corrections and Rehabilitation. In February 2006, the U.S. District Court for the Northern District of California appointed a receiver over the department's health care operations in connection with a class action suit, Plata v. Schwarzenegger. Under the terms of the court's action, the receiver has broad powers to achieve the goal of 'restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable.' The receiver's powers include the duty to control and direct 'all administrative, personnel, financial, accounting, contractual, legal, and other operational functions of the medical delivery component' of the department."*
>
> (2006 OIG Accountability Audit 8).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BACKGROUND

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

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

Need for Meaningful, Effective Oversight and Management

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

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

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

Need to Implement and Enforce Effective Clinical Management Processes

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

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

Need to Improve and Monitor Pharmacy Contracting and Procurement

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

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

Need to Improve Pharmacy Workforce

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

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

Need to Redesign Pharmacy Distribution System

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

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

Need for a New Pharmacy Information Management System

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

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

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

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

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

(2003 OIG 7)

MAXOR ON-SITE INSPECTION OBSERVATIONS

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

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

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

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

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

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

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

-- A key issue identified in previous audits is the need for an effective centralized Pharmacy and Therapeutics Committee (P&T). CDCR has responded that a P&T Committee has been established and is functioning well. Based on interviews with CDCR staff, review of P&T minutes, and more importantly results of committee actions, the current CDCR P&T committee is a shell entity with little or no meaningful impact on the overall pharmacy process. There is little or no support from central medical authorities in regards to P&T Committee participation. Formulary and procedures are not always followed at the institution level and there is no systematic way to monitor formulary compliance. Some one-way, top-down communication regarding formulary, drug use controls and procedures occurs. Data is collected for some parameters (although not clinical outcome-driven) and sent back to administration. No follow-up is provided. There is limited or no cross-pollination between institution pharmacies or collaboration between central administration and institution level teams. A quality, evidence-based guideline for the treatment of HCV was developed, but workforce level education and training appeared lacking and no outcome-based follow-up was conducted to determine if the guideline is used or if desired results are achieved.

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

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

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

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

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

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

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

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

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

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

-- **Key Maxor Finding**: While the previous audits identified centralized clinical management and control issues, **the CDCR Pharmacy recommendations lacked a patient-centered, outcome-based focus**. The focus has been on drug distribution and central clinical administration such as formulary management, drug use evaluation and treatment guidelines, but lacks a patient-centered, outcome-based, performance-driven focus. The healthcare system should use outcome-based criteria to drive treatment decisions, processes, educational focus and infrastructure redesign. By reviewing how patients are treated, and assessing disease outcomes obtained, systems / prescribing / competency can be tailored to meet determined goals.

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

FINANCIAL ANALYSIS

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

-- The financial analysis, coupled with Maxor's on-site observations and CDCR's responses to the findings, indicate an overall lack of central oversight, infrastructure and technology to properly manage drug costs, including contracting, procurement, distribution, reclamation and inventory control. The fragmentation of responsibilities and oversight of the CDCR/DGS pharmacy procurement and distribution program has resulted in the absence of clear lines of authority and accountability, a breakdown in communications, inefficiencies, waste and the potential for illegal diversion, the sum result of which has seriously endangered the quality and appropriateness of offender health care. The current system has minimal controls to preclude or detect diversion and does not meet basic patient care and safety needs, fundamental standards of practice, or medical/pharmacy practice regulations. Furthermore, the system's lack of such controls places patients at serious risk and opens the door to large scale fraud and/or theft of State property in the form of prescription drugs.

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

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

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

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

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

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

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

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

CDCR TOP 20 MISSED SAVINGS OPPORTUNITIES

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

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

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

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

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

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

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

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

(B) For each prescription dispensed by the pharmacy:

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

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

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

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

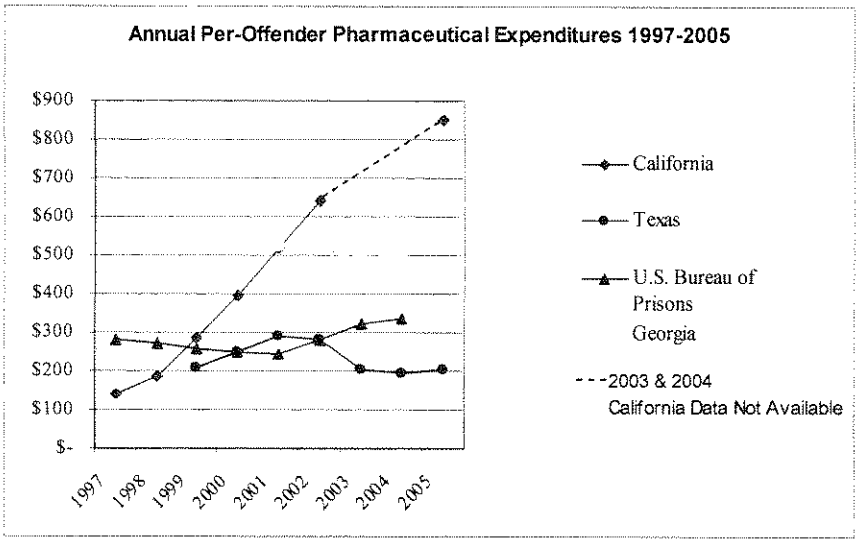
CDCR Purchases vs. Dispenses of Selected Antipsychotic and Narcotic Medications – CY 2005

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

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

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

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



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

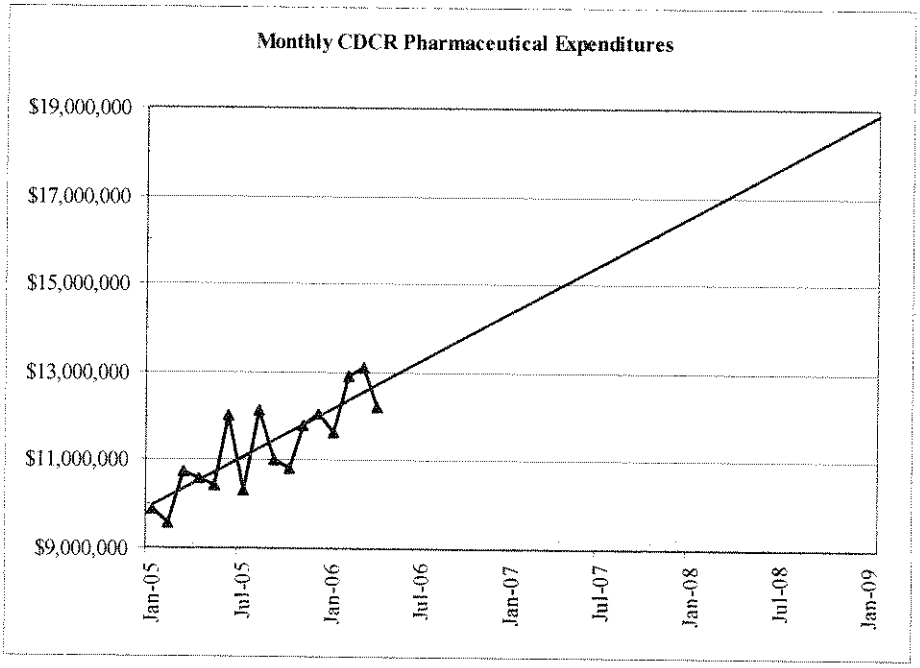
DRUG COST EXPENDITURES COMPARISON 2005

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

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

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

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



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

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

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

THE ROAD MAP CONCEPT

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

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

As clearly demonstrated by past audits and recent reports, change in the way of doing business does not come easy or quickly. Obstacles such as resistance to change, lack of resources, inadequate staffing, and antiquated technology will not be corrected overnight. Therefore, the road map's goals and supporting objectives are packaged in a crawl, walk and run sequence that outline the destinations that must be reached and a general timeframe for reaching them. Should the goals and objectives in this report be formally adopted, detailed scheduling for each goal and objective will follow. The "road to recovery" will begin with critical, incremental steps ("crawl") toward progress. By building on the strong foundation achieved in the "crawl" phase, greater progress will be achieved in the "walk" phase, with the eventual "run" phase in which all the previous steps culminate into a high performing system. In all phases, however, improved patient care remains the first priority and a primary driver.

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

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

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

The road map is outlined in seven key goals. Each of the goals is supported by a number of objectives outlining necessary tasks to be accomplished to achieve the desired outcome. Each objective is further defined by identifying detailed actions to be taken. It should be noted that the actions proposed herein are based on what is presently known. This document should be considered a living plan that will change and adapt to the conditions encountered as actions move forward. Nevertheless, **effective implementation will result in a system that is sustainable over the long haul – that means making changes, internalizing those changes, and having mechanisms in place to continually evaluate, modify and improve the overall pharmacy systems.**

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

COMPREHENSIVE ACTION PLAN

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

KEY ACTION PLAN GOALS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective A.5.1:	(See Objective A.4).
Objective A.5.2:	(See Objective A.3.5).
Objective A.5.3:	Use an action plan tracking grid to establish timelines and monitor implementation of the road map (see Appendix C for example).
Objective A.5.4:	Establish standardized institution audit process to assess adherence to standards of practice and P&P.
Objective A.5.5:	Create a stoplight grid to post institution audit results with links to detail reports. Post on website or other shared forum to allow comparison between institutions. Discuss at monthly P&T committee meetings. Require corrective action plans from institutions not meeting requirements (see Appendix D for example).
Objective A.5.6:	Develop standardized pharmaco-economic analysis consultations for institutions not meeting overall goals. The analysis will include assessment of scorecards, dashboards, adherence to operational and disease management guidelines, prescribing practices and local issues based on care level and type. The consultation provides detailed recommendations for change to close the performance gap.
Objective A.5.7:	Develop a standardized format for identification of needed disease management guidelines, criteria development, data collection, reporting, monitoring and follow-up.

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

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

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

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

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

Objective B.1.1 Develop an interdisciplinary P&T Committee with membership experienced in formulary management. Include central, regional and institution level participation as appropriate.

Objective B.1.2: Establish a clear committee charter utilizing principles stated in Objectives A3, A4, and A5.

Objective B.1.3: Assign committee members responsibility for various functions; assign implementation oversight and ownership to gain accountability from all members.

Objective B.1.4: Methodically work through the formulary categories and various reports and measures identified under Goal A to implement initiatives as identified.

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

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

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

Objective B.3.1: See Objectives A4 and A5.

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

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

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

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

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

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

Objective C.1.1: Load purchasing contracts in a central data repository to allow for electronic monitoring of contract pricing.

Objective C.1.2: Electronically monitor contract pricing on a continual basis and identify those items for which contract pricing is not being received.

Objective C.1.3: Work with wholesaler account to ensure that the correct contract pricing is loaded.

Objective C.1.4: Reconcile credit processes to ensure that wholesaler credits are received in the amount equal to the loss in contract pricing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

determine appropriate staffing compliment and numbers.

Objective D.1.2: Hire employees to fill all vacant pharmacy manager (Pharmacist II) positions.

Objective D.1.3: Recommend and implement meaningful salary levels as determined by the Receiver.

Objective D.1.4: Hire employees to fill all other vacant positions.

Objective D.1.5: Train new employees and define methodologies for monitoring and evaluating employee competence and performance.

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

Objective D.2.1: Identify knowledge deficits in clinical, operational, and fiscal matters.

Objective D.2.2: Prioritize in-services and develop time frames for conducting training.

Objective D.2.3: Assign team leaders and implementation teams to conduct in-services in the identified knowledge deficits.

Objective D.2.4: Conduct in-services on a monthly or quarterly basis, as needed. Use web-based e-authoring tools to develop "smart," self-paced competency and training system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective E.1.1.1.2 Expand service agreement as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Objective F.3.1: Organize an interdisciplinary team of pharmacy experts with clinical, operational, fiscal, and technological backgrounds to evaluate the current pilot program, VistA.
- Objective F.3.2: Establish guidelines for product evaluation using financial, operational, clinical, and technological indicators.
- Objective F.3.3: Evaluate VistA and alternate products on the market.
- Objective F.3.4: Compile findings based on product evaluation; choose the most suitable pharmacy information management solution.
- Objective F.3.5: Install needed hardware and software to support uniform pharmacy information management system.

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

- Objective F.4.1: Conduct inventories at each pharmacy and input inventory in pharmacy system.
- Objective F.4.2: Conduct data conversion where possible and input current prescriptions and allergies information for data that cannot be converted.
- Objective F.4.3: Introduce transition teams of highly trained staff to train pharmacy employees on new system to minimize implementation time.
- Objective F.4.4: With the direct participation and oversight of transition teams, "go live" on uniform pharmacy information management system.

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

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

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

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

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

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

Objective F.6.1: See Objective C.4

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

	ensuring that cost control initiatives are maximized.
Objective F.6.3:	Integrate use of electronic MAR and barcode checking to ensure that the right medication is administered to the right patient at the right time.

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

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

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

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

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

Objective G.1.1: Assemble an interdisciplinary committee with input from persons experienced in both ACA and NCCHC systems.

Objective G.1.2: Assess the standards of both ACA and NCCHC to determine the best match for the healthcare and custody system.

Objective G.1.3: Develop a standards audit readiness team.

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

Objective G.2.1: Begin the process of mock audits to identify standards in violation.

Objective G.2.2: Implement process improvement and procedural change to become compliant with standards in violation.

Objective G.2.3: Continue mock audits until violations are resolved.

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

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

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

PHASE I: CRAWL (0-12 MONTHS)

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

PHASE II: WALK (12-24 MONTHS)

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

PHASE III: RUN (2-3 Years)

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

Works Cited

Federal Bureau of Prisons. Office of the Inspector General. Audit of the Federal Bureau of Prisons Pharmacy Services, Audit Report 06-03. OIG, 2005. <http://www.usdoj.gov/oig/reports/BOP/a0603/intro.htm>

FOX Systems, Inc. California Department of Corrections Health Care Services Division Pharmacy Services Alternatives For Improvement. FOX, 2001.

State of California. California Department of Corrections, Division of Correctional Health Care Services. Health Care Services Pharmacy Series Vacancy As of March 31, 2006. Denny Salade, 2006.

State of California. California Department of Corrections. CDCR Vacancy Information for Pharmacy Classifications Statewide Information CDCR, December 2005.

State of California. California Department of Corrections. HCCUP Report, YTD Data from Contract Monitoring Database. CDCR, 07/01/05 thru 12/31/05.

State of California. California State Auditor. Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements. Bureau of State Audits, 2002.

State of California. Office of the Inspector General. Survey of California Department of Corrections Pharmaceutical Expenditures. OIG, 2003.

State of California. Office of the Inspector General. 2006 Accountability Audit Pharmaceutical Expenditures. OIG, 2006.

State of California. Senate Advisory Commission on Cost Control in State Government. Controlling the Costs of California's Prison Pharmacy Operations. California State Senate, 2002.

State of Georgia. Department of Corrections Office of Health Services. Georgia Department of Corrections Health Services Overview for FY 2004. William P. Kissel, CCHP, Director of Health Services, 2004.

State of Texas. Correctional Managed Health Care Committee. Quarterly Financial Reports. CMHCC, 2003-2005.

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

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

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

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

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

APPENDIX B-1: SAMPLE DASHBOARD

Yellow - At risk for not meeting target/off target

Measure	Measure Definitions	Actual FY 2005	FY 2006 YTD	Jan	Feb	Mar	Apr	May	etc	FY06 Target	Stoplight Status (R/Y/G)	Data Link
Workload												
Rx Volume Total	Rx Processed/1000 patients											
Rx Volume Central Pharmacy	Rx Processed/1000 patients											
Rx Volume X institution	Rx Processed/1000 patients										Y	
Returned Drug Institution X	# Rx and $											
Clinical												
Rx Errors Total	leaving pharmacy control											
Rx Errors Institution X	leaving pharmacy control											
Guidelines Deployed	Disease Management Practice/ Guidelines Deployed											
Staffing Vacancies												
RPh	#(%)											
Tech	#(%)											
Institution X RPh	#(%)											
Institution X Tech	#(%)											
Compliance												
Institution Audits	% passing											
Initiatives (Milestones)												
Central Pharmacy	Milestones											
Procedures Updated & Deployed	Milestones											
Institution level Redesign	Milestones											
Budget												
Drug	% Variance to budget											
Salary/Benefits	% Variance to budget											

APPENDIX B-2: SAMPLE INSTITUTION LEVEL BALANCED SCORE CARD

Green - On target

Yellow - At risk for not meeting target/off target

Red - [illegible]

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

APPENDIX C: ACTION PLAN TRACKING GRID

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

(ROUGH EXAMPLE ONLY)

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

APPENDIX D: SAMPLE UNIT INSPECTION GRID

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

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

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

Mr. Pollard,

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

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

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

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

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

3. Describe procedures used to detect and prevent diversion.

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

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

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

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

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

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

Please contact us if you have any questions.

Paul Mello

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

Mr. Doe/Mr. Roth

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

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

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

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

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

Please call if you would like to discuss the data.

Thank you
Rick Pollard

APPENDIX E: E-MAIL CORRESPONDENCE

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

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

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

Mr. Pollard-

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

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

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

Mr. Pollard,

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

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

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

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

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

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

Question 6: DGS is still evaluating this.

Thank you.

Paul Mello

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

APPENDIX E: E-MAIL CORRESPONDENCE

Mr. LaSala/Mr. Doe

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

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

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

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

Rick

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

Rick,

Attached is my analysis of the Zyprexa rebates.

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

NDC/UPC
00002411230
00002411530
00002411630
00002411730
00002441530
00002442030
00002759701

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

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

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

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

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

****
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prohibited. If you have received this communication in error, please immediately notify the sender by telephone or email, and permanently delete all copies, electronic or other, you may have.

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

The foregoing applies even if this notice is imbedded in a message that is forwarded or attached.
****

APPENDIX E: E-MAIL CORRESPONDENCE

"Rick Pollard"
<rpollard@maxor.com>
05/24/2006 02:04 PM

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

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

Please clarify

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

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

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

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

1. Is that not true?

2. Is this an exception?

3. Where would the rebates be received and reconciled?

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

Rick

APPENDIX E: E-MAIL CORRESPONDENCE

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

Mr. Pollard-

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

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

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

Thank you.

-Jon

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

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

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

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

GM Denny:

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

Thanks,

Jim

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

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

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

APPENDIX E: E-MAIL CORRESPONDENCE

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

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

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

There is no additional information regarding San Quentin. Apparently the situation is as was indicated in the e-mail.
SCO does not release reports until the 5th so we cannot provide you an update just yet.

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

GM Denny:

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

Thanks,

Jim

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

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

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

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

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

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

I'll let you know what I find out.

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

-----Original Message-----
From: Sallade, Denny
Sent: Wednesday, April 26, 2006 2:51 PM
To: VanOrnum, Terry
Subject: FW: Pharmacy Series Vacancy--March
We provided an SCO report showing that a 1.0 Pharm II was allocated to San Quentin and that the position is filled. This obviously conflicts with our information regarding Mr. Salacci. Could you see if San Quentin can provide clarification? Thanks. It could be that someone is on Administrative Leave/Military Leave or something.

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

Hi Denny:

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

Thanks for taking the time to clarify this for me.

Jim

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

APPENDIX E: E-MAIL CORRESPONDENCE

From: Sallade, Denny

To: Jim Riley
Sent: Tuesday, April 25, 2006 6:39 PM
Subject: RE: Pharmacy Series Vacancy--March

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

-----Original Message-----
From: Jim Riley [mailto:jriley@maxor.com]
Sent: Tuesday, April 25, 2006 4:31 PM
To: Sallade, Denny
Subject: Re: Pharmacy Series Vacancy--March

Thanks Denny!

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

Jim
----- Original Message -----
From: Sallade, Denny

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

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

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

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

APPENDIX F-1: INTERNAL AFFAIRS MEMORANDUM

State of California — Department of Corrections and Rehabilitation

Memorandum

Date : June 23, 2006

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX F-1: INTERNAL AFFAIRS MEMORANDUM

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

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

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

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

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

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

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

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

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

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

Bob Ballard
Special Agent
Internal Affairs-North

Bryan Kingston
Special Agent
Internal Affairs-North

Ernie McCoy
Special Agent
Internal Affairs-North

MAXOR
National Pharmacy Services Corp.

SENT VIA EMAIL

June 27, 2006

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

Dear Mr. Sillen:

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

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

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

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

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(806) 324-5400 • (800) 658-6146 • Fax (806) 324-5495

APPENDIX F-2: MAXOR RESPONSE TO INTERNAL AFFAIRS MEMORANDUM

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

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

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

Sincerely,

Jerry Hodge, R.Ph.
Chairman

Enclosure

EXHIBIT 12

PHARMACY MANAGEMENT CONSULTING SERVICES

Monthly Progress Report
To The
California Prison Health Care
Receivership Corporation

January 2007

Contents

PHARMACY MANAGEMENT CONSULTING SERVICES

Monthly Progress Report
January 2007

Introduction

The California Prison Health Care Receivership Corporation (CPR) and Maxor National Pharmacy Services Corporation (Maxor) entered into an agreement to provide pharmacy management consulting services to achieve necessary improvements to the California Department of Corrections and Rehabilitation (CDCR). The implementation of the Agreement made effective January 1, 2007, commenced on schedule. Key members of the Maxor team arrived in Sacramento on January 1, 2007 and established an administrative office at 428 J Street Ste 610, Sacramento, CA 95814.

With the approval of the Receiver, the Maxor team was able to recruit and make immediately available to the CPR experienced and well qualified correctional pharmaceutical clinicians to wit: Glenn Johnson, MD, Project Manager, Matt Keith, RPh, BCPS, FASHP, Pharmacy Administrator, Dick Cason, RPh, MS, Senior Pharmacy Consultant and Melanie Roberts, RPh, PharmD, Clinical Pharmacy Consultant. Collectively, the management consulting team has over 70 years of direct oversight involvement with correctional and commercial pharmacy programs nationwide.

During this reporting period, the Receiver's office was instrumental in transitioning the Maxor team into the CPR program. Breakout meetings were arranged, security clearances achieved, administrative and operational guidance given and most importantly, the Receiver's direction and priorities were established. These priorities include working closely with the Court's experts in the *Coleman* (mental health) and *Perez* (dental) litigation. Additionally, the Receiver requested and Maxor provided an initial 90 day plan of specific implementation actions which was subsequently reviewed and approved by the Receiver on January 24th.

The collective efforts of the pharmacy improvement program will evolve around the court approved *Road Map to Excellence* adopted by the CPR with priority given to achieving patient safety, evidenced based practice and cost efficiency. Emphasis will be placed on efforts to ensure effective ***Plata/Coleman/Perez*** interfaces. The required improvements outlined in the *Road Map* are organized into seven primary goals. Each goal is supported by specific objectives and timelines for accomplishing those objectives.

This document provides a status report of the progress made during the month towards achieving each goal, summarizes any changes to the projected timelines, identifies potential obstacles or issues that may delay or impact progress and provides an updated timeline (Appendix A) and financial status (Appendix B) for the project.

Executive Summary of Key Points in this Report

The following summary highlights key accomplishments, identifies any delays experienced and notes obstacles or issues related to achieving the required goals and objectives explained in more detail within this month's Progress Report.

Objectives Completed

- A central pharmacy services administration, budget and enforcement authority was established. (Objective A.1.)
- Direct lines of authority to all pharmacy services personnel and linkage to central medical staff were established with the Receiver's approval. (Objective A.2)

Objectives Delayed

- All objectives are progressing according to schedule.

Obstacles or Issues for Success

Several issues have been identified that may impact the achievement of planned objectives within the expected timeframes or require modification of scheduled work products. Each of these items is being addressed by the Maxor project team with the assistance of the Receiver.

- There is currently no active process for central operational procedure review and approval.
- CDCR lacks a central pharmacy information management system which has contributed to delays in collecting purchasing, prescription and outcomes data for process improvement. Current pharmacy utilization data are unreliable and restricted to purchases. Until such a system is in place, data will remain unreliable.
- The system-wide inventory that was to be conducted during the first quarter to establish a baseline would be of no value in inventory tracking in light of the absence of a CDCR pharmacy management system capable of accurately and uniformly recording dispensing data. Accordingly, Maxor is proposing a change in the timeline of Objective C.2.1. We request to limit the requirement of a system-wide inventory to controlled substances. A system-wide full inventory should occur with the deployment of an interim pharmacy system, which may occur in the first quarter, but is more likely to be completed in the second quarter.

- Initial delays were encountered when attempting to compare CDCR drug purchases with Department of General Services (DGS) contract prices. Access to one specific contract was delayed for a period of several weeks due to legal review.
- Although obtaining and disseminating documentation of Maxor's authority to intercept, review and credit orders to the wholesaler took longer than anticipated, a letter of authority from the Receiver's Chief of Staff was provided January 23, 2007 and actions are now underway.
- An initial audit of CDCR purchases and contract pricing since the initial 2006 Maxor review was conducted. A detailed listing of overcharges in the amount of $299,000 has been sent to the wholesaler. Since November 2005, eligible rebates in the amount of $474,000 for Zyprexa were reconciled and the receipt of $343,000 has been confirmed. The additional $131,000 is still being researched to ensure credit was received.

Progress Report Detail by Goal

For each goal in the *Road Map*, a summary of actions taken and progress achieved during the last 30 days is listed, along with the identification of any obstacles or issues that may impede progress.

Goal A

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

Actions Taken

- Maxor's Sacramento office was established on January 1, 2007 with the opening of project headquarters at 428 J Street Ste 610, Sacramento, CA 95814 (Objective A.1)
- Maxor project team members arrived on site for orientation and initial briefing by Corporate. The team includes a Project Manager, Senior Pharmacy Administrator and two pharmacy consultants. (Objective A.1; also see Appendix C)
- Meetings were conducted with the Receiver and staff to receive initial guidance and project direction. (Objective A.1)
- In conjunction with the Receiver's staff attorney, plans were developed and timelines established for implementing centralized oversight, control and monitoring over the CDCR pharmacy services program. (Objective A.1)
- An initial 90 day plan of action was prepared by the Maxor team and submitted for review and approval to the Receiver's Office. Subsequently, the 90-day plan was approved by letter dated January 24, 2007, from John Hagar, Chief of Staff to the Receiver. Maxor was also directed to work closely with the Court's experts in the additional two health care legal cases *Coleman* (mental health) and *Perez* (dental).

- Job descriptions for Director, Assistant Director and Clinical Pharmacists were finalized. (Objective A.1)
- Recruitment of the Pharmacy Director, Assistant Director and Clinical Pharmacy specialists commenced. Maxor is in the process of assessing and making an offer to an Assistant Director candidate. (Objective A.1)
- An agreement was established with the Receiver on the recruitment of 8 clinical pharmacists and a supplemental fiscal note was submitted for approval. This note establishes the clinical positions as Maxor employees. In addition, the agreement creates a "drop-in" strike team to include a manager and 4 technicians to help remedy problems in pharmacies with significant and immediate service issues. (Objective A.1)
- Early interaction by the Maxor team has additionally identified the need for a professional pharmacy nurse liaison to assist with nursing issues associated with distribution and administration of medications to patients and aid the Maxor Project Manager's efforts to ensure effective *Plata/Coleman/Perez* interfaces. A supplemental budget request was submitted by the Maxor team to the Receiver's Chief of Staff, and has been forwarded to the Receiver with a recommendation for approval. (Objective A.1)
- Meetings with CPR and CDCR staff have commenced and have included interactions with Dr. Terry Hill, Dr. Odegaar-Turner, Dr. Kuykendall, Linda Buzzini, John Hummell, Dr. Justin Graham, the DGS and AmeriSource Bergen to discuss the *Road Map* and future relationships. (Objective A.2)
- A clear organizational chart of reporting relationships and chains of command and coordination was developed with input from and approval by the Receiver's Chief of Staff. A letter was sent by the CPR Chief of Staff to CDCR officials delineating the role of Maxor. (Objective A.2; see Appendix C)
- Lines of communications were established with the CPR and CDCR Health Services office. (Objective A.2)
- With the approval of the Receiver, system wide CDCR Pharmacy staff information briefings on the *Road Map* were scheduled. (Objective A.2)
- A Regional Provider meeting was conducted on January 30, 2007 to provide orientation to the *Road Map* and the organizational structure established by Maxor and the Office of the Receiver. (Objective A.2)
- Central Policies & Procedures were obtained for review during the first quarter. A collection of facility specific Policies & Procedures are also being assembled. (Objective A.3)
- Early policy and procedure revisions will target the Pharmacy & Therapeutics Committee empowerment and essential activities. Suggested changes will be presented to the P&T Committee during its initial February 2007 meeting. (Objective A.3)
- A dashboard of pharmacy utilization was created and is being populated as data becomes available. Information sources and data reliability continue to be assessed. The existing pharmacy system data has been determined to be unreliable, and non-reproducible. Current data sources are limited to medication purchases without individual medical record review. Until a central pharmacy

information management system is instituted, data will remain unreliable. (Objective A.4 & A.5; see Appendix D)

- A project management file structure was created to track activities and initiatives as they develop (Objective A.5)
- An initiative timeline & tracking grid was developed to monitor implementation of the *Road Map*. (Objective A.4 & A.5: see Appendix A)
- A stoplight grid and facility inspection tool was developed to assess baseline facility level adherence to regulations, standards and security concerns. (Objective A.5; see Appendix E)
- A schedule for completing facility inspections has been developed and will be deployed in February. (Objective A.5)
- A disease management guideline (asthma) is under development and will be presented for review of content and form at the March P&T Committee meeting. (Objective A.5)

Objectives Completed

- Objective A.1. A central pharmacy services administration, budget and enforcement authority was established on January 23, 2007.
- Objective A.2. A pharmacy organizational chart was approved by the Receiver establishing direct lines of authority to all pharmacy services personnel and defining linkage to central medical staff.

Issues or Obstacles to Success

- There is currently no active process for central operational procedure review and approval. Recommendations for changes in Pharmacy Policy & Procedures will be prepared for discussion at the first system-wide P&T Committee scheduled for February 13, 2007.
- Current pharmacy utilization data are unreliable and restricted to purchases. There is no reproducible or reliable system for tracking dispensing or outcomes data. Until a central pharmacy information management system is instituted, data will remain unreliable.

Goal B

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

Actions Taken

- A reconstituted P&T Committee is being formed—anticipated members are 3 physicians (recommended by Regional MDs), Dr. Odegaard-Turner (Nursing), Jacki Clark (Nursing), Dr. Kuykendall (Dental Services), Dr. Hill, Dr. Winslow, Dr. Jeff Metzner (Colemen psychiatric expert), Dr. Andrew Swanson (Psychiatry) and the Maxor team (Johnson, Keith, Roberts and Cason). (Objective B.1)

- The initial P&T meeting is scheduled for Tuesday, February 13, 2007. The schedule for future meetings will be decided on at the initial meeting. (Objective B.1)
- A P&T Committee Charter is to be established at the first meeting (Objective B.1)
- Health Services Policy & Procedure changes will be recommended to the P&T Committee to establish their organizational structure and empowerment. (Objective B.1)
- A routine agenda format for the P&T Committee has been developed and will be presented. (Objective B.1)
- A new Correctional Formulary (based on the California Common Drug Formulary) is under development and will be presented in February for P&T review and approval. (Objective B.l)
- Formulary adherence and compliance will be reviewed upon approval of the Correctional Formulary. However, it should be noted that until the pharmacy management system is in operation, data gathering will continue to be unreliable. (Objective B.2)
- Therapeutic category utilization reports are being created and trends analyzed for discussion at first P&T meeting. (Objective B.2)
- The first disease management guideline (asthma) will be presented for review of content and style in March. This guideline will serve as the prototype for developing additional guidelines. (Objective B.3)
- Therapeutic category utilization data are being reviewed to determine a schedule for guideline development. Guidelines will focus on chronic illnesses to include asthma, hypertension, diabetes, hyperlipidemia and seizure disorder. Additional guidelines will be created as scheduled by the P&T Committee. (Objective B.3)
- Facility audit procedures have been established. Initial audits will begin statewide in February 2007. (Objective B.4; see Appendix E)

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- CDCR lacks a central pharmacy information management system which has contributed to delays in collecting prescription and outcomes data for process improvement. Maxor has an interim system in place to collect purchasing and dispensing data. Processing this data is cumbersome and data reliability is a concern as research indicates that dispensing data are not always entered into the existing systems. An integrated pharmacy information management system is vital for all reporting functions in order to provide true targeted process improvement.

Goal C

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

Actions Taken

- CDCR purchases were downloaded from Amerisource Bergen (wholesaler) and an audit of contract pricing since the last review was conducted. (Objective C.1)
- A detail listing of overcharges in the amount of $299,000 has been sent to the wholesaler. A meeting was held to discuss the credit/re-bill process. (Objective C.1)
- Since November 2005, eligible rebates in the amount of $474,000 for Zyprexa were reconciled and the receipt of $343,000 has been confirmed. The additional $131,000 is still being researched to ensure credit was received. A retrospective review from the beginning of the rebate contract through November 2005 will be conducted. (Objective C.1)
- Until a comprehensive data system is in place to intercept, review and edit orders submitted daily to ensure contract compliance, a review schedule has been put in place that continually monitors CDCR purchases to assure that the correct price is charged, eligible rebates are obtained, and contract terms are met. (Objective C.1)
- In light of the absence of a CDCR pharmacy system capable of accurately and uniformly recording dispensing data, we will request a modification to the scope and timing of Objective C2.1. Conducting a system-wide inventory in order to establish a baseline at this time would not be of value from an inventory tracking standpoint.
    - The scope change requested is to limit the requirement of a system-wide inventory and establishment of a baseline to Controlled Substances until an interim pharmacy system is implemented. Controlled Substances have manual dispensing logs that can be used to inventory and immediately begin tracking during the first quarter in accordance with the original time requirement. We will request that a system-wide full inventory occur in conjunction with the deployment of an interim pharmacy management system, which may occur in the first quarter, but is more likely to be completed in the second quarter. This would also allow an audited inventory to be initially loaded into the system from the very beginning. (Objective C.2)
- A procedure is in place to compare all purchases versus dispenses to identify potential diversions or misuse. A written inventory control procedure will be drafted in the first quarter once facility audits are completed. (Objective C.2)
- A meeting with the Department of General Services and the wholesaler was held in order to establish an arrangement for the coordination and improvement of pharmaceutical procurement and contracting activities. An agreed upon method for standardizing order entry through the Echo System was suggested. Once the orders are consolidated in Echo, Maxor's supply system will "intercept" the order,

review it for contract compliance in conjunction with availability at the wholesaler's local distribution centers, edit the order and resubmit it electronically. This will ensure that the best value contracted item is purchased and enable dialogue with the wholesaler to continually stock the appropriate contracted items necessary to meet the demands of CDCR. This process is not anticipated to create a delay in treatment or delivery of the requested drugs. (Objective C.3)

- DGS was provided with access to Maxor's enterprise reporting system and given instruction on how to use the tools to better monitor purchasing for contract compliance and future negotiations. (Objective C.3)
- A meeting with the CPR's Chief Medical Information Officer and Chief Information Officer was held to discuss interim solutions to immediately begin capturing uniform dispensing data and improve patient safety. An agreement will be made after a thorough review of available interim solutions and a CDCR pilot system (Pelican Bay) currently in place. (Objective C.3)
- A review of 340B pricing feasibility has been initiated. This study will assess the feasibility of achieving cost savings through the utilization of 340B pricing to mitigate the rising prescription drug expenditures by the CDCR. This study will be conducted to quantify the potential cost savings for California taxpayers resulting from access to 340B pricing by the CDCR. The study will also address the potential barriers associated with implementing this strategy and the initial steps necessary for establishing a 340B Drug Discount Program. A request to the Receiver's Chief of Staff for permission to engage the Heinz Family Foundation to assist in this review has been made. (Objective C.5)

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- Initial delays were encountered when attempting to compare CDCR drug purchases with DGS contract prices. Access to one specific contract was delayed for a period of several weeks due to legal review by DGS. On January 26, 2007, Maxor received a letter from the DGS Office of Legal Services expressing their intent to provide the requested contracts. On January 29, 2007, Maxor received the delayed contract in question.
- Although obtaining and disseminating documentation of Maxor's authority to intercept, review and credit orders to the wholesaler took longer than anticipated, a letter of authority was provided January 23, 2007 and actions are now underway.

Goal D

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

Actions Taken

- Maxor has requested all staffing agency service contracts for review. Billing summaries will also be reviewed and audited. (Objective D.1)
- Maxor is obtaining staffing levels and position descriptions (CDCR, Registry, Vacant) to populate an employee tracking system. The system will allow the Maxor Team to identify vacancies to be filled as well as provide a tracking mechanism for employee training, education and disciplinary actions. (Objective D.2)
- Web based software was reviewed to identify a product that could provide information (education & training modules created by the Maxor team) to CDCR pharmacy staff and allow for competency assessment tests. Test tracking will assure all staff complete required training. The products assure deployment of important procedural changes, educational information and other key information. (Objective D.2)

Objectives Completed

- All objectives are in progress

Issues or Obstacles to Success

- No significant issues or obstacles encountered to date.

Goal E

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

Actions Taken

- An assessment of potential sites for establishing a centralized pharmacy facility has commenced and including at a minimum: Fresno, Stockton and Sacramento. Criteria include access to lines of transportation (air and ground), location, proximity to pharmaceutical distribution centers, ability to recruit and maintain qualified pharmacy staff and costs. (Objective E.2)
- Contact with potential sources of prepackaged product is occurring. The outsourced product will be considered for pre-centralization to assist facilities in meeting their service and product control needs. (Objective E.2)

- A Maxor team member spent two days at San Quentin reviewing pharmacy and nursing practices and assessing immediate service needs. Operating procedures for a "drop-in" strike team are being formulated. (Objective E.1)

Objectives Completed

- All objectives are in progress

Issues or Obstacles to Success

- No significant issues or obstacles encountered to date.

Goal F

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

Actions Taken

- A repository of prescription data from the existing PDTS system has been designed for consistent data accumulation and reporting. (Objective F.1)
- Rudimentary utilization reports have been designed and will be distributed to the Receiver and the P&T Committee on a monthly basis and electronically to facilities when connectivity is established. The reports will become more sophisticated as data collection becomes more reliable. (Objective F.1)
- The CPR's CIO agreed to address all of the connectivity issues between the institutions. In the interim, we will work with him to establish connectivity using commercial digital subscriber line (DSL) and virtual private network (VPN) solutions. (Objective F.2)
- A list of initial equipment necessary to modernize the institutions and implement an interim solution has been provided to the CIO for procurement/authorization. (Objective F.2)
- The use of *Guardian Rx*, a pharmacy information management system that Maxor uses extensively in several operations throughout the nation, is currently being evaluated as a possible interim solution. IT requirements have been identified and submitted to the Receiver's IT representatives. (Objective F.3)

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- No significant issues or obstacles encountered to date.

Goal G

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

Actions Taken

- No action taken in the first 90-days, pending completion of related objectives.

Objectives Completed

- No objectives completed.

Issues or Obstacles to Success

- No issues or obstacles to date.

Summary of Changes to Timeline

In the sections below, a listing of completed objectives, objective timelines proposed for change (subject to review and approval of CPR) and a listing of timeline changes that have been approved by the CPR are provided.

Objectives Completed

- Objective A.1. A central pharmacy services administration, budget and enforcement authority was established on January 1, 2007.
- Objective A.2. Received Receiver's approval to establish direct lines of authority to all pharmacy services personnel and define linkage to central medical staff.

Objective Timelines Proposed for Change

- As discussed under Goal C above, Maxor requests approval of a modification to the scope and timing of Objective C.2.1:
    - The scope change requested is to limit the requirement of a system-wide inventory and establishment of a baseline to Controlled Substances until an interim pharmacy system is implemented.
    - Modification of the timeline to reflect that a system-wide full inventory will occur in conjunction with the deployment of an interim pharmacy system, which may occur in the first quarter, but is more likely to be completed in the second quarter. .

Objective Timeline Change Approvals

- Objective C.2.1 - timeline change approval pending.

Conclusion

Maxor remains committed to the accomplishment of the *Road Map* goals and objectives and has prepared this Progress Report as part of its ongoing initiative to maintain direct, open and constant communication with CPR throughout the pharmacy improvement project.

Maxor would like to thank the Receiver, his staff, and CDCR for their cooperation and support.

Appendix A— Updated Timeline

Appendix B— Financial Summary

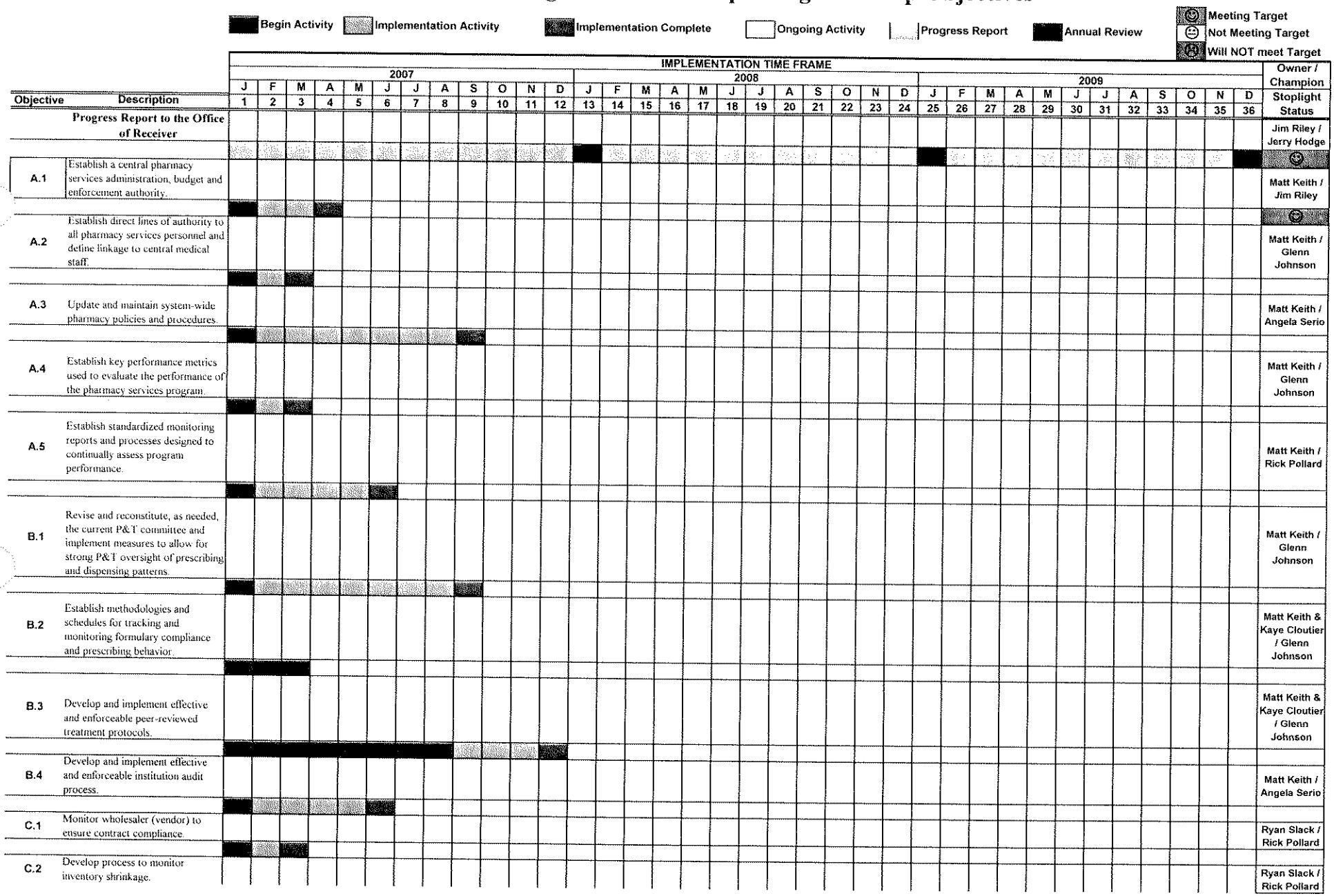
Appendix C— Project Organization Chart & Authority Letter

Appendix D— Pharmacy Dashboard

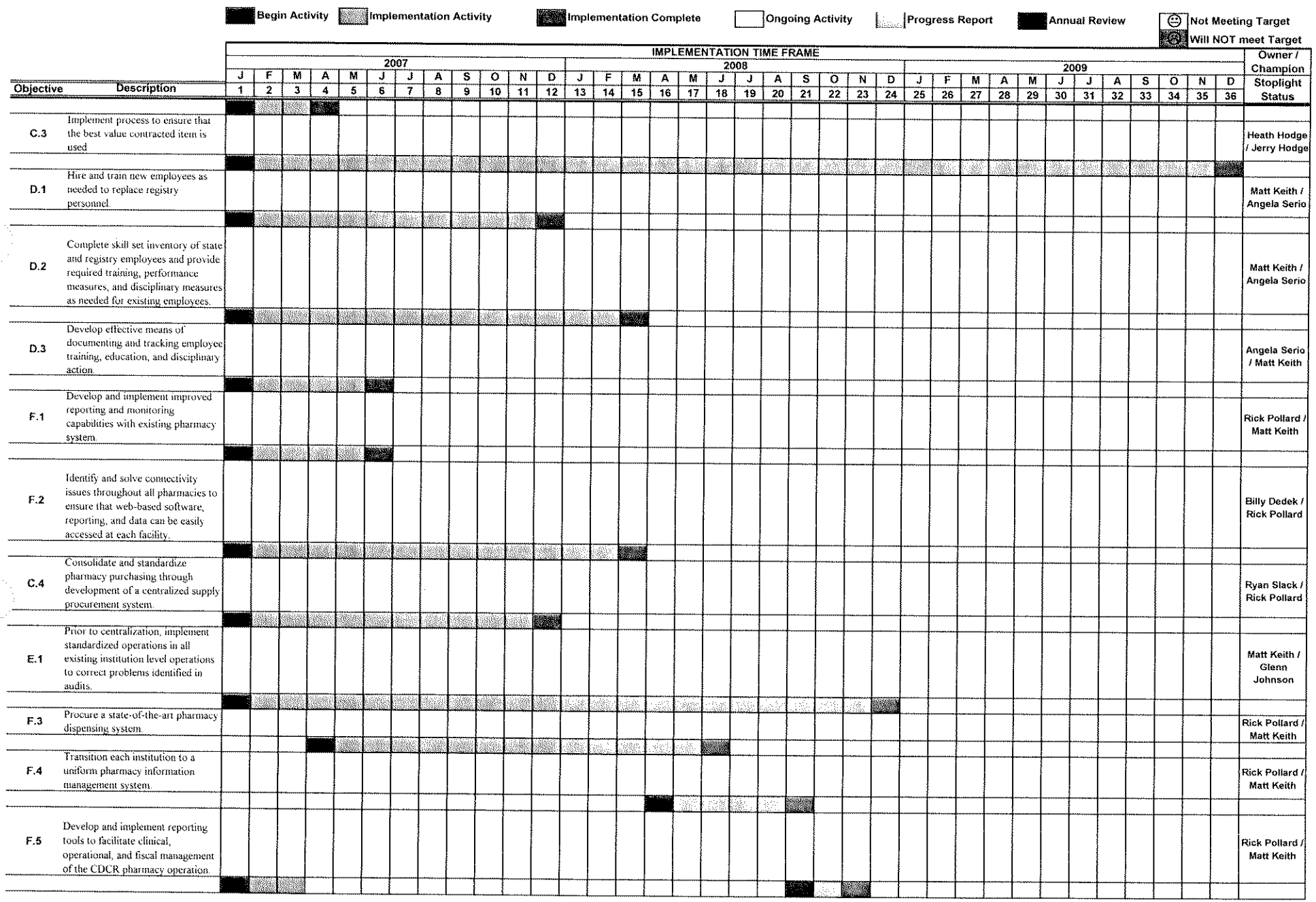
Appendix E— Pharmacy Inspection Grid / Monthly Inspection Form / Baseline Inspection Profile

APPENDIX A

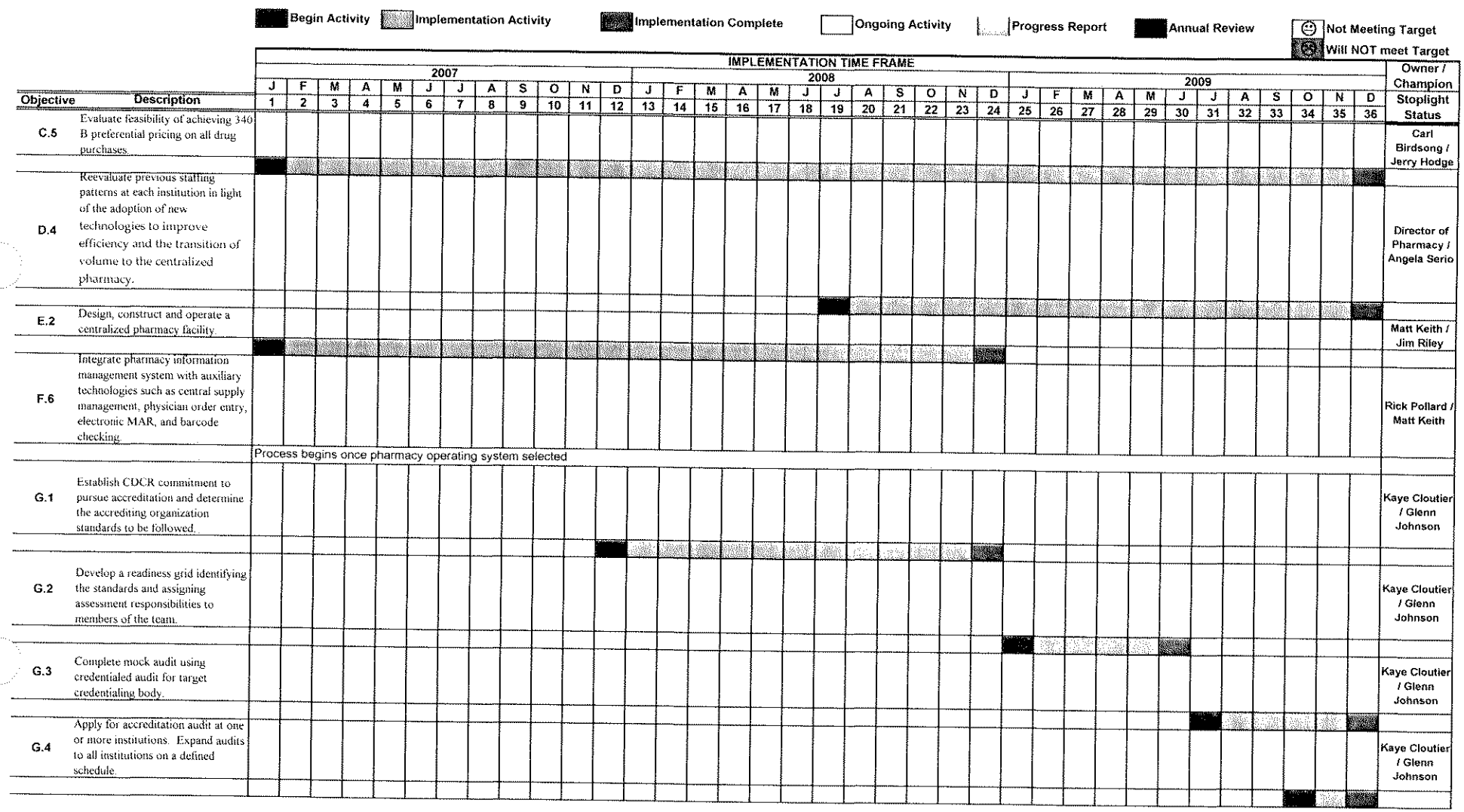
Maxor Timeline and Tracking Grid for Accomplishing Roadmap Objectives



APPENDIX A


Begin Activity
Implementation Activity
Implementation Complete
Ongoing Activity
Progress Report
Annual Review
Not Meeting Target
Will NOT meet Target
IMPLEMENTATION TIME FRAME
2007
2008
2009
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36
Objective
Description
Owner / Champion
Stoplight Status
C.3
Implement process to ensure that the best value contracted item is used
Heath Hodge / Jerry Hodge
D.1
Hire and train new employees as needed to replace registry personnel.
Matt Keith / Angela Serio
D.2
Complete skill set inventory of state and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing employees.
Matt Keith / Angela Serio
D.3
Develop effective means of documenting and tracking employee training, education, and disciplinary action.
Angela Serio / Matt Keith
F.1
Develop and implement improved reporting and monitoring capabilities with existing pharmacy system.
Rick Pollard / Matt Keith
F.2
Identify and solve connectivity issues throughout all pharmacies to ensure that web-based software, reporting, and data can be easily accessed at each facility.
Billy Dedek / Rick Pollard
C.4
Consolidate and standardize pharmacy purchasing through development of a centralized supply procurement system.
Ryan Slack / Rick Pollard
E.1
Prior to centralization, implement standardized operations in all existing institution level operations to correct problems identified in audits.
Matt Keith / Glenn Johnson
F.3
Procure a state-of-the-art pharmacy dispensing system.
Rick Pollard / Matt Keith
F.4
Transition each institution to a uniform pharmacy information management system.
Rick Pollard / Matt Keith
F.5
Develop and implement reporting tools to facilitate clinical, operational, and fiscal management of the CDCR pharmacy operation.
Rick Pollard / Matt Keith

APPENDIX A



Timeline Assumptions

(1) The timeframes are contingent upon prerequisite approvals, funding and regulatory issues being addressed in a timely manner.
(2) Some activities may begin earlier than shown and other activities may slide forward dependent upon the completion of related activities.
(3) Ongoing activities may include addressing any lingering implementation issues, as well as addressing the transition of activity to the CDCR.
(4) A proposed progress report schedule is included for documenting the accomplishments and identifying the need for schedule changes.

APPENDIX C

CPR Office of the California Prison Receivership
Robert Sillen, Receiver

[redacted]

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

January 14, 2007

To: Wardens
Health Care Managers/Chief Medical Officers
Regional Administrators
Regional Directors of Nursing
Pharmacists in Charge

Effective January 1, 2007 the Maxor National Pharmacy Services Corporation ("Maxor") commenced a contract with the California Prison Health Care Receivership Corporation ("CPR") to provide pharmacy management consulting services to CPR. Concerning these services, Maxor functions as a consultant empowered by the Receiver to perform services, including direct management services, as summarized in the "Maxor Timeline and Tracking Grid for Accomplishing Roadmap Objectives." In this regard, the requirements for cooperation with the Receiver set forth in Judge Henderson's Order of February 14, 2006 apply fully to Maxor.

Maxor is in the process of establishing direct lines of authority over all California Department of Corrections and Rehabilitation pharmacy services personnel, and is also in the process of establishing direct relations with California's control agencies, including but not limited to the Department of Finance and the Department of General Services. Maxor has established an office at 428 J Street, Suite 610, Sacramento California, 95814 and Dr. Glenn Johnson, Maxor's Project Manager can be reached by telephone at (916) 441-1089.

Yours truly,

John Hagar
Chief of Staff

APPENDIX C - Pharmacy Dashboard
Facility Workload

White - Under construction
Green - On target
Yellow - Short of target
Red - Significantly below target

Measure	Measure Definitions	Actual CY 2005	Actual CY 2006	Actual CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
WORKLOAD	**Rx #**	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average Rx #/Pharmacy																			
Staffing	**RPH #**	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			

APPENDIX C - Pharmacy Dashboard
Facility Workload

White - Under construction
Green - On target
Yellow - Short of target
Red - Significantly below target

Measure	Measure Definitions	Actual																FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
		CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07			
WORKLOAD	**Rx #**	Mo Avg	Mo Avg	Mo Avg																
CMF - Ca Medical Facility																				
COR - Ca State Prisons, Corcoran																				
CRC - Ca Rehabilitation Center																				
CTF - CorrTraining Facility																				
CVSP - Chuckawalla Valley State Prison																				
DVI - Deuel Vocational Institute																				
FOL - Folsom																				
HDSP - High Desert State Prison																				
ISP - Ironwood State Prison																				
KVSP - Kern Valley State Prison																				
LAC - Ca State Prison LA																				
MCSP - Mule Creek State Prison																				
NKSP - North Kern State Prison																				
PBSP - Pelican Bay State Prison																				
PVSP - Pleasant Valley State Prison																				
RJD - RJ Donovan Corr Facility																				
SAC - California State Prison, Sacramento																				
SATF - California Substance Abuse TF																				
SCC - Sierra Conservation Center																				
SOL - Ca State Prison, Solano																				
SQ - San Quentin																				
SVSP - Salina Valley State Prison																				
VSPW - Valley State Prison for Women																				
WSP - Wasco State Prison																				
CDCR Average RPh/Pharmacy																				
Staffing	**Tech #**	Mo Avg	Mo Avg	Mo Avg																
ASP - Avenal State Prison																				
CAL - Calipatria State Prison																				
CCC - Ca Corr Center																				
CCI - Ca Corr Institute																				
CCWF - Central Ca Women's Facility																				
CEN - Centinela State Prison																				
CIM - Ca Institute for Men																				
CIW - Corr Institute for Women																				
CMC - Ca Men's Colony																				
CMF - Ca Medical Facility																				
COR - Ca State Prisons, Corcoran																				
CRC - Ca Rehabilitation Center																				
CTF - CorrTraining Facility																				
CVSP - Chuckawalla Valley State Prison																				
DVI - Deuel Vocational Institute																				
FOL - Folsom																				
HDSP - High Desert State Prison																				
ISP - Ironwood State Prison																				

APPENDIX C - Pharmacy Dashboard
Facility Workload

White - Under construction
Green - On target
Yellow - Short of target
Red - Significantly below target

Measure	Measure Definitions	Actual CY 2005	Actual CY 2006	Actual CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
WORKLOAD	**Rx #**	Mo Avg	Mo Avg	Mo Avg															
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
'D - RJ Donovan Corr Facility																			
.C - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average Tech/Pharmacy																			
Number of Rx/RPh		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
'F - Ca Medical Facility																			
R - Ca State Prisons, Corcoran																			
RC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			

APPENDIX C - Pharmacy Dashboard
Facility Workload

White - Under construction
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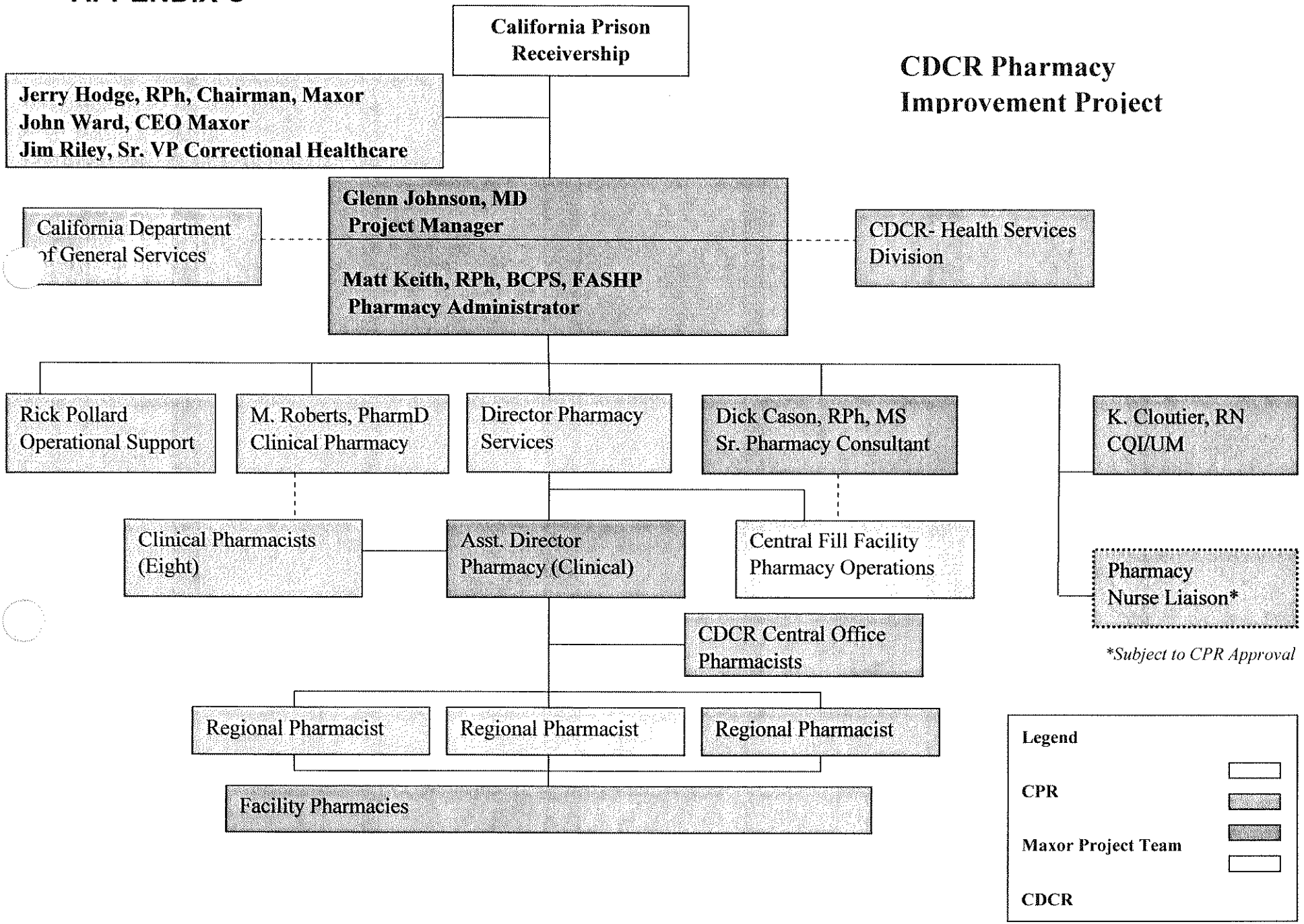
Red - Significantly below target

Measure	Measure Definitions	Actual CY 2005	Actual CY 2006	Actual CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
WORKLOAD	**Rx #**	Mo Avg	Mo Avg	Mo Avg															
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average Rx/RPh																			
Number of Rx/Tech		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
IP - Ironwood State Prison																			
SP - Kern Valley State Prison																			
AC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average Rx/Tech																			

APPENDIX C


California Prison Receivership
CDCR Pharmacy Improvement Project
Jerry Hodge, RPh, Chairman, Maxor
John Ward, CEO Maxor
Jim Riley, Sr. VP Correctional Healthcare
Glenn Johnson, MD
Project Manager
California Department of General Services
CDCR- Health Services Division
Matt Keith, RPh, BCPS, FASHP
Pharmacy Administrator
Rick Pollard
Operational Support
M. Roberts, PharmD
Clinical Pharmacy
Director Pharmacy Services
Dick Cason, RPh, MS
Sr. Pharmacy Consultant
K. Cloutier, RN
CQI/UM
Clinical Pharmacists (Eight)
Asst. Director Pharmacy (Clinical)
Central Fill Facility Pharmacy Operations
Pharmacy Nurse Liaison*
CDCR Central Office Pharmacists
*Subject to CPR Approval
Regional Pharmacist
Regional Pharmacist
Regional Pharmacist
Facility Pharmacies
Legend
CPR
Maxor Project Team
CDCR

APPENDIX D
DASHBOARD

White - Under construction
Green - On target
Yellow - Short of target
Red - Significantly below target

Measure	Measure Definitions	Actual CY 2005	Actual CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	Drug Purchase $ PMPM	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison			41.66																
CAL - Calipatria State Prison			13.87																
CCC - Ca Corr Center			8.53																
[illegible]Ca Corr Institute			72.31																
[illegible] - Central Ca Women's Facility			193.82																
CEN - Centinela State Prison			14.58																
CIM - Ca Institute for Men			152.42																
CIW - Corr Institute for Women			131.68																
CMC - Ca Men's Colony			143.99																
CMF - Ca Medical Facility			462.05																
COR - Ca State Prisons, Corcoran			117.01																
CRC - Ca Rehabilitation Center			57.24																
CTF - CorrTraining Facility			29.03																
CVSP - Chuckawalla Valley State Prison			15.48																
DVI - Deuel Vocational Institute			92.45																
FOL - Folsom			44.05																
HDSP - High Desert State Prison			36.04																
ISP - Ironwood State Prison			14.54																
KVSP - Kern Valley State Prison			31.28																
LAC - Ca State Prison LA			66.10																
MCSP - Mule Creek State Prison			103.00																
NKSP - North Kern State Prison			70.18																
PBSP - Pelican Bay State Prison			96.19																
PVSP - Pleasant Valley State Prison			99.14																
RJD - RJ Donovan Corr Facility			134.03																
SAC - California State Prison, Sacramento			172.79																
[illegible] - California Substance Abuse TF			54.58																
[illegible] Sierra Conservation Center			23.61																
[illegible] Ca State Prison, Solano			94.70																
SQ - San Quentin			91.77																
SVSP - Salina Valley State Prison			105.38																
VSPW - Valley State Prison for Women			124.81																
WSP - Wasco State Prison			82.60																
CDCR Average NF+F Drug Cost PMPM			83.04																
Formulary Purchase $ PMPM		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			

APPENDIX D
DASHBOARD

Measure	Measure Definitions	CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	Drug Purchase $ PMPM	Mo Avg	Mo Avg	Mo Avg															
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
[illegible] - Mule Creek State Prison																			
[illegible] - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average F Cost PMPM																			
Non-Formulary Purchase $ PMPM		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
[illegible] - Ca Men's Colony																			
[illegible] - Ca Medical Facility																			
[illegible] - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			

APPENDIX D
DASHBOARD

Measure	Measure Definitions	CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	**Drug Purchase $ PMPM**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average NF Cost PMPM																			
WORKLOAD	**Rx PMPM #**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
[illegible] Ca Corr Center																			
[illegible] Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
[illegible] California State Prison, Sacramento																			
[illegible] California Substance Abuse TF																			
[illegible] Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average Total Rx # PMPM																			
Formulary Rx PMPM #		**Mo Avg**	**Mo Avg**	**Mo Avg**															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			

APPENDIX D
DASHBOARD

Measure	Measure Definitions	CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	Drug Purchase $ PMPM	Mo Avg	Mo Avg	Mo Avg															
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
- Kern Valley State Prison																			
Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average F # Rx PMPM																			
Non-Formulary Rx PMPM #		**Mo Avg**	**Mo Avg**	**Mo Avg**															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
Ca Institute for Men																			
Corr Institute for Women																			
- Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			

APPENDIX D
DASHBOARD

Measure	Measure Definitions	CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	**Drug Purchase $ PMPM**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average NF Rx # PMPM																			
CLINICAL	**Rx Error # (Chg to rate when Rx # Reliable)**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
[illegible] - North Kern State Prison																			
[illegible] Pelican Bay State Prison																			
[illegible] - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Total Rx Errors																			
Guidelines Deployed		**Mo Avg**	**Mo Avg**	**Mo Avg**															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			

APPENDIX D
DASHBOARD

Measure	Measure Definitions	CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	**Drug Purchase $ PMPM**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
[illegible] - CorrTraining Facility																			
[illegible] - Chuckawalla Valley State Prison																			
[illegible] Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
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SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Total Guidelines																			
Unit Audit Compliance		**Mo Avg**	**Mo Avg**	**Mo Avg**															
[illegible] System-wide Percentage Passing-[illegible]acy																			
CDCR System-wide Percentage Passing-Non-Pharmacy																			
STAFFING	**Vacancy #(%)RPH/Tech**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			

APPENDIX D
DASHBOARD

Measure	Measure Definitions	CY 2005	CY 2006	CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	**Drug Purchase $ PMPM**	**Mo Avg**	**Mo Avg**	**Mo Avg**															
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
[illegible]SP - Mule Creek State Prison																			
[illegible] - North Kern State Prison																			
[illegible] - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Total Vacancy																			
BUDGET	% Variance to budget	**Annual**	**Annual**	**YTD**															
Drug	System-wide Total																(+/-) 5%		
Salary/Benefits	System-wide Total																(+/-) 5%		

EXHIBIT 13

PHARMACY MANAGEMENT CONSULTING SERVICES

Monthly Progress Report
To The
California Prison Health Care Receivership Corporation

February 2007

Contents

PHARMACY MANAGEMENT CONSULTING SERVICES

Monthly Progress Report
February 2007

Introduction

The California Prison Health Care Receivership Corporation (CPR) and Maxor National Pharmacy Services Corporation (Maxor) entered into an agreement to provide pharmacy management consulting services for achieving necessary improvements to the California Department of Corrections and Rehabilitation (CDCR). The collective efforts of the pharmacy improvement program evolve around the court approved *Road Map* to excellence with priority given to a California approach for achieving patient safety, evidenced based practice and cost efficiency.

Since commencement of the contract on January 1, 2007, and last month's progress report, several key accomplishments have been realized. A reconstituted Pharmacy and Therapeutics Committee was formed and an introductory meeting held to establish the organizational structure, empowerment and charter of the Committee. In addition, Maxor presented to the Committee for review and approval a new correctional formulary (based on the California Common Drug Formulary), a disease management guideline release schedule, asthma guidelines, and the first of many policy and procedure revisions. Additional meetings were also held with pharmacy, medical and nursing staff to complete a system wide orientation to the *Road Map* and further relations toward accomplishing the goals and objectives set forth.

State wide facility inspections have commenced and several targets for immediate service improvements and model implementation possibilities have been identified. From inspections conducted thus far, the overall pharmacy drug distribution system appears to be in moderately good working order while the medication management system (what happens outside the pharmacy walls from dispensing to administration) is in need of restructuring. With the approval of the Receiver, a professional nurse liaison (Marjory Pulvino, RN, PhD) with expertise in corrections and medication management systems was added to Maxor's correctional consulting team to assist with nursing related issues. Also, an Assistant Director of Pharmacy Services (Lucy Michael, RPh, PharmD, MS) was hired and will officially join the Maxor Team the first week of March 2007.

This document provides a status report of the progress made during February 2007 towards achieving each goal, summarizes any changes to the projected timelines, identifies potential obstacles or issues that may delay or impact progress and provides an updated timeline and financial status for the project.

Summary of Key Points in this Report

The following summary listings highlight key accomplishments, delays experienced and obstacles or issues related to achieving the required goals and objectives noted in more detail within this month's Progress Report.

Objectives Completed

- Objective A.1. A central pharmacy services administration, budget and enforcement authority was established on January 23, 2007. Recruitment and selection efforts for key management positions continued in the month of February.
- Objective A.2. Direct lines of authority were established to all pharmacy services personnel and linkages to central medical staff were defined. Meetings were held with CPR legal and personnel representatives to further define direct line authority with regards to State personnel requirements. Orientation meetings for key pharmacy staff and health care providers were conducted during the month.
- Objective B.2. A revised and reconstituted Pharmacy & Therapeutics Committee was established and held its organizational meeting on February 13, 2007. Current membership includes representation from central, regional and institutional level providers, as well as experts representing *Coleman* and *Perez* issues.

Objectives Delayed

- All objectives except for F.2 are progressing according to schedule.
- A change requested in the January Monthly Progress Report relating to the timeline for Objective C.2.1 has been submitted for approval to the Receiver.

Obstacles or Issues for Success

- The issue identified in the January Monthly Progress Report relating to the lack of an active process for central operational procedure review and approval is being addressed through recommendations in Pharmacy Policy & Procedures that were presented at the first system-wide P&T Committee.
- Maxor has been unsuccessful in retrieving PPTS data from every facility for 2006. At this time we have not received 4th quarter 2006 data for 9 facilities. We are coordinating with Dr. Eugene Roth (CDCR central pharmacist) in an attempt to obtain the remaining information.
- DGS confidentiality agreements with specific vendors (Roche, Astra Zeneca and Lilly) in earlier preferential pricing contracts have presented a challenge in providing aggregate data to the Heinz Family Foundation for analysis of 340B pricing. The problem is expected to be resolved within the next reporting period.
- IT related challenges at several targeted facilities continue delaying the establishment of an interim pharmacy information management system. A joint CPR/Maxor IT working group is addressing ways to resolve connectivity issues.

Progress Report by Goal

For each goal in the *Road Map*, a summary of actions taken and progress achieved during the last 30 days is listed, along with the identification of any obstacles or issues that may impede progress.

Goal A

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

Actions Taken

- An Assistant Director of Pharmacy has been selected. Dr. Lucy Michael will start on March 5, 2007. (Objective A.1)
- Maxor continues to actively recruit for the Director of Pharmacy and Clinical Pharmacist positions. One candidate for Director and 4 candidates for clinical pharmacist were interviewed this month. (Objective A.1)
- Approval was obtained from the Receiver's office to create a "drop-in" team to include a pharmacist manager and 4 technicians to help remedy problems in pharmacies with significant and immediate service issues. Maxor is actively recruiting for these positions. Two candidates have been interviewed for the drop-in team management position and twenty technician applications are being screened. (Objective A.1)
- A professional nurse liaison position was approved by the Receiver to aid in resolving nursing issues associated with the distribution and administration of medications to patients. Dr. Marjory Pulvino joined the Maxor Team on February 26, 2007. Her expertise and extensive experience as a professional nurse liaison will provide essential skills required for restructuring the medication management system. (Objective A.1)
- At the invitation of the Receiver, members of the Maxor Team briefed the *Coleman* Special Master and *Perez* Experts on February 23, 2007, on the Maxor Road Map and process thus far in meeting the goals and objectives. (Objective A.2)
- Orientations were held with all Pharmacists-in-Charge (PIC) the week of February 12, 2007, to educate staff on the *Road Map* objectives and to clearly delineate lines of authority. Quarterly PIC meetings will be conducted to keep key pharmacy personnel abreast of current initiatives and ensure timely implementation of the *Road Map* objectives. (Objective A.2)
- A second Regional Provider (Medical, Nursing, Mental Health, Administrator) meeting was held February 15, 2007, to clarify direction on the *Road Map* goals and objectives and to assist in developing the relationships necessary for success. Monthly meetings have been scheduled to discuss ongoing operational issues and ensure achievement of the stated goals & objectives. (Objective A.2)
- A review of system wide pharmacy policy and procedures was initiated and continues as on ongoing effort. Three key policy revisions (relating to the functions and authority of the P&T Committee, the management of the CDCR

Formulary and the processes for pharmacy policy & procedure manual updates) and one new policy (Disease Management Guidelines) were presented to the state wide P&T Committee on February 13, 2007. Approval and finalization of these policies will occur at the March 2007 P&T Committee meeting. Once the initial policy and procedure review is complete, a schedule for annual reviews of policies and procedures will be put into practice to assure an accurate reflection of practice maturation. (Objective A.3)

- Facility level policy and procedures have been collected and will be reviewed in tandem with facility inspections. (Objective A.3)
- Revisions to policies and procedures related to controlled substances have been initiated. Facility specific operational procedures related to controlled substances are being evaluated to ensure that the revised policy and procedure provides consistency and meets all state and federal legal requirements. A meeting with the California State Board of Pharmacy has been scheduled for March 1, 2007, to clarify board rules as they apply to corrections. (Objective A.3)
- PPTS prescription data is being compiled and will be made available for reporting and monitoring purposes. (Objective A.4 & A.5)
- A pharmacy initiative tracking grid, balanced scorecard and dashboard were developed and presented last month. Reports are continually updated as data becomes available. Operational targets will be modified as processes improve, procedures are modified and data availability and reliability improve. (Objective A.4 & A.5)
- Initial facility inspections are underway and scheduled to be completed March 30, 2007. The eight facility inspections completed in February included (Objective A.5):
    - Sierra Conservation Center
    - San Quentin
    - California Medical Facility
    - High Desert State Prison
    - California Correctional Center
    - Ironwood State Prison
    - Chuckawalla Valley State Prison,
    - Centinela State Prison.
- A schedule for disease management guideline adoption and release including a standardized format and development process was prepared and submitted to the P&T Committee on February 13, 2007 for approval. Maxor's goal is to establish at least one new or revised and updated disease management guideline per month. In February, asthma disease management guidelines were submitted for review of content and form. The guideline schedule, standard format, process for development and asthma guidelines will be finalized at the March 2007 P&T Committee meeting. (Objective A.5)

Objectives Completed

- Objective A.1. A central pharmacy services administration, budget and enforcement authority was established on January 23, 2007. Recruitment and

selection efforts for key management positions continued in the month of February.

- Objective A.2. Direct lines of authority to all pharmacy services personnel were established and linkages to central medical staff were defined. Meetings were held with CPR legal and personnel representatives to further define direct line authority with regards to State personnel requirements. Orientation meetings for key pharmacy staff and health care providers were conducted during the month.

Issues or Obstacles to Success

- The issue identified in the January Monthly Progress Report relating to the lack of an active process for central operational procedure review and approval is being addressed through recommendations in Pharmacy Policy & Procedures that were presented at the first system-wide P&T Committee.
- Maxor has been unsuccessful in retrieving PPTS data from every facility for 2006. At this time we have not received 4th quarter 2006 data for 9 facilities. We are coordinating with Dr. Eugene Roth (CDCR central pharmacist) in an attempt to get the remaining information.

Goal B

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

Actions Taken

- A reconstituted Pharmacy & Therapeutics Committee was established. Membership currently includes:
    - Dr. Terry Hill (Chief Medical Officer, CPR)
    - Dr. Dwight Winslow (State wide Medical Director, CDCR)
    - Dr. Steven Ritter (Regional Medical Director, South, CDCR)
    - Dr. Glenn Thiel (Regional Medical Director, North, CDCR)
    - Dr. Jasdeep Bal (Chief Medical Officer, SAC, CDCR)
    - Dr. Andrew Swanson (Chief Psychiatrist, CDCR)
    - Dr. William Kuykendall (Chief Dentist, CDCR)
    - Dr. Susan Odegaard-Turner (State wide Nursing Director, CPR)
    - Dr. Jeffrey Metzner (Coleman Expert)
    - Dr. Joe Scalzo (Perez Expert) or Dr. Jay Shulman (Perez Experts) and,
    - The Maxor Team (Johnson, Keith, Cason, and Roberts).
- A P& T Meeting schedule has been adopted. Monthly meetings will be held on the second Tuesday of each month. (Objective B.1)
- A revised Policy & Procedure detailing the organizational structure, empowerment and charter of the P&T Committee was submitted for Committee review in February with final approval pending in March 2007. (Objective B.1)

- Further discussion and delineation of roles and responsibilities of P&T Committee members will take place at the March 2007 meeting. (Objective B.1)
- A formal routine agenda format was presented and approved by the Committee. (Objective B.1)
- The California Common Drug Formulary was reviewed identifying redundant medications and patient safety risks. From this review, a new correctional CDCR Formulary was proposed and presented for review and approval by the P&T Committee. Formal Committee approval of the Correctional Formulary will take place at the March 2007 meeting. (Objective B.1)
- A tracking system for monitoring Formulary adherence and compliance has been established and will be implemented upon approval of the Correctional Formulary. Until the proposed pharmacy management system is in operation, data gathering will remain unreliable. (Objective B.2)
- Current CDCR medication use protocols and disease management guidelines were reviewed. Revisions and recommendations are underway and will be provided to the P&T Committee for review and adoption. (Objective B.3)
- A schedule including the development process and format for Disease Management Guidelines was presented to the P&T Committee this month for review and approval in March. Asthma guidelines and suggested related asthma management indicators were also introduced. (Objective B.3)
- As noted under Goal A, facility inspections are underway by the Maxor Team. Once initial inspections are complete, pharmacists-in-charge will be responsible for conducting monthly facility inspections. The final reports will be submitted on an ongoing basis to the P&T Committee utilizing the Facility Inspection Grid. (Objective B.4)

Objectives Completed

- Objective B.2. A revised and reconstituted Pharmacy & Therapeutics Committee was established on February 13, 2007. Current membership includes representation from central, regional and institutional level providers. Operational guidance and direction in the form of a P&T Committee policy and procedure statement, agenda format, and a schedule for development of disease management guidelines were prepared and presented.

Issues or Obstacles to Success

- No previously unidentified or significant issues or obstacles have been encountered in this reporting period.

Goal C

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

Actions Taken

- A system for downloading and monitoring CDCR purchases on an ongoing basis to assure that the correct price is charged, eligible rebates are obtained, and contract terms are met is operational . (Objective C.1)
- Credit and rebill information was identified and has been discussed with the wholesaler and the Department of General Services (DGS). A detailed report was sent to Amerisource Bergen. (Objective C.1)
- A "requirements notification" was sent to Amerisource Bergen to ensure the wholesaler is stocking all contracted items at an appropriate level in each of its local distribution centers. (Objective C.1)
- A procedure was established and implemented to provide all facility pharmacists-in-charge with a list indicating medications they should have purchased under contract in lieu of more expensive comparable items that were purchased. (Objective C.4)
- CDCR CY 2006 purchase and prescription data have been collected and will be analyzed for trends and projections. (Objective C.1)
- Registry contracts were obtained and will be audited for billing hours. (Objective C.1)
- A baseline inventory of all controlled substances is being conducted in conjunction with facility inspections. The controlled substance inventory will be completed by March 30, 2007. (Objective C.2)
- A contract amendment with Amerisource Bergen was reviewed and proposed recommendations were made to the DGS regarding the return and destruction of pharmaceuticals. Any contract negotiated should include a clause pertaining to the destruction of "loose waste". (Objective C.2)
- Maxor has obtained and is carefully reviewing copies of all current contracts from the DGS. (Objective C.3)
- Maxor has scheduled weekly meeting with the DGS in order to coordinate and improve pharmaceutical procurement and contracting activities. (Objective C.3)
    - The DGS will be provided a calendar of the Pharmacy and Therapeutics Committee therapeutic category reviews in order to facilitate manufacturer contract requests.
    - The DGS presented Maxor with a list of drugs for which they have requested bids to obtain contracts. Two of the drugs are not currently part of the Common Drug Formulary, and will need to be reviewed by the Common Drug Formulary P&T Committee. The other medications appeared to be sole source brands, in which any contract price reductions achieved would be beneficial as long as the contract language did not preclude the CDCR P&T Committee from removing the medications from

the formulary in the future if their use was not clinically indicated, or alternative medications were available. (Objective C.3)

- Maxor was provided "The Department of General Services Request for Business Proposal" format and is reviewing the document. Feedback will be provided at the next DGS meeting. (Objective C.3)
- Research and efforts toward achieving 340B pricing are continuing.

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- DGS confidentiality agreements with specific vendors (Roche, Astra Zeneca and Lilly) in earlier preferential pricing contracts have presented a challenge in providing aggregate data to the Heinz Family Foundation for analysis of 340B pricing. The problem is expected to be resolved within the next reporting period.

Goal D

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

Actions Taken

- Separate meetings with union officials from CCSO (California Correctional Supervisors Organization) and AFSCME (American Federation of State, County and Municipal Employees) were held in order to establish a working relationship, to clarify issues regarding union rules and regulations and to provide them with an introduction to the *Road Map* goals and objectives as they relate to union employees. (Objective D.1)
- Maxor obtained copies of Registry contracts in order to compare, cross reference and analyze submitted billing hours for accuracy. (Objective D.1)
- A personnel survey including staffing levels and position descriptions (CDCR, Registry, and Vacant) has been completed and will be verified during on-site facility inspections within the next thirty days. A state employee list was provided to Maxor by CPR officials. The information acquired will be used to populate an employee tracking system capable of identifying vacancies to be filled as well as provide a tracking mechanism for employee training, education and disciplinary actions. (Objectives D.1, D.2 & D.3)
- Maxor is working with CPR staff to clarify direct management authority and hiring authority at facilities. Facility pharmacists-in charge have been informed to

advise, and receive recommendations from Maxor until facility hiring authority coordination has been achieved. (Objective D.1)

- A software web-based training program has been selected and will be implemented in March 2007 to deploy key information and training modules to CDCR pharmacy staff. The product will allow competency assessments, report cards and training verification to be maintained electronically. (Objective D. 2)
- A needs assessment survey was sent to all staff to be completed and returned by March 1, 2007. The results will be tabulated and used to determine a starting point for developing a learning growth program and to assist in identifying necessary operational and fiscal requirements. (Objective D.2)
- Data gathered during facility inspections will be used to evaluate staffing patterns and workload statistics. Appropriate pharmacist and technician staffing numbers will be determined after a close review. (Objective D.1 & D.4)

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- No previously unidentified or significant issues or obstacles have been encountered in this reporting period.

Goal E

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

Actions Taken

- Maxor's early initial system wide assessment has determined that the pharmacy drug distribution system (within the walls of the pharmacy) is in fair working order while the medication management system outside of the pharmacy will require extensive work. (Objective E.1)
- The Receiver approved the use of a"drop-in" team to be sent to problem areas to implement pre-centralization strategies and improve work flow. (Objective E.1)
- Maxor representatives visited Pelican Bay in order to evaluate their current system's automation requirements and review the use of that system as a possible interim pharmacy system. (Objective E.1)
- The assessment of potential sites for establishing a centralized pharmacy facility continues and includes at a minimum: Fresno, Stockton and Sacramento. Criteria established include access to lines of transportation (air and ground), location, proximity to pharmaceutical distribution centers, ability to recruit and maintain qualified pharmacy staff and costs. (Objective E.2)

- Contact with potential sources of prepackaged product continues. The outsourced product will be considered prior to centralization to assist facilities in meeting their service and product control needs. (Objective E.2)
- On February 20, 2007, four Maxor Team members along with the CDCR central pharmacist completed the first facility inspection at San Quentin. While at San Quentin this group also discussed a report entitled San Quentin Medication Management Assessment written after the January 23-24th visit to San Quentin by Maxor. The report was presented to Dr. Renee Kanan (CDCR) and Jayne Russell with the Receiver's office. Maxor representatives were asked to participate in weekly facility based quality improvement meetings. (Objective E.1)

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- No previously unidentified or significant issues or obstacles have been encountered in this reporting period.

Goal F

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

Actions Taken

- Rudimentary utilization reports have been designed and will be distributed to the Receiver and the P&T Committee on a monthly basis and electronically to facilities once connectivity is established. The reports will become more sophisticated as data collection becomes more reliable. (Objective F.1)
- A repository of prescription data from the existing PPTS system has been designed and data collection is ongoing. Data will be made available for reporting and monitoring purposes. (Objective F.1)
- In coordination with the Receiver's staff, a decision was made to use Guardian Rx as an interim pharmacy management system. The Guardian system will be initially implemented at San Quentin and the California Medical Facility. Mr. Hummel is working on a contract to establish connectivity at each of these facilities. Paul Whittaker from the Receiver's office has been assigned project manager to assist in the deployment of Guardian Rx. Maxor has provided Mr. Whittaker with an implementation plan. (Objective F.2)
- A meeting between CPR IT and Maxor IT was held to discuss continuing connectivity challenges.

- CPR IT staff visited Maxor headquarters in Amarillo to confirm data confidentiality and security within the Maxor IT systems.

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- IT related challenges at several targeted facilities continue delaying the establishment of an interim pharmacy information management system. A joint CPR/Maxor IT working group is addressing ways to resolve connectivity issues.

Goal G

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

Actions Taken

- No action taken in the first 90-days, pending completion of related objectives.

Objectives Completed

- All objectives are in progress.

Issues or Obstacles to Success

- No significant issues or obstacles encountered to date.

Summary of Changes to Timeline

In the sections below, a listing of completed objectives, objective timelines proposed for change (subject to review and approval of CPR) and a listing of timeline changes that have been approved by the CPR are provided.

Objectives Completed

- Objective A.1. A central pharmacy services administration, budget and enforcement authority was established on January 23, 2007. Recruitment and selection efforts for key management positions continued in the month of February.
- Objective A.2. Established direct lines of authority to all pharmacy services personnel and defined linkage to central medical staff. Meetings were held with CPR legal and personnel representatives to further define direct line authority with regards to State personnel requirements. Orientation meetings for key pharmacy staff and health care providers were conducted during the month.

- Objective B.2. A revised and reconstituted Pharmacy & Therapeutics Committee was established and held its organizational meeting on February 13, 2007. Current membership includes representation from central, regional and institutional level providers, as well as experts representing *Coleman* and *Perez* issues.

Objective Timelines Proposed for Change

- Objective F.2 – *Establish basic connectivity in all pharmacies.* Maxor will work with the CPR IT staff to establish an implementation schedule based on the establishment of connectivity. Maxor's First Ninety Day plan had assumed the availability of connectivity within the first quarter of 2007. Unanticipated challenges at several of the targeted facilities have resulted in the need to request a timeline extension for at least ninety days for implementation of connectivity required deliverables, such as the transition to a contemporary pharmacy information management system and real time data accumulation.

Objective Timelines Change Approvals

- Objective C.2.1 (system wide baseline inventory in the first quarter) – request for timeline change approval pending.

Conclusion

Maxor remains committed to the accomplishment of the *Road Map* goals and objectives and has prepared this Progress Report as part of its ongoing initiative to maintain direct, open and constant communication with CPR throughout the pharmacy improvement project.

Maxor would like to thank the Receiver, his staff, and CDCR for their cooperation and support.

Appendix A—Updated Timeline

Appendix B—Financial Summary

Appendix C—Pharmacy Dashboard

Appendix D—Updated Maxor Organizational Chart

Appendix E— Curriculum Vitae of incoming Maxor employees during this reporting period (Michael, Pulvino)

APPENDIX A

Maxor Timeline and Tracking Grid for Accomplishing Roadmap Objectives

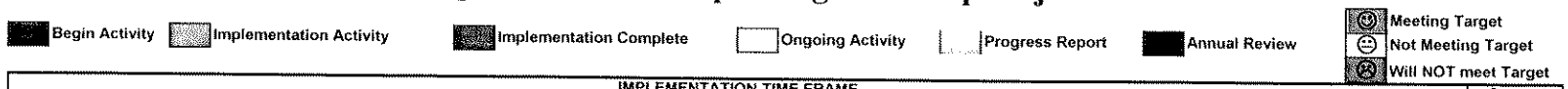
Begin Activity | Implementation Activity | Implementation Complete | Ongoing Activity | Progress Report | Annual Review

Meeting Target | Not Meeting Target | Will NOT meet Target

Objective	Description	IMPLEMENTATION TIME FRAME																																		Owner / Champion
		2007												2008												2009												
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Stoplight Status
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	
	Progress Report to the Office of Receiver																																					Jim Riley / Jerry Hodge
A.1	Establish a central pharmacy services administration, budget and enforcement authority.																																					Matt Keith / Jim Riley
A.2	Establish direct lines of authority to all pharmacy services personnel and define linkage to central medical staff.																																					Matt Keith / Glenn Johnson
A.3	Update and maintain system-wide pharmacy policies and procedures.																																					Matt Keith / Angela Serio
A.4	Establish key performance metrics used to evaluate the performance of the pharmacy services program.																																					Matt Keith / Glenn Johnson
A.5	Establish standardized monitoring reports and processes designed to continually assess program performance.																																					Matt Keith / Rick Pollard
B.1	Revise and reconstitute, as needed, the current P&T committee and implement measures to allow for strong P&T oversight of prescribing and dispensing patterns.																																					Matt Keith / Glenn Johnson
B.2	Establish methodologies and schedules for tracking and monitoring formulary compliance and prescribing behavior.																																					Matt Keith & Kaye Cloutier / Glenn Johnson
B.3	Develop and implement effective and enforceable peer-reviewed treatment protocols.																																					Matt Keith & Kaye Cloutier / Glenn Johnson
B.4	Develop and implement effective and enforceable institution audit process.																																					Matt Keith / Angela Serio
C.1	Monitor wholesaler (vendor) to ensure contract compliance.																																					Ryan Slack / Rick Pollard
C.2	Develop process to monitor inventory shrinkage.																																					Ryan Slack / Rick Pollard

APPENDIX A

Maxor Timeline and Tracking Grid for Accomplishing Roadmap Objectives



Objective	Description	IMPLEMENTATION TIME FRAME																																		Owner / Champion
		2007												2008												2009												
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Stoplight Status
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	
C.3	Implement process to ensure that the best value contracted item is used																																					Heath Hodge / Jerry Hodge
D.1	Hire and train new employees as needed to replace registry personnel																																					Matt Keith / Angela Serio
D.2	Complete skill set inventory of state and registry employees and provide required training, performance measures, and disciplinary measures as needed for existing employees																																					Matt Keith / Angela Serio
D.3	Develop effective means of documenting and tracking employee training, education, and disciplinary action																																					Angela Serio / Matt Keith
F.1	Develop and implement improved reporting and monitoring capabilities with existing pharmacy system																																					Rick Pollard / Matt Keith
F.2	Identify and solve connectivity issues throughout all pharmacies to ensure that web-based software, reporting, and data can be easily accessed at each facility																																					Billy Dedek / Rick Pollard
C.4	Consolidate and standardize pharmacy purchasing through development of a centralized supply procurement system																																					Ryan Slack / Rick Pollard
E.1	Prior to centralization, implement standardized operations in all existing institution level operations to correct problems identified in audits																																					Matt Keith / Glenn Johnson
F.3	Procure a state-of-the-art pharmacy dispensing system																																					Rick Pollard / Matt Keith
F.4	Transition each institution to a uniform pharmacy information management system																																					Rick Pollard / Matt Keith
F.5	Develop and implement reporting tools to facilitate clinical, operational, and fiscal management of the CDCR pharmacy operation																																					Rick Pollard / Matt Keith

APPENDIX A

Maxor Timeline and Tracking Grid for Accomplishing Roadmap Objectives

Begin Activity | Implementation Activity | Implementation Complete | Ongoing Activity | Progress Report | Annual Review

Meeting Target | Not Meeting Target | Will NOT meet Target

Objective	Description	IMPLEMENTATION TIME FRAME																																		Owner / Champion
		2007												2008												2009												
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Stoplight Status
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	
C.5	Evaluate feasibility of achieving 340 B preferential pricing on all drug purchases.																																					Carl Birdsong / Jerry Hodge
D.4	Reevaluate previous staffing patterns at each institution in light of the adoption of new technologies to improve efficiency and the transition of volume to the centralized pharmacy.																																					Director of Pharmacy / Angela Serio
E.2	Design, construct and operate a centralized pharmacy facility																																					Matt Keith / Jim Riley
F.6	Integrate pharmacy information management system with auxiliary technologies such as central supply management, physician order entry, electronic MAR, and barcode checking.																																					Rick Pollard / Matt Keith
		Process begins once pharmacy operating system selected																																				
G.1	Establish CDCR commitment to pursue accreditation and determine the accrediting organization standards to be followed.																																					Kaye Cloutier / Glenn Johnson
G.2	Develop a readiness grid identifying the standards and assigning assessment responsibilities to members of the team.																																					Kaye Cloutier / Glenn Johnson
G.3	Complete mock audit using credentialed audit for target credentialing body.																																					Kaye Cloutier / Glenn Johnson
G.4	Apply for accreditation audit at one or more institutions. Expand audits to all institutions on a defined schedule.																																					Kaye Cloutier / Glenn Johnson

Timeline Assumptions

(1) The timeframes are contingent upon prerequisite approvals, funding and regulatory issues being addressed in a timely manner.
(2) Some activities may begin earlier than shown and other activities may slide forward dependent upon the completion of related activities.
(3) Ongoing activities may include addressing any lingering implementation issues, as well as addressing the transition of activity to the CDCR.
(4) A proposed progress report schedule is included for documenting the accomplishments and identifying the need for schedule changes.

APPENDIX C - Pharmacy Dashboard
Facility PMPM Report

White - Under construction
Green - On target
Yellow - Short of target
Red - Significantly below target

Measure	Measure Definitions	Actual CY 2005	Actual CY 2006	Actual CY 2007 YTD	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
FISCAL	**Drug Purchase $ PMPM**	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison			41.66	49.15	49.15														
CAL - Calipatria State Prison			13.87	26.49	26.49														
CCC - Ca Corr Center			8.53	10.91	10.91														
CCI - Ca Corr Institute			72.31	64.11	64.11														
CCWF - Central Ca Women's Facility			193.82	221.02	221.02														
CEN - Centinela State Prison			14.58	19.21	19.21														
CIM - Ca Institute for Men			152.42	221.60	221.60														
CIW - Corr Institute for Women			131.68	140.93	140.93														
CMC - Ca Men's Colony			143.99	183.85	183.85														
CMF - Ca Medical Facility			462.05	422.29	422.29														
COR - Ca State Prisons, Corcoran			117.01	109.72	109.72														
CRC - Ca Rehabilitation Center			57.24	79.11	79.11														
CTF - CorrTraining Facility			29.03	49.36	49.36														
CVSP - Chuckawalla Valley State Prison			15.48	24.42	24.42														
DVI - Deuel Vocational Institute			92.45	99.52	99.52														
FOL - Folsom			44.05	57.24	57.24														
HDSP - High Desert State Prison			36.04	43.10	43.10														
ISP - Ironwood State Prison			14.54	27.35	27.35														
KVSP - Kern Valley State Prison			31.28	40.41	40.41														
LAC - Ca State Prison LA			66.10	71.32	71.32														
MCSP - Mule Creek State Prison			103.00	147.85	147.85														
NKSP - North Kern State Prison			70.18	65.10	65.10														
PBSP - Pelican Bay State Prison			96.19	112.78	112.78														
PVSP - Pleasant Valley State Prison			99.14	124.32	124.32														
RJD - RJ Donovan Corr Facility			134.03	133.30	133.30														
SAC - California State Prison, Sacramento			172.79	185.27	185.27														
SATF - California Substance Abuse TF			54.58	90.03	90.03														
SCC - Sierra Conservation Center			23.61	26.55	26.55														
SOL - Ca State Prison, Solano			94.70	107.05	107.05														
SQ - San Quentin			91.77	112.66	112.66														
SVSP - Salina Valley State Prison			105.38	105.66	105.66														
VSPW - Valley State Prison for Women			124.81	149.77	149.77														
WSP - Wasco State Prison			82.60	85.69	85.69														
CDCR Average NF+F Drug Cost PMPM			83.04	96.56	96.56														
Formulary Purchase $ PMPM		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			

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		CY 2005	CY 2006	CY 2007 YTD															
FISCAL	Drug Purchase $ PMPM	Mo Avg	Mo Avg	Mo Avg															
CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average F Cost PMPM																			
Non-Formulary Purchase $ PMPM		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
CRC - Ca Rehabilitation Center																			
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KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			

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FISCAL	**Drug Purchase $ PMPM**	Mo Avg	Mo Avg	Mo Avg															
PBSP - Pelican Bay State Prison																			
PVSP - Pleasant Valley State Prison																			
RJD - RJ Donovan Corr Facility																			
SAC - California State Prison, Sacramento																			
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average NF Cost PMPM																			
WORKLOAD	**Rx PMPM #**	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
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CRC - Ca Rehabilitation Center																			
CTF - CorrTraining Facility																			
CVSP - Chuckawalla Valley State Prison																			
DVI - Deuel Vocational Institute																			
FOL - Folsom																			
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KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
MCSP - Mule Creek State Prison																			
NKSP - North Kern State Prison																			
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PVSP - Pleasant Valley State Prison																			
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SVSP - Salina Valley State Prison																			
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FISCAL	Drug Purchase $ PMPM	Mo Avg	Mo Avg	Mo Avg															
WSP - Wasco State Prison																			
CDCR Average Total Rx # PMPM																			
Formulary Rx PMPM #		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
CIW - Corr Institute for Women																			
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CTF - CorrTraining Facility																			
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HDSP - High Desert State Prison																			
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SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average F # Rx PMPM																			
Non-Formulary Rx PMPM #		Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
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FISCAL	**Drug Purchase $ PMPM**	Mo Avg	Mo Avg	Mo Avg															
CIW - Corr Institute for Women																			
CMC - Ca Men's Colony																			
CMF - Ca Medical Facility																			
COR - Ca State Prisons, Corcoran																			
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SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Average NF Rx # PMPM																			
CLINICAL	**Rx Error # (Chg to rate when Rx # Reliable)**	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
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		CY 2005	CY 2006	CY 2007 YTD															
FISCAL	Drug Purchase $ PMPM	Mo Avg	Mo Avg	Mo Avg															
HDSP - High Desert State Prison																			
ISP - Ironwood State Prison																			
KVSP - Kern Valley State Prison																			
LAC - Ca State Prison LA																			
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SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
	CDCR Total Rx Errors																		
	Guidelines Deployed	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
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FISCAL	**Drug Purchase $ PMPM**	Mo Avg	Mo Avg	Mo Avg															
SATF - California Substance Abuse TF																			
SCC - Sierra Conservation Center																			
SOL - Ca State Prison, Solano																			
SQ - San Quentin																			
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
CDCR Total Guidelines																			
Unit Audit Compliance		Mo Avg	Mo Avg	Mo Avg															
CDCR System-wide Percentage Passing-Pharmacy																			
CDCR System-wide Percentage Passing-Non-Pharmacy																			
STAFFING	**Vacancy #(%)RPH/Tech**	Mo Avg	Mo Avg	Mo Avg															
ASP - Avenal State Prison																			
CAL - Calipatria State Prison																			
CCC - Ca Corr Center																			
CCI - Ca Corr Institute																			
CCWF - Central Ca Women's Facility																			
CEN - Centinela State Prison																			
CIM - Ca Institute for Men																			
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FISCAL	**Drug Purchase $ PMPM**	Mo Avg	Mo Avg	Mo Avg															
SVSP - Salina Valley State Prison																			
VSPW - Valley State Prison for Women																			
WSP - Wasco State Prison																			
	CDCR Total Vacancy																		
BUDGET	% Variance to budget	Annual	Annual	YTD															
Drug	System-wide Total																(+/-) 5%		
Salary/Benefits	System-wide Total																(+/-) 5%		

APPENDIX C - Phamacy Dashboard
Therapeutic Category Report

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	Therapeutic Category (AHFS)	CY 2006	CY 2006	CY 2007 YTD	CY 2007 YTD	Jan-Mar 07 Mo Avg		Apr-Jun 07 Mo Avg		Jul-Sep 07 Mo Avg		Oct-Dec 07 Mo Avg		FY07 Target or FY06 vs FY07	Stoplight Status (R/Y/G)	Detail Data
						$	%	$	%	$	%	$	%			
	Fiscal System Wide	Mo Avg $	Mo Avg %	Mo Avg $	Mo Avg %											
40404	ANTIHISTAMINE DRUGS: 1st Gen. Ethanolamine Derivatives	10,668.92	0.08	11,845.91	0.08											
40412	ANTIHISTAMINE DRUGS: 1st Gen. Phenothiazine Derivatives	4,189.32	0.03	4,790.37	0.03											
40420	ANTIHISTAMINE DRUGS: 1st Gen. Propylamine Derivatives	7,081.85	0.05	9,780.42	0.06											
40492	ANTIHISTAMINE DRUGS: 1st Gen. Miscellanous	1,359.64	0.01	1,443.64	0.01											
40800	ANTIHISTAMINE DRUGS: 2nd Gen.	25,763.81	0.19	25,371.15	0.16											
80800	ANTI_INFECTIVES: Anthelmintics	304.93	0.00	172.00	0.00											
81202	ANTI-INFECTIVES: Antibiotics: Aminoglycosides	6,320.79	0.05	11,439.60	0.07											
81206	ANTI-INFECTIVES: Antibiotics: Cephalosporins	23,674.29	0.18	14,710.38	0.09											
81207	ANTI-INFECTIVES: Antibiotics: Misc. B-Lactams	6,540.82	0.05	5,464.86	0.03											
81212	ANTI-INFECTIVES: Antibiotics: Macrolides	41,179.13	0.30	41,317.18	0.26											
81216	ANTI-INFECTIVES: Antibiotics: Penicillins	45,361.62	0.34	55,479.60	0.36											
81218	ANTI-INFECTIVES: Antibiotics: Quinolones	54,333.74	0.40	75,006.16	0.48											
81220	ANTI-INFECTIVES: Antibiotics: Sulfonamides	11,652.47	0.09	20,192.11	0.13											
81224	ANTI-INFECTIVES: Antibiotics: Tetracyclines	10,185.56	0.08	7,800.11	0.05											
81228	ANTI-INFECTIVES: Antibiotics: Miscellaneous	47,136.19	0.35	58,624.50	0.38											
81404	ANTI-INFECTIVES: Antifungals: Allylamines	34,637.61	0.26	61,602.06	0.39											
81408	ANTI-INFECTIVES: Antifungals: Azoles	82,795.95	0.61	176,227.00	1.13											
81428	ANTI-INFECTIVES: Antifungals: Polyenes	3,424.41	0.03	914.36	0.01											
81432	ANTI-INFECTIVES: Antifungals: Pyrimidines	831.78	0.01	0.00	0.00											
81492	ANTI-INFECTIVES: Antifungals: Miscellaneous	52,049.59	0.39	53,526.50	0.34											
81604	ANTI-INFECTIVES: Antimycobacterials: Antituberculosis Agents	36,996.80	0.27	30,486.55	0.20											
81692	ANTI-INFECTIVES: Antimycobacterials Miscellaneous	448.31	0.00	354.48	0.00											
81808	ANTI-INFECTIVES: Antiretrovirals	1,676,417.44	12.41	2,093,879.97	13.41											
81820	ANTI-INFECTIVES: Antivirals: Interferons	197,037.70	1.46	221,299.67	1.42											
81828	ANTI-INFECTIVES: Antivirals: Neuraminidase Inhibitors	725.92	0.01	798.60	0.01											
81832	ANTI-INFECTIVES: Antivirals: Nucleosides & Nucleotides	94,362.78	0.70	73,148.87	0.47											
81892	ANTI-INFECTIVES: Antivirals: Miscellaneous	327.34	0.00	0	0											
83004	ANTI-INFECTIVES: Antiprotozoals: Amebicides	8.50	0.00	0	0											
83008	ANTI-INFECTIVES: Antiprotozoals: Antimalarials	2,681.69	0.02	2,554.68	0.02											
83092	ANTI-INFECTIVES: Antiprotozoals: Miscellaneous	13,652.81	0.10	12,406.79	0.08											
83600	ANTI-INFECTIVES: Urinary Anti-Infectives	2,870.29	0.02	1,250.76	0.01											
100000	ANTINEOPLASTIC AGENTS	85,961.64	0.64	97,138.25	0.62											
20400	AUTONOMIC DRUGS: Parasympathomimetics (Cholinergics)	6,495.30	0.05	6,748.47	0.04											
20804	AUTONOMIC DRUGS: Anticholinergics: Antiparkinsonian Agents	20,053.95	0.15	17,507.50	0.11											
120808	AUTONOMIC DRUGS: Anticholinergics: Antimuscarinics/Antispasmodics	56,018.03	0.41	60,897.54	0.39											
121200	AUTONOMIC DRUGS: Sympathomimetic Adrenergic Agents	95,490.80	0.71	90,669.20	0.58											
121204	AUTONOMIC DRUGS: Sympatholytic α-Adrenergic Agonists	64.96	0.00	0.98	0.00											
121208	AUTONOMIC DRUGS: Sympatholytic β-Adrenergic Agonists	221,989.85	1.64	291,896.71	1.87											
121212	AUTONOMIC DRUGS: Sympatholytic α & β-Adrenergic Agonists	1,256.78	0.01	2,619.02	0.02											
121600	AUTONOMIC DRUGS: Sympatholytic Adrenergic Blocking Agents	2,465.94	0.02	3,072.94	0.02											
122000	AUTONOMIC DRUGS: Skeletal Muscle Relaxants	31,034.48	0.23	33,444.93	0.21											
129200	AUTONOMIC DRUGS: Miscellaneous	-14.75	0.00	272.52	0.00											
160000	BLOOD DERIVATIVES	344.53	0.00	0.00	0.00											
200404	BLOOD FORMATION & COAGULATION: Antianemia Drugs: Iron Preparations	4,253.63	0.03	5,383.18	0.03											
201218	BLOOD FORMATION & COAGULATION: Anticoagulants	10,616.16	0.08	917.93	0.01											
201220	BLOOD FORMATION & COAGULATION: Thrombolytic Agents	121.26	0.00	331.90	0.00											
201600	BLOOD FORMATION & COAGULATION: Hematopoietic Agents	206,134.52	1.53	282,757.11	1.81											
202400	BLOOD FORMATION & COAGULATION: Hemorreologic Agents	477.90	0.00	657.17	0.00											
202816	BLOOD FORMATION & COAGULATION: Hemostatics	18,110.08	0.13													
240404	CARDIOVASCULAR DRUGS: Cardiac Drugs: Antiarrhythmic Agents	4,137.99	0.03	4,077.42	0.03											
240408	CARDIOVASCULAR DRUGS: Cardiac Drugs: Cardiotonic Agents	1,336.30	0.01	1,466.47	0.01											

240492	CARDIOVASCULAR DRUGS: Cardiac Drugs: Miscellaneous	203.78	0.00	163.02	0.00													
240604	CARDIOVASCULAR DRUGS: Antilipedemic Agents: Bile Acid Sequestrants	2,537.26	0.02	3,427.18	0.02													
240605	CARDIOVASCULAR DRUGS: Antilipedemic Agents: Cholesterol Absorption Inhibitors	10,076.71	0.07	17,316.74	0.11													
240606	CARDIOVASCULAR DRUGS: Antilipedemic Agents: Fibric Acid Derivatives	11,870.44	0.09	16,256.27	0.10													
240608	CARDIOVASCULAR DRUGS: Antilipedemic Agents: HMG-COA Reductase Inhibitors	593,978.31	4.40	791,606.75	5.07													
240692	CARDIOVASCULAR DRUGS: Antilipedemic Agents: Miscellaneous	2,612.48	0.02	5,306.81	0.03													
240816	CARDIOVASCULAR DRUGS: Hypotensive Agents: Central α-Agonists	16,638.33	0.12	22,895.63	0.15													
240820	CARDIOVASCULAR DRUGS: Hypotensive Agents: Direct Vasodilators	3,408.20	0.03	3,991.43	0.03													
241208	CARDIOVASCULAR DRUGS: Vasodilating Agents: Nitrates	7,153.85	0.05	7,793.00	0.05													
241212	CARDIOVASCULAR DRUGS: Vasodilating Agents: Phosphodiesterase Inhibitors	371.92	0.00	2,260.88	0.01													
241292	CARDIOVASCULAR DRUGS: Vasodilating Agents: Miscellaneous	1,274.98	0.01	1,388.56	0.01													
241600	CARDIOVASCULAR DRUGS: Sclerosing Agents	71.18	0.00															
242000	CARDIOVASCULAR DRUGS: α-Adrenergic Blocking Agents	8,268.32	0.06	8,938.25	0.06													
242400	CARDIOVASCULAR DRUGS: β-Adrenergic Blocking Agents	59,196.37	0.44	91,492.41	0.59													
42808	CARDIOVASCULAR DRUGS: Calcium Channel Blockers: Dihydropyridines	212,052.34	1.57	275,239.42	1.76													
42892	CARDIOVASCULAR DRUGS: Calcium Channel Blockers: Misc.	12,691.59	0.09	12,480.22	0.08													
243204	CARDIOVASCULAR DRUGS: RAAS Inhibitors: ACE Inhibitors	44,380.55	0.33	56,244.88	0.36													
243208	CARDIOVASCULAR DRUGS: RAAS Inhibitors: Angiotensin II Receptor Antagonists	36,926.70	0.27	39,748.23	0.25													
243220	CARDIOVASCULAR DRUGS: RAAS Inhibitors: Mineralocorticoid (Aldosterone) Antagonists	12,371.86	0.09	10,825.54	0.07													
280400	CNS AGENTS: General Anesthetics	2,307.53	0.02	3,199.38	0.02													
280804	CNS AGENTS: Nonsteroidal Anti-inflammatory Agents	147,857.42	1.09	229,805.73	1.47													
280808	CNS AGENTS: Opiate Agonists	85,454.32	0.63	101,245.80	0.65													
280812	CNS AGENTS: Opiate Partial Agonists	40.87	0.00	13.50	0.00													
280892	CNS AGENTS: Miscellaneous Analgesics & Antipyretics	10,408.50	0.08	14,102.97	0.09													
281000	CNS AGENTS: Opiate Antagonists	480.07	0.00	435.70	0.00													
281204	CNS AGENTS: Anticonvulsants: Barbiturates	4,419.01	0.03	5,214.58	0.03													
281208	CNS AGENTS: Anticonvulsants: Benzodiazepines	956.40	0.01	741.30	0.00													
281212	CNS AGENTS: Anticonvulsants: Hydantoins	64,785.96	0.48	68,656.78	0.44													
281220	CNS AGENTS: Anticonvulsants: Succinimides	51.64	0.00	119.48	0.00													
281292	CNS AGENTS: Anticonvulsants: Miscellaneous	951,813.55	7.05	1,126,134.29	7.21													
281604	CNS AGENTS: Psychotherapeutic Agents: Antidepressants	719,110.45	5.33	788,543.14	5.05													
281608	CNS AGENTS: Psychotherapeutic Agents: Antipsychotics	4,645,626.82	34.40	4,622,112.00	29.60													
282004	CNS AGENTS: Anorex. Respir. & Cerebral Stimulants: Amphetamines	1,772.62	0.01	784.34	0.01													
282092	CNS AGENTS: Anorex. Respir. & Cerebral Stimulants: Misc.	44.96	0.00	23.80	0.00													
282404	CNS AGENTS: Anxiolytic/Sedative/Hypnotics: Barbiturates	1,758.41	0.01	1,801.93	0.01													
282408	CNS AGENTS: Anxiolytic/Sedative/Hypnotics: Benzodiazepines	2,469.48	0.02	2,166.40	0.01													
2492	CNS AGENTS: Anxiolytic/Sedative/Hypnotics: Miscellaneous	35,616.21	0.26	33,619.88	0.22													
2800	CNS AGENTS: Antimanic Agents	13,445.69	0.10	14,079.15	0.09													
283228	CNS AGENTS: Antimigraine Agents (Selective Serotonin Agonists)	118,970.40	0.88	156,351.26	1.00													
289200	CNS AGENTS: Miscellaneous	42,443.90	0.31	65,730.50	0.42													
340000	DENTAL AGENTS	21.88	0.00	92.48	0.00													
360000	DIAGNOSTIC AGENTS: Miscellaneous	54.30	0.00	95.00	0.00													
360400	DIAGNOSTIC AGENTS: Adrenocortical Insufficiency	55.21	0.00	662.50	0.00													
362600	DIAGNOSTIC AGENTS: Diabetes Mellitus	19,227.27	0.14	38,061.23	0.24													
364000	DIAGNOSTIC AGENTS: Kidney Function	3.31	0.00	0	0													
365600	DIAGNOSTIC AGENTS: Myastenia Gravis	-11.03	0.00	0	0													
366800	DIAGNOSTIC AGENTS: Roentgenography	5,221.36	0.04	5,624.29	0.04													
368400	DIAGNOSTIC AGENTS: Tuberculosis	44,076.33	0.33	68,844.71	0.44													
368800	DIAGNOSTIC AGENTS: Urine & Feces Content: Misc.	430.45	0.00	220.72	0.00													
368812	DIAGNOSTIC AGENTS: Urine & Feces Content: Ketones	14.10	0.00	0	0													
368820	DIAGNOSTIC AGENTS: Urine & Feces Content: Occult Blood	10.90	0.00	0	0													
368824	DIAGNOSTIC AGENTS: Urine & Feces Content: PH	19.93	0.00	0	0													
380000	DISINFECTANTS (FOR NON-DERMATOLOGIC USE)	359.20	0.00	601.12	0.00													
400400	ELECTR/CALORIC/WATER BALANCE: Acidifying Agents	10.56	0.00	0	0													
400800	ELECTR/CALORIC/WATER BALANCE: Alkalinizing Agents	321.28	0.00	334.79	0.00													

401000	ELECTR/CALORIC/WATER BALANCE: Ammonia Detoxicants	4,053.84	0.03	4,585.90	0.03													
401200	ELECTR/CALORIC/WATER BALANCE: Replacement Preparations	8,189.12	0.06	14,107.68	0.09													
401818	ELECTR/CALORIC/WATER BALANCE: Potassium Removing Agents	820.24	0.01	1,043.72	0.01													
401819	ELECTR/CALORIC/WATER BALANCE: Phosphate Removing Agents	42,608.77	0.32	61,876.90	0.40													
402000	ELECTR/CALORIC/WATER BALANCE: Caloric Agents	36,955.14	0.27	36,186.37	0.23													
402800	ELECTR/CALORIC/WATER BALANCE: Diuretics	23,030.64	0.18	25,980.45	0.17													
403600	ELECTR/CALORIC/WATER BALANCE: Irrigating Solution	467.28	0.00	117.74	0.00													
404000	ELECTR/CALORIC/WATER BALANCE: Uricosuric Agents	172.10	0.00	235.00	0.00													
440000	ENZYMES	0.00	0.00	1,422.85	0.01													
480800	ANTITUSSIVES	3,864.42	0.03	8,828.28	0.06													
481024	LEUKOTRIENE MODIFIERS	99,207.99	0.73	134,109.77	0.86													
481032	MAST-CELL STABILIZERS	776.65	0.01	168.42	0.00													
481600	EXPECTORANTS	5,839.54	0.04	18,396.21	0.12													
482400	MUCOLYTIC AGENTS	179.02	0.00	15.57	0.00													
520200	EENT: Antiallergic Agents	6,210.63	0.05	8,206.15	0.05													
520404	EENT: Antibacterials	26,503.48	0.20	24,721.12	0.16													
520416	EENT: Antifungals	116.00	0.00	0	0													
520420	EENT: Antivirals	853.88	0.01	562.16	0.00													
520492	EENT: Miscellaneous anti-infectives	2,416.20	0.02	2,195.49	0.01													
?0808	EENT: Corticosteroids	220,657.19	1.63	250,453.71	1.60													
?0820	EENT: Nonsteroidal Anti-inflammatory Agents	4,832.75	0.04	7,764.70	0.05													
520892	EENT: Miscellaneous Anti-inflammatory Agents	1,289.53	0.01	1,893.76	0.01													
521000	EENT: Carbonic Anhydrase Inhibitors	16,322.68	0.12	28,657.20	0.18													
521200	EENT: Contact Lens Solutions	333.36	0.00	395.28	0.00													
521600	EENT: Local Anesthetics	1,286.84	0.01	1,210.35	0.01													
522000	EENT: Miotics	73.45	0.00	48.71	0.00													
522400	EENT: Mydriatics	661.05	0.00	582.93	0.00													
522800	EENT: Mouthwashes & Gargles	9.24	0.00	215.57	0.00													
523200	EENT: Vasoconstrictors	4,629.22	0.03	5,083.53	0.03													
529200	EENT: Miscellaneous Agents	48,951.36	0.36	68,487.46	0.44													
560400	GASTROINTESTINAL AGENTS: Antacids & Adsorbents	9,565.69	0.07	11,392.97	0.07													
560800	GASTROINTESTINAL AGENTS: Antidiarrheal Agents	5,617.05	0.04	6,228.25	0.04													
561000	GASTROINTESTINAL AGENTS: Antiflatulents	1,300.96	0.01	1,995.04	0.01													
561200	GASTROINTESTINAL AGENTS: Cathartics & Laxatives	25,729.36	0.19	36,913.85	0.24													
561400	GASTROINTESTINAL AGENTS: Cholelitholytic Agents	1,288.72	0.01	1,162.15	0.01													
561600	GASTROINTESTINAL AGENTS: Digestants	3,622.06	0.03	5,136.20	0.03													
562000	GASTROINTESTINAL AGENTS: Emetics	12.66	0.00	0	0													
562208	GASTROINTESTINAL AGENTS: Antihistamines	1,622.61	0.01	1,375.78	0.01													
562220	GASTROINTESTINAL AGENTS: 5-HT3 Receptor Antagonists	21,194.48	0.16	26,632.23	0.17													
562292	GASTROINTESTINAL AGENTS: Antiemetics, Micellaneous	67.50	0.00	316.24	0.00													
562812	GASTROINTESTINAL AGENTS: H2- Antagonists	13,341.92	0.10	12,272.56	0.08													
562828	GASTROINTESTINAL AGENTS: Prostaglandins	223.03	0.00	227.59	0.00													
562832	GASTROINTESTINAL AGENTS: Protectants	1,376.00	0.01	2,464.01	0.02													
2836	GASTROINTESTINAL AGENTS: Proton Pump Inhibitors	273,492.80	2.03	411,593.21	2.64													
3200	GASTROINTESTINAL AGENTS: Prokinetic Agents	1,441.78	0.01	2,263.61	0.01													
563600	GASTROINTESTINAL AGENTS: Anti-inflammatory Agents	21,495.53	0.16	30,462.59	0.20													
569200	GASTROINTESTINAL AGENTS: Miscellaneous	2,233.87	0.02	2,797.92	0.02													
640000	HEAVY METAL ANTAGONISTS	707.49	0.01	4,975.46	0.03													
680400	HORMONES: Adrenals	302,451.55	2.24	402,896.32	2.58													
680800	HORMONES: Androgens	4,739.78	0.04	3,953.15	0.03													
681200	HORMONES: Contraceptives	7,044.37	0.05	9,094.77	0.06													
681604	HORMONES: Estrogens	34,209.95	0.25	32,832.07	0.21													
681612	HORMONES: Estrogen Agonist/Antagonists	33.20	0.00	0	0													
682002	HORMONES: Antidiabetic Agents: α-Glucosidase Inhibitors	630.70	0.00	699.78	0.00													
682003	HORMONES: Antidiabetic Agents: Amylinomimetics	52.45	0.00	0	0													
682004	HORMONES: Antidiabetic Agents: Biguanides	23,002.66	0.17	29,361.60	0.19													
682008	HORMONES: Antidiabetic Agents: Insulins	80,637.11	0.60	141,058.95	0.90													
682016	HORMONES: Antidiabetic Agents: Meglitinides	202.26	0.00	329.91	0.00													
682020	HORMONES: Antidiabetic Agents: Sulfonylureas	15,618.47	0.12	17,153.01	0.11													
682028	HORMONES: Antidiabetic Agents: Thiazolidinediones	107,024.41	0.79	177,221.05	1.13													
682092	HORMONES: Antidiabetic Agents: Miscellaneous	370.06	0.00	649.42	0.00													
682212	HORMONES: Antidiabetic Agents: Glycogenolytic Agents	5,180.89	0.04	9,090.77	0.06													

682400	HORMONES: Parathyroid	419.07	0.00	284.19	0.00												
682800	HORMONES: Pituitary	1,436.60	0.01	3,094.43	0.02												
683200	HORMONES: Progestins	3,776.74	0.03	4,345.38	0.03												
683604	HORMONES: Thyroid Agents	13,100.67	0.10	11,495.26	0.07												
683608	HORMONES: Antithyroid Agents	2,179.25	0.02	2,394.40	0.02												
720000	LOCAL ANESTHETICS (PARENTERAL)	941.75	0.01	1,252.72	0.01												
760000	OXYTOCICS	89.81	0.00	87.90	0.00												
800400	SERUMS	2,245.44	0.02	7,684.90	0.05												
800800	TOXOIDS	13,516.49	0.10	12,155.89	0.08												
801200	VACCINES	99,754.07	0.74	109,246.89	0.70												
840404	SKIN & MUCOUS MEMBRANE: Antibacterials	17,459.37	0.13	20,885.97	0.13												
840406	SKIN & MUCOUS MEMBRANE: Antivirals	6,973.68	0.05	6,872.71	0.04												
840408	SKIN & MUCOUS MEMBRANE: Antifungals	29,389.71	0.22	32,275.72	0.21												
840412	SKIN & MUCOUS MEMBRANE: Scabicides & Pediculicides	1,489.02	0.01	3,307.92	0.02												
840492	SKIN & MUCOUS MEMBRANE: Miscellaneous Local Anti-Infectives	15,815.97	0.12	17,748.03	0.11												
840600	SKIN & MUCOUS MEMBRANE: Anti-Inflammatory Agents	19,175.31	0.14	22,896.21	0.15												
840800	SKIN & MUCOUS MEMBRANE: Antipruritics & Local Anesthetics	5,698.08	0.04	8,440.87	0.05												
841200	SKIN & MUCOUS MEMBRANE: Astrigents	581.99	0.00	833.64	0.01												
841600	SKIN & MUCOUS MEMBRANE: Cell Stimulants & Proliferants	1,711.14	0.01	-3,126.26	-0.02												
12000	SKIN & MUCOUS MEMBRANE: Detergents	542.42	0.00	1,536.63	0.01												
42400	SKIN & MUCOUS MEMBRANE: Emollients, Demulcents & Protectants	0.88	0.00	0.00	0.00												
842404	SKIN & MUCOUS MEMBRANE: Basic Lotions & Liniments	1,534.33	0.01	2,452.07	0.02												
842408	SKIN & MUCOUS MEMBRANE: Basic Oils & Other Solvents	333.36	0.00	821.68	0.01												
842412	SKIN & MUCOUS MEMBRANE: Basic Ointments & Protectants	2,695.90	0.02	5,026.05	0.03												
842416	SKIN & MUCOUS MEMBRANE: Basic Powders & Demulcents	90.27	0.00	164.87	0.00												
842800	SKIN & MUCOUS MEMBRANE: Keratolytic Agents	8,411.85	0.06	11,024.90	0.07												
843200	SKIN & MUCOUS MEMBRANE: Keratoplastic Agents	4,437.72	0.03	5,900.62	0.04												
845004	SKIN & MUCOUS MEMBRANE: Depigmenting Agents	211.19	0.00	154.89	0.00												
848000	SKIN & MUCOUS MEMBRANE: Sunscreen Agents	245.93	0.00	312.53	0.00												
849200	SKIN & MUCOUS MEMBRANE: Miscellaneous Agents	51,054.22	0.38	71,658.94	0.46												
861200	GENITOURINARY SMOOTH MUSCLE RELAXANTS	9,278.20	0.07	14,005.29	0.09												
861600	RESPIRATORY SMOOTH MUSCLE RELAXANTS	1,681.51	0.01	1,693.17	0.01												
880400	VITAMIN A	7.34	0.00	14.54	0.00												
880800	VITAMIN B COMPLEX	3,510.51	0.03	3,553.24	0.02												
881200	VITAMIN C	653.72	0.00	1,134.84	0.01												
881600	VITAMIN D	11,872.99	0.09	22,483.30	0.14												
882000	VITAMIN E	329.17	0.00	575.43	0.00												
882400	VITAMIN K ACTIVITY	1,070.34	0.01	1,780.80	0.01												
882800	MULTIVITAMIN PREPARATIONS	3,295.68	0.02	4,468.50	0.03												
920000	MISCELLANEOUS THERAPEUTIC AGENTS	242,730.22	1.80	350,429.98	2.24												
940000	DEVICES	6,307.72	0.05	4,632.95	0.03												
960000	PHARMACEUTICAL AIDS	2,023.58	0.01	1,973.54	0.01												
201204	ANTICOAGULANTS	61,815.35	0.46	69,452.97	0.44												
	NULL	110,460.17	0.82	0	0												
	TOTAL	**13,504,297.37**	**100**	**15,616,073.43**	**100**												

EXHIBIT 14

1. Reception Standards and Compliance

Project Lead: Jayne Russell

At the outset, the major objective for this subproject was to comply with the Plata standards related to Reception; however, upon assignment of Jayne Russell as the San Quentin Program Director, it was determined that the Plata standards were creating an immense backlog and exceeded both industry standard and National Commission of Correctional Health Care recommendations for intake processes. With court approval, San Quentin was granted authorization to modify the Plata requirements, making it possible to complete intake screenings on the same day of arrival for all incoming inmates.

The objective for his subproject was modified to enable San Quentin staff to provide to all inmates on the same day as arrival a comprehensive multidisciplinary screening and evaluation to identify any serious or immediate health care needs. A Quality Improvement Team was formed and drafted a new integrated screening process that includes a medical screening, a basic dental screening, and a mental health evaluation. Implementation of the new process will complete all intakes each day, with the exception of those inmates referred to a mid-level provider [assigned to the Receiving and Release (R&R) area] for further evaluation of health care issues identified during the medical screening. Depending on the daily intake volume, health care staff will also be scheduled to accommodate inmates arriving during 2nd and 3rd watch; however those inmates arriving after 7p.m. or on weekends are scheduled for a separate mental health and dental evaluation.

Though, the current screening process has improved within the existing infrastructure, implementation of the integrated screening plan cannot occur until the current R&R space is modified and adequate working space is available. A mental health relocatable building has been purchased and is located outside the current R&R space; the relocatable building will be utilized for the new screening process. Vanir estimates that the construction will be completed in the R&R on March 2007.

Following implementation of the integrated plan, a program has been designed wherein staff will complete tracking logs to monitor the intake flow, evaluate the process for quality of care and service delivery, and collect necessary data. An Access database will also provide multidisciplinary screening information which will allow staff to access previous evaluation dates to avoid screening duplications.

San Quentin is in need of IT support and equipment to support the new intake screening processes. Jayne Russell has initiated an evaluation of existing and necessary IT resources and will present the findings to the Receiver's team upon completion.

This subproject is ongoing, and the monitoring should continue through 2007.

1	RECEPTION STANDARDS AND COMPLIANCE Team Oversight: J. Russell	Start Date	Completion Date	Responsible Party
	Design a Receiving & Release area that complies with *Plata* standards.	**7/19/2006**	**8/21/2007**	**J. Russell & Dr. Saylor**
1.1	**Gather and analyze data regarding 'through put' of patients being evaluated and/or treated at the reception center.**	**7/5/2006**	**8/18/2006**	**M. Connell**
1.2	**Evaluate the following current areas:** Assessment, intake, triage and referral processes Space (clinical and support) Medical records Privacy	**7/5/2006**	**8/18/2006**	**M. Connell**
1.3	**Implement a medical confidentiality agreement for all correctional officers**	**8/1/2006**	**8/17/2006**	**Capt. Day & D. Meier**
1.4	**Implement a process regarding transfer lists**	**8/1/2006**	**10/26/2006**	**Capt. Day**
1.4.1	Establish a 12 p.m. noon deadline for finalizing and distributing the transfer lists to Health Records, Pharmacy, Transfer Nurse, and R&R Nurse.	8/1/2006	8/18/2006	S. Petrakis
1.4.2	Distribute a notice immediately that ensures transfer lists and parole lists are finalized by 12p.m. noon the day before the transfer and are distributed immediately	7/19/2006	8/18/2006	Dr. Saylor, S. Petrakis & Capt. Day
1.4.3	Conduct a QIT to address the R&R transfer process (tasks 1.4.1 and 1.4.2 are accomplished but did not solve the larger transfer list problem)	9/21/2006	10/26/2006	Capt. Day, J. Russell & Ricardo Brau
1.5	**Design a new R&R model which includes appropriate space for administrative support; provides proximity/access to all ancillary services; and ensures the model includes privacy based upon security/custody level.**	**3/19/2007**	**8/21/2007**	**VANIR, Dr. Saylor, J. McGrath, J. Russell & K. Page**
1.5.1	Implement an interim R&R checklist based on current process	8/1/2006	8/4/2006	M. Connell
1.5.2	Establish policies and procedures regarding R&R processes (including a policy regarding when, how and whom will distribute medications in the R&R including when it is appropriate for a c.o. to give meds and a policy regarding transfer lists and distribution timeframes)	3/19/2007	8/21/2007	J. Russell, Tonya Church, M. Connell, Dr. Silacci, & Capt. Day
1.5.3	Implement a check list, according to the new R&R model, that requires completion prior to any inmate leaving the R&R	3/19/2007	8/21/2007	M. Connell
1.6	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

2. Outpatient Housing Unit

Project Lead: Terry Hill, M.D.

The overall objectives for this subproject were achieved. Policies and procedures (P&Ps) were drafted for the OHU, and Dr. Hill recommends that San Quentin implement the P&Ps.

Monitoring the implementation of the OHU P&PS should continue through 2007.

2	OUTPATIENT HOUSING UNIT Team Oversight: Dr. Hill	Start Date	Completion Date	Responsible Party
	Ensure appropriate levels of quality care based on determined treatment criteria.	**7/5/2006**	**11/2/2006**	**J. Russell & Dr. Saylor**
2.1	**Evaluate Outpatient Housing Unit (OHU) by reviewing the following:** Purpose statement and clarification of clinical criteria for care in OHU Policies (e.g., timely transfer of patients to outside hospitals or other prisons) Staffing Equipment and supplies Admission, discharge and treatment criteria with quality and utilization oversight	**7/5/2006**	**8/3/2006**	**J. Robinson**
2.2	**Define the OHU program**	**7/21/2006**	**8/18/2006**	**Dr. Saylor & J. Robinson**
2.2.1	Determine clinical criteria for admission and discharge; who is authorized to admit and discharge; treatment criteria; criteria for transfer of patients to an outside hospital; quality and utilization oversight, etc.	7/19/2006	8/18/2006	Dr. Saylor & J. Robinson
2.2.2	Determine what clinical responsibilities are required for various levels of care (i.e. are vitals for all OHU patients each shift necessary?)	7/19/2006	8/18/2006	Dr. Saylor & J. Robinson
2.2.3	Revise the current OHU operating procedure to include the clinical criteria, admit/discharge criteria, treatment criteria and related processes, etc. OR develop a new OHU policy and procedure	7/19/2006	8/18/2006	Dr. Saylor & J. Robinson
2.3	**Evaluate current and anticipated staffing levels and compose a staffing plan that includes nursing posts (24/7)**	**7/19/2006**	**8/18/2006**	**Dr. Saylor & J. Robinson**
2.4	**Evaluate and determine necessary space for administrative staff and equipment**	**7/27/2006**	**8/18/2006**	**Dr. Saylor & J. Robinson**

2.5	**Determine necessary equipment and supplies for the OHU (including a call system)**	**8/2/2006**	**8/18/2006**	**J. Robinson**
2.5.1	Order new cell doors for the 2nd floor	7/27/2006	7/27/2006	J. Curzon
2.5.2	Coordinate with A. Laird to ensure ongoing availability of all needed equipment and supplies	8/2/2006	8/18/2006 and ongoing	J. Robinson & J. Dominie
2.6	**Improve availability and administration of medication in the OHU**	**8/2/2006**	**8/23/2006**	**J. Robinson & Dr. Silacci**
2.6.1	Evaluate availability and administration of medication in the OHU	8/2/2006	8/18/2006	J. Robinson & Dr. Silacci
2.6.2	Consider implementing a PYXIS unit in the OHU	8/2/2006	8/18/2006	J. Robinson & Dr. Silacci
2.7	**Coordinate with Jeff Metzner and Michael Keating regarding OHU issues**	**7/5/2006**	**ongoing**	**Dr. Hill & J. Hagar**
2.8	**Metrics (data on adverse patient incidents)**	**9/15/2006**	**TBD**	**SQ Project Team**

3. Supplies & Equipment

Project Lead: Linda Buzzini

Many of the objectives of the Supplies and Equipment subproject were accomplished. A streamlined ordering and approval policy and procedure for supplies and equipment were implemented, making acquisition of goods easier and timelier. The streamlined process primarily happens locally, and what was discovered in designing the new process is that the Department of General Services was not the problem. Rather, internal CDCR processes were creating delays and difficulty. As a result of the revised ordering and approval process, necessary medical supplies and equipment were obtained in the various clinical areas at the Institution and a truck was purchased to assist with supply delivery on Institution grounds. The M&SSI from Pelican Bay State Prison visited San Quentin and assisted staff with organizing their current storage areas.

A single temporary medical supply area was not established at the Institution, and supplies are still located in various locations on grounds. Establishment of a temporary site never occurred because it is believed that construction of the permanent medical warehouse could be accomplished rather quickly. A site for the medical warehouse has been identified, and the M&SS I from Pelican Bay will assist Vanir Construction Management in the design of the warehouse. Vanir estimates that the medical warehouse will be completed in December 2007. Still pending, in addition to the construction of the warehouse, are the subsequent implementation of the policies and procedures associated with the medical warehouse and use of the current SLAMM system within the new warehouse facility.

Monitoring of this subproject is ongoing and should continue through 2007.

3	**MEDICAL SUPPLIES** **Team Oversight: L. Buzzini**	**Start Date**	**Completion Date**	**Responsible Party**
	Ensure the adequate, appropriate, timely ordering, inventory, storage, and receipt of supplies by all clinical areas and a standard compliment of equipment by function and provider-type.	**7/5/2006**	**12/12/2006**	**K. Mitchell**
3.1	**Evaluate ordering, taking into consideration the following:** Internal and external procurement processes Standardization and exception for procurement processes Determine what role, if any, the warden should have in health care procurement processes and decisions	**7/5/2006**	**8/18/2006**	**L. Buzzini & QIT**
3.2	**Evaluate the following with respect to supplies:** Delivery to San Quentin Warehousing Delivery to clinical sites Security Inventory Control systems Accounting and timely payment of invoices Clinical site storage Standard compliment of supplies by function and provider-type	**7/5/2006**	**8/18/2006**	**L. Buzzini & QIT**
3.3	**Identify source of PIA requirements and determine what is necessary for a waiver for SQ to utilize SQ's PIA services**	**7/19/2006**	**8/18/2006**	**L. Buzzini**
3.4	**Implement a streamlined ordering and approval policy and procedure for supplies and equipment (i.e. from originator to CMO for approval; P.O. to procurement officer and Budget Analyst; P.O. to vendor, etc.)**	**7/27/2006**	**8/24/2006**	**K. Mitchell**
3.4.1	Set up a QIT to evaluate the ordering and approval process and to develop a standard process	8/2/2006	ongoing	L. Buzzini
3.4.1.1	Implement a temporary 90-day process (HCM approval, 24-hour turn-around on Form 5s, no veto in procurement office)	7/27/2006	7/27/2006	J. Curzon, J. Dominie, & A. Laird
3.4.1.2	Develop a flowchart of new request and purchase order process resulting in routine procurement requests being processed in 2-3 days	8/2/2006	8/25/2006	J. Dominie
3.4.1.3	Provide a flowchart illustrating a new "service and expense" process resulting in routine requests being processed in 2-3 days	8/2/2006	8/25/2006	J. Dominie

3.4.1.4	Review and identify statutes, rules, regulations and policies that require change in order to implement most efficient and timely procurement of supplies, equipment, and staff	8/10/2006	8/18/2006	K. Mitchell
3.4.1.5	Obtain secondary access to DGS procurement program so healthcare can prepare its own routine purchase orders	8/10/2006	8/18/2006	K. Mitchell
3.4.1.6	Determine what percentage of procurement exceeds SQ's delegated authority, why its not all delegated, and whether delegation is possible	8/10/2006	8/25/2006	K. Mitchell & L. Buzzini
3.4.1.7	Order another 'drop' for supply room computer	8/17/2006	8/24/2006	D. Marshall
3.5	**Construct a medical supply and equipment warehouse and improve warehousing processes**	**7/19/2006**	**unknown**	**VANIR & K. Mitchell**
3.5.1	Form a QIT (determine the size necessary for a warehouse, define inventory of supplies and equipment, do we need refrigeration?, who will have access?)	10/18/2006	12/12/2006	VANIR, J. Robinson, K. Mitchell, R. Rossen, T. McKay & Dr. Saylor
3.5.1.1	Determine a site for a temporary medical supply warehouse (UPS warehouse)	8/3/2006	pending QIT	VANIR & Dr. Saylor
3.5.1.2	Move all supplies to temporary space, inventory all supplies, and enter data into the Slamm system	8/3/2006	pending QIT	J. Jordan
3.5.1.3	Ensure outside vendors, UPS, and FedEx are aware of new delivery site for medical supplies	8/3/2006	pending QIT	J. Jordan
3.5.2	Establish usage patterns and reorder points for needed supplies	8/18/2006	pending QIT	J. Jordan
3.5.3	Establish a distribution system for centrally located supplies	8/18/2006	pending QIT	J. Jordan
3.5.4	Establish an inventorying, ordering, and delivery system for supplies stored in each clinic location.	8/18/2006	pending QIT	J. Jordan
3.5.5	Hire a M&SSI to receive all medical and stationary supplies, maintain warehouse storage area and assist with supply orders and deliveries	7/19/2006	10/3/2006	J. Dominie
3.5.6	Adjust and amend the SLAMM (State Logistics and Materials Management) system to monitor and control the inventory of equipment and supplies	pending QIT	pending QIT	J. Jordan
3.5.6.1	Set up a revised office and forms supply catalog	Pending SLAMM implementation	Pending SLAMM implementation	J. Jordan
3.5.7	Establish policies regarding supply and equipment processes (including a policy and logbook for after-hours access to supply areas and provisions for custody access)	8/8/2006	9/5/2006	B. Welch & A. Laird

3.5.7.1	Compose a letter regarding how and when to order supplies in the interim until the new policies are distributed	8/18/2006	8/24/2006	J. Robinson & Dr. Saylor
3.5.8	Establish medical supply room policies regarding supply room processes and functions	9/21/2006	10/26/2006	B. Welch & T. McKay
3.5.9	Determine if a van, forklift or other equipment is necessary for warehouse	9/15/2006	12/12/2006	J. Jordan
3.6	**Purchase 40 text pagers for clinical staff supervisors**	**7/27/2006**	**8/10/2006**	**Dr. Saylor**
3.7	**Compose a letter to R. Kirkland (HQ Budgets) regarding SQ not subject to CDCR handbook related to procurement. R.Kirkland to contact J. Hagar if there are questions**	**8/17/2006**	**8/24/2006**	**K. Mitchell**
3.8	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

4. HEALTH RECORDS

PROJECT LEAD: KATHY PAGE

The major objectives for this subproject have not been accomplished, although some improvements have been made in Health Records. A health records consultant was hired to review the San Quentin Health Records Unit, and the consultant provided a report with several quick-fix and long-term recommendations. To date, some of the quick-fix recommendations have been implemented: a drop-box will be installed for return of health records to the Unit; a golf cart was purchased for staff to deliver and pick up health records on grounds; and a half-door was installed in the Unit to maintain a more secure environment while providing access to staff. The consultant also recommended that a full-time Medical Records Director be hired to assist in more comprehensive and sustainable improvements in Medical Records, because without strong leadership and supervision in Health Records, sound patient care and an effectively functioning Health Records Unit cannot be achieved. The Medical Records Director is in the process of being hired for San Quentin and is expected to begin work in the next few weeks. Additionally, Giselle Matteson was hired at San Quentin as the Chief of Support Operations, and she will oversee Health Records and provide assistance to the Medical Records Director in effectuating long-term positive change.

Health Records is one of two areas at San Quentin that remains most problematic, as the operations and performance of the Health Records Unit has not changed significantly. It is common to see three or four clinical staff standing outside of the Health Record Unit awaiting receipt of a record; however nearly 50% of all records requests are not retrievable. Clinic staff also make hundreds of calls to the Health Records Unit each week requesting information in order to treat patients; this volume of phone calls further impedes the work of both San Quentin clinicians and the Health Records staff. There are also various systemic issues which are causing difficulty in Health Records. For example, management of the flow of inmates continues to be a major problem; the limited hours of operations in Health Records require healthcare staff to access and search for health information on their own; and ducating and re-ducating of inmates who are "no-shows" causes health records to be pulled, filed, and re-pulled several times.

Several changes implemented by the Receiver have not had the desired outcome. For example, new positions were established in the Health Records Unit to assist with the backlog, but currently approximately half of the Health Records staff are registry personnel who are untrained, unmotivated, and may hinder patient care. The Receiver's group learned more staff were necessary, but increasing the number of positions did not solve the problem. Also, standard timeframes (24-hours max.) were established when loose filing is to be filed in health record and when loose filing needs to be mailed to other institutions for inmates who had transferred. San Quentin is currently complying with the requirement to send loose filing to other institutions when an inmate transfers but is not complying with the requirement that filing in the health record be completed within 24-hours. The failure of Health Records staff to file within the appropriate timeframe results in a delay of treatment and inefficiencies. Request for care, procedures, prescriptions, outside consultants reports, and pertinent medical histories are not filed for days, weeks, and even months. The failure to have this information

appropriately filed has resulted in many bad outcomes and unnecessary hospitalizations.

This subproject is ongoing through 2007-2008, as critical improvements, procedural changes, and requirements have not yet been implemented.

4	HEALTH RECORDS Team Oversight: K. Page	Start Date	Completion Date	Responsible Party
	Ensure the availability of timely, complete and accurate medical records.	**7/5/2006**	**11/2/2006**	**Dr. Saylor & S. Van Hook**
4.1	**Evaluate medical records operations and processes, including the following:** Space and location Personnel (numbers and minimum qualifications) Equipment (e.g., facsimile, scanner) Storage, delivery (including availability), return and retention of records Coding Transfer of patients to other facilities and parole Shredding of county jail medical information Organization and content of medical records	**7/5/2006**	**7/19/2006**	**S. Van Hook**
4.2	**Provide a refresher/retrain regarding Plata P&Ps related to medical records**	**8/1/2006**	**8/31/2006**	**M. Meyers**
4.2.1	Revise the P&Ps to be more user-friendly, to eliminate redundant information, and to add additional info.	8/31/2006	TBD	Pending Medical Records Director
4.3	**Improve supervision and staffing in Medical Records**	**7/19/2006**	**8/18/2006**	**Dr. Saylor**
4.3.1	Obtain new position for a Medical Records Director	8/10/2006	8/18/2006	L. Buzzini
4.3.2	Secure SPB approval to use existing Medical Records Director class beginning immediately	8/10/2006	8/18/2006	L. Buzzini
4.3.3	Secure revision to Medical Records Director class specification	8/18/2006	9/5/2006	L. Buzzini
4.3.4	Secure an additional HRT III position (new Medical Records Director to select IIIs)	7/27/2006	7/28/2006	L. Buzzini
4.3.5	Obtain an out-of-class for S. Van Hook (HRT III)	8/1/2006	8/2/2006	SQ Personnel
4.3.6	Move scheduling responsibility from S. Van Hook to Jane Robinson (memo from Dr. Saylor)	8/1/2006	8/2/2006	Dr. Saylor & J. Robinson
4.4	**Evaluate and report to Receiver's staff regarding equipment needs (i.e. medical records locator, status of stools)**	**7/19/2006**	**8/31/2006**	**B. Welch & A. Laird**

4.5	**Move mailboxes from Medical Records area to create secure medical records area**	**7/19/2006**	**8/4/2006**	**M. Barker**
4.6	**Transfer census coding/logbook from Health Records to appropriate nursing unit**	**8/18/2006**	**8/24/2006**	**J. Robinson**
4.7	**Assess training needs of Health Records staff and develop a training plan.**	**TBD**	**TBD**	**Pending Medical Director Director**
4.8	**Research contracting options for transcription services and report on findings**	**8/3/2006**	**8/18/2006**	**D. Sallade & Dr. Saylor**
4.8.1	Initiate lay off of current transcriptionist	8/3/2006	8/11/2006	L. Buzzini
4.9	**Establish daily overnight mailing of loose filing health documents left behind when an inmate transfers**	**8/18/2006**	**9/1/2006**	**S. Van Hook**
4.10	**Arrange for medical document shredding with a shredding company**	**8/24/2006**	**9/7/2006**	**J. Robinson**
4.11	**Metrics (possible metrics could be data on the increase in delivery/retrieval of medical records to the clinic areas following addition of new staff; collection of data on information not provided in the logbooks for coding census purposes; spot audit findings regarding HR organization, errors, etc.; data on availability and delivery of HRs when an inmate transfers)**	**9/15/2006**	**TBD**	**SQ Project Team**

5. Specialty Services

Project Lead: Terry Hill, M.D.

The objectives of this subproject have been accomplished. However, despite the progress and successes in this area, specialty services at San Quentin are still vulnerable.

San Quentin staff organized and eliminated a severe backlog of specialty services, and regular reports to the Receiver from Renee Kanan M.D. indicate that specialty services are under control. San Quentin is now effectively tracking specialty services (manually and with IMSATS), but an IT improvement is necessary immediately for tracking and scheduling. A solution should be delivered to San Quentin quickly, and the Receiver's group recommends that John Hummel, Chief Information Officer (CIO), and Justin Graham M.D., Chief Medical Information Officer, (CMIO) be enlisted to assist San Quentin with a scheduling and tracking application. This solution should not be an Access database, and should be acquired with statewide implementation in mind, considering the statewide backlog of requests for specialty appointments recently uncovered by the regional nurses.

Contracting for specialty services for San Quentin was stalled in the Doctors Hospital debacle. It was recently discovered that the Office of Business Services was awaiting direction from the Receiver's Office before proceeding in establishing the contracts.

San Quentin staff developed P&Ps and protocols for specialty services, and Dr. Hill recommends that San Quentin implement the P&Ps and the protocols.

Health Care Access

Project Lead: Joe McGrath

The concept for the Health Care Access Teams originated from the Specialty Services subproject but should be addressed separately. Initially, San Quentin staff were recruited to assist with the development of this program, but the Receiver's group learned that the institutions do not have the resources to do this locally. Therefore, the Receiver will have to design and implement a health care access program.

Although, this subproject progressed slower than originally expected, Joe McGrath, Don Meier, and Don Hill have prepared a complete package program that includes all documentation necessary to implement the program. Linda Buzzini and Joe McGrath met with CCPOA and they are currently awaiting a response from CCPOA regarding the program.

5	SPECIALTY SERVICES Team Oversight: Dr. Hill	Start Date	Completion Date	Responsible Party
	Ensure the availability of timely medical specialty services necessary for quality medical care.	**7/5/2006**	**11/2/2006**	**Dr. Saylor**
5.1	**Evaluate specialty services delivery, including the following:** On-site (preferred, as appropriate) and off-site Scheduling Transportation (internal and external) Telemedicine Utilization review (internal and external) Need for appropriate clinical and support staff (e.g., scheduling and tracking services) Reimbursement for private providers Propose a timeframe and milestones for the above elements	**7/5/2006**	**7/19/2006**	**Dr. Saylor**
5.2	**Designate an administrative position/individual to coordinate schedules with outside providers from 8:30a.m. to 4:30p.m. (not an RN) and transition responsibilities**	**7/27/2006**	**8/31/2006**	**J. Robinson**
5.2.1	Coordinate with frequently used off-site providers to have specific days/times reserved for inmate patients	8/16/2006	8/31/2006	J. Robinson
5.3	**Develop a contract with Doctors Medical Center for approval by the Receiver**	**8/3/2003**	**9/7/2006**	**D. Sallade & Dr. Hill**
5.3.1	Visit Doctors to discuss the lock-up area in facility	8/2/2006	8/2/2006	J. McGrath, Dr. Saylor & Dr. Hill
5.3.2	Meet with the chief of police of San Pablo regarding community concerns of use of the hospital space	8/17/2006	8/17/2006	J. McGrath & B. Ayers
5.3.3	Identify a coordinator (LVN) to be responsible to manage Doctors Medical Center relationship and scheduling (i.d. problems, troubleshoot, and ride on the transfers)	8/24/2006	9/7/2006	Dr. Saylor
5.4	**Establish a QIT (with representatives from medical and custody-transportation) to coordinate all off-site specialty appointments and transportation**	**7/19/2006**	**9/6/2006**	**Dr. Kanan, Capt. Day & M. Barker**
5.4.1	Implement a short-term plan: Immediately triage all requests for services and prioritize requests (urgent & routine)	8/1/2006	8/4/2006	Dr. Kanan
5.4.1.1	Schedule and complete all urgent requests for services on-site and off-site (@ Doctors)	8/1/2006	8/25/2006	Dr. Kanan & Sgt. Melton
5.4.1.2	Triage routine requests for service and prioritize requests	8/7/2006	8/11/2006	Dr. Kanan
5.4.2	Develop a long term specialty services plan	8/2/2006	9/28/2006	Capt. Day, Dr. Kanan & Sgt. Melton

5.4.2.1	Assemble a health care access team and submit a proposal to Receiver's staff regarding scheduling, transportation etc.	7/27/2006	9/28/2006	J. McGrath & D. Meier
5.4.2.2	Establish contracts for on-site services with Doctors Medical Center (Ortho, Gastro, and Cardio) and for off-site services with UCSF (HIV and PCP)	7/19/2006	10/3/2006	Dr. Saylor & Dr. Kanan
5.4.3	Implement a primary care model with assistance from UCSF (Buddy system)	8/1/2006	8/7/2006	Dr. Kanan & Dr. Saylor
5.4.4	Develop and implement policies and procedures related to specialty services	8/1/2006	9/28/2006	Dr. Saylor & T. Church
5.5	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

6. Laboratory Services

Project Lead: Kathy Page

The objectives of this subproject were accomplished. P&Ps related to laboratory operations were implemented, and a standard timeframe (72 hours) was established from when a lab test is ordered until a lab specimen is drawn. Two new positions were added to assist with the new timeframe requirements, and a lab technician was assigned to the R&R area to expedite lab work and decrease the number of inmates that need to be "ducated" in the future. Quest Lab revised a lab form, at the request of San Quentin staff, to include a space for the date the provider ordered the test. The new form will be implemented when the current supply runs out. IT, lab staff and the Quest Lab coordinated, and Triage and Treatment Area staff now have direct access to on-line lab reports, as needed.

Although progress was made related to lab services, additional workload and time requirement for lab draws may be problematic due to inconsistent staffing levels. Untimely filing of the lab reports by Medical Records staff results in delay of treatment and inefficiencies. Clinic staff makes hundreds of calls to the lab each week to request lab results in order to treat the patients, and the high volume of phone calls between clinicians and laboratory services staff further hinders the work of the lab staff. "Ducating" special program inmates and West Block inmates continues to be problematic as well.

Strong leadership is not present in the lab, and constant reinforcement and encouragement of the lab staff are needed due to years of being "powerless." Giselle Matteson was recently hired at San Quentin as the Chief of Support Operations, and she will oversee Laboratory Services and provide assistance to the staff in effectuating long-term positive change.

Monitoring of laboratory services is critical through 2007, as procedural changes have not yet been.

6	LABORATORY SERVICES Team Oversight: K. Page	Start Date	Completion Date	Responsible Party
	Ensure the availability of timely, complete and accurate laboratory services needed for quality medical care.	**7/5/2006**	**11/2/2006**	**Dr. Saylor & R. Tejada**
6.1	**Evaluate laboratory services, including the following:** Phlebotomy Level of services on-site Contracts for off-site services Process for ordering, processing, receiving results, acting on results and storing results Demand data Coordinating patient transfers with receipt of laboratory results Reporting the results to patients	**7/5/2006**	**7/19/2006**	**R. Tejada**
6.2	**Utilize contract phlebotomists to fill 2 current vacancies**	**7/24/2006**	**8/18/2006**	**K. Tate**
6.2.1	Add 2 civil service clinical lab technologist (phlebotomist) positions	8/10/2006	8/18/2006	L. Buzzini
6.3	**Improve the turn-around times from request for service to service delivery to reporting to physician**	**7/27/2006**	**8/31/2006**	**R. Tejada**
6.3.1	Re-define the lab process flow	7/27/2006	8/18/2006	K. Page
6.3.2	Identify appropriate standard regarding timeframes (72 hours max.)	7/27/2006	8/18/2006	K. Page
6.3.3	Establish a means to measure compliance	8/17/2006	8/31/2006	J. Robinson & Dr. Saylor
6.3.4	Modify duty statements to include standards	8/24/2006	8/31/2006	J. Robinson & Dr. Saylor
6.4	**Improve ducating issues, no-show rate, and adherence to pre-lab instructions (coordinate custody interface regarding meals and lab fasting)**	**7/5/2006**	**8/23/2006**	**J. Robinson & Sgt. Melton**
6.4.1	Team (Van Hook, Sgt. Melton, Lt. Massey) will review and evaluate the existing functional Ducat procedure for problematic areas.	7/5/2006	8/7/2006	J. Robinson & Sgt. Melton
6.4.1.1	Evaluate the impact of phlebotomists collecting blood in the units vs. ducating	7/5/2006	8/7/2006	Sgt. Melton, R. Tejada & J. Robinson
6.5	**Address issues related to Quest and Nichols (UCSF) computers and staff access**	**7/27/2006**	**9/6/2006**	**D. Marshall**
6.5.1	Provide D. Marshall an overview of IT Lab needs	7/27/2006	8/10/2006	R. Tejada
6.5.2	Team to provide HCM with a report regarding an upgraded system to include cost, availability, and system capabilities	8/3/2006	8/9/2006	R. Tejada & D. Marshall
6.6	**Develop and implement policies and procedures related to laboratory services**	**8/10/2006**	**10/3/2006**	**R. Tejada**
6.7	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

7. Diagnostic Imaging

Project Lead: Kathy Page

Some of the objectives of this subproject were accomplished. Inmate workers are no longer allowed to perform x-ray functions, and the x-ray storage area has been cleaned out and back log of unfiled x-rays have been archived. A 72-hour timeframe for when an x-ray is ordered until the x-ray is taken has been established. A contract agency now provides one technician to meet new timeframe requirements, and the overall quality of films has improved. However, the current employee (for whom a lay-off was initiated) continues to take x-rays and the quality of films taken by this employee are poor.

Many challenges still exist in the diagnostic imaging area. The current imaging equipment is old and in constant need of repair. This causes delays in effective and efficient patient care, and the fumes from the old developer tanks are an on-going concern. New radiology equipment has been ordered, but Vanir estimates that the relocatable building and equipment will not be operable until November 2007. Additionally, untimely return of x-ray reports also causes a delay in treatment, and untimely filing of the x-ray reports by Medical Records results in delay of treatment and inefficiencies.

Although one of the initial objectives and the responsibility of the radiology consultant, a contract has not been established for taking, reading, and managing the results of films at San Quentin. Issuance of an RFP for diagnostic imaging at San Quentin did not occur as planned due to negotiations with Doctors Hospital. Further, this process was delayed because it was determined that contracting out of this service should be consistent with the statewide plan. In formulating the statewide plan, the Receiver's group also recommends that an alternate radiology consultant be utilized, as the original consultant was helpful in making suggestions and answering questions but not in assisting with long-term plans.

Monitoring of diagnostic imaging is critical through 2007, as the long-term radiology solution is still outstanding, and personnel and procedural issues continue to be problematic.

7	DIAGNOSTIC IMAGING Team Oversight: K. Page	Start Date	Completion Date	Responsible Party
	Ensure performance and storage of diagnostic studies by qualified personnel who are properly trained and equipped.	**7/5/2006**	**11/2/2006**	**Dr. Saylor**
7.1	**Evaluate diagnostic imaging services by reviewing the following:** Qualifications of personnel Viability, licensure and quality of equipment, including maintenance and repair Process for ordering, performing studies, receiving results, acting on results, storing results and informing patients Contracts for services Demand data Coordinating patient transfers with availability of study results	**7/5/2006**	**7/19/2006**	**Dr. Saylor**
7.2	**Secure a radiology consultant to assess the long-term radiology needs and to propose a solution for SQ**	**8/24/2006**	**9/7/20006**	**Receiver's Team**
7.3	**Order and obtain new x-ray equipment**	**8/10/2006**	**9/1/2006**	**Dr. Saylor**
7.4	**Implement an interim process for diagnostic imaging**	**7/21/2006**	**unknown**	**Dr. Saylor**
7.4.1	Contract out all Radiology Services for 90 days to include taking x-rays, reading films, on-line availability, and transcription	7/21/2006	unknown	D. Sallade
7.4.2	Initiate lay-off of x-ray tech	7/27/2006	10/4/2006	L. Buzzini
7.4.3	Evaluate the effectiveness of the radiology contract and the long-term feasibility of continuing and expanding throughout the State the radiology contract (vs. utilizing civil service positions)	7/21/2006	unknown	D. Sallade & Team
7.5	**Metrics (possible metrics may include data on the no-show log system, data on loose filing audits, data on medical records audits, data on equipment maintenance)**	**9/15/2006**	**TBD**	**SQ Project Team**

8. Patient Advocacy Process

Project Lead: Joe McGrath

The objectives of this subproject have been accomplished, and the Patient Advocacy program is a genuine success of the San Quentin project. Currently there are two RNs administering the Patient Advocacy program, and the data shows that the nurses are addressing many patient concerns at a lowest level. Consequently, the second and third level health care related appeals have been reduced from levels present before this program was implemented. Data related to overdue appeals and workload is being reviewed currently to determine if another RN position is necessary.

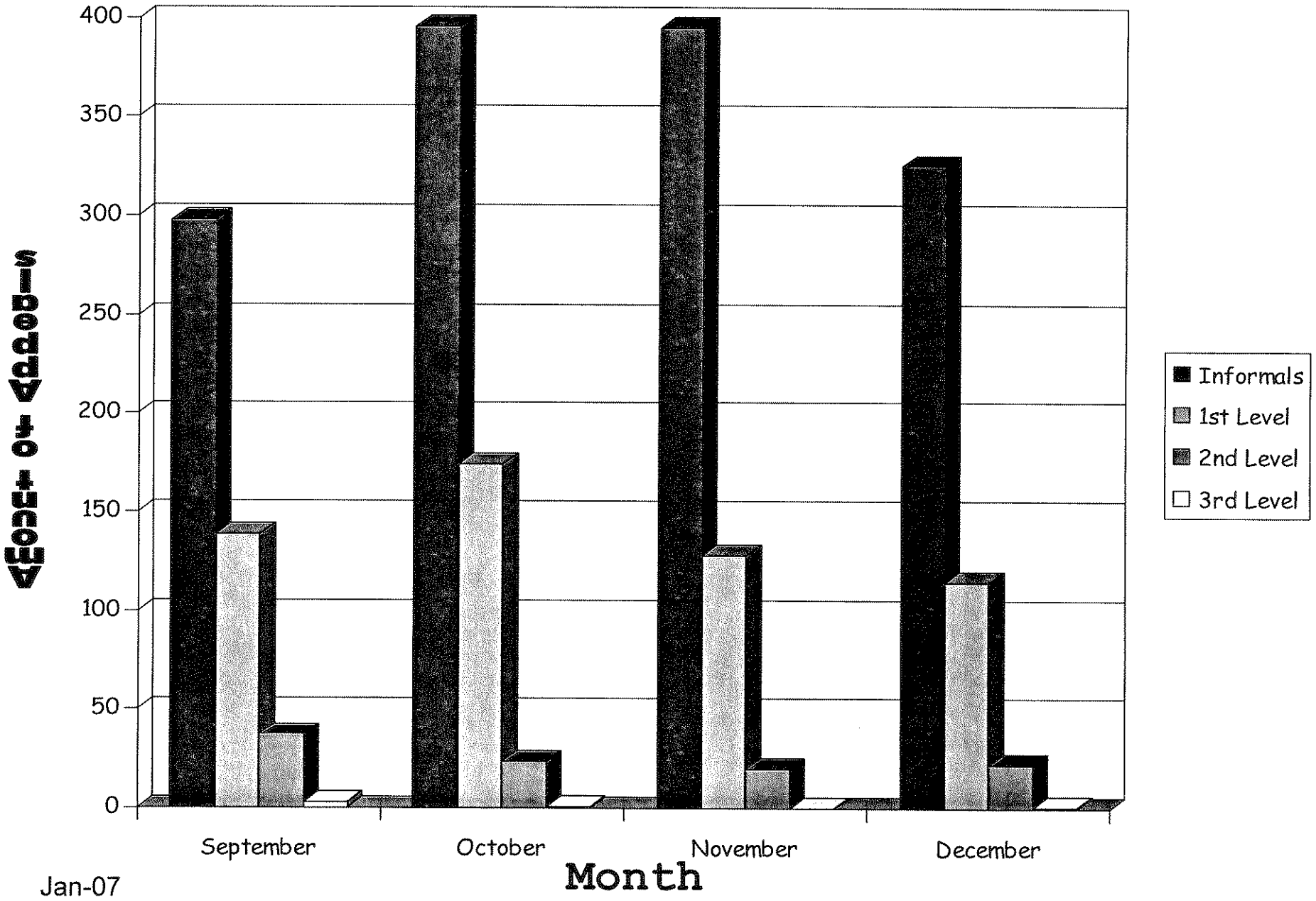
Although not part of the original pilot project, a patient advocacy correspondence process has been included. The correspondence attorney has been hired and will assist the Health Care Manager and Warden in responding to outside correspondence related to inmate health care that requires legal expertise.

P&Ps were developed for the Patient Advocacy program and capture the program appropriately but need to be refined somewhat. Once the P&Ps are improved by the Receiver's group, the P&Ps are recommended for implementation.

Monitoring of the Patient Advocacy process should continue through 2007 for the purpose of reviewing and analyzing the program for statewide implementation.

8	PATIENT ADVOCACY & CORRESPONDENCE PROCESSES Team Oversight: J. McGrath	Start Date	Completion Date	Responsible Party
	Ensure the effectiveness of the Patient Advocacy Process	**7/5/2006**	**11/2/2006**	**M. Stokes**
8.1	**Develop and implement a local supplemental triage process for effective response to patient clinical complaints and patient grievances that demand immediate attention (detailing immediate nurse intervention for medical complaints and grievances that does not initially route medical appeals through the Appeals Coordinator).**	**7/5/2006**	**8/3/2006**	**M. Stokes**
8.1.1	Refine the clinical criteria and duty statement regarding what the RN does not respond to and which dental and mental health issues should be responded to medically	8/24/2006	9/7/2006	M. Stokes
8.2	**Hire RN to provide patient advocacy function and implement triage process**	**7/21/2006**	**7/31/2006**	**J. Robinson**
8.2.1	Develop duty statements for appeals analyst and RN (must include that RN shall personally respond to some complaints)	8/3/2006	8/18/2006	M. Stokes
8.3	**Determine and implement a mechanism for collecting complaints and that ensures timely pick-up of complaints**	**8/24/2006**	**9/7/2006**	**Dr. Saylor**
8.3.1	Paint the medical slip boxes	9/21/2006	10/3/2006	M. Stokes
8.4	**Upgrade appeals OA position to OT**	**8/10/2006**	**8/18/2006**	**K. Mitchell**
8.4.1	Colocate and coordinate the medical and inmate appeals OT's	pending hire of OT	TBD	M. Stokes
8.5	**Develop and implement a patient advocacy correspondence process**	**9/7/2006**	**10/3/2006**	**M. Stokes**
8.5.1	Develop a policy and procedure which establishes the following: (1) routes correspondence from inmate families and attorneys related to patient healthcare to the Patient Advocate for review, attention, coordination with the patient, and response; (2) manages duplicate correspondence received by all involved parties (including the PLO); (3) routes correspondence to the Receiver's Office, DCHCS, and the institution as appropriate; (4) an attorney position that reports to the Health Care Manager and Warden and who partners with the Patient Advocate and who manages all attorney responses	9/7/2006	9/14/2006	M. Stokes
8.5.2	Coordinate with CDCR's Legal Affairs regarding attorney position	9/7/2006	9/14/2006	L. Buzzini
8.6	**Look into data recovery and whether the loss of data was intentional**	**8/3/2006**	**8/10/2006**	**M. Stokes**
8.7	**Follow up on Bowen case**	**8/3/2006**	**8/10/2006**	**M. Stokes**
8.8	**Develop policies and procedures related to Patient Advocacy**	**8/24/2006**	**10/26/2006**	**M. Stokes**
8.9	**Evaluate Patient Advocacy process for implementation statewide**	**9/14/2006**	**ongoing**	**Receiver's Team**
8.10	**Metrics (data on the number of grievances and complaints, appeal issue, housing unit, and number progressing to a higher level)**	**9/15/2006**	**TBD**	**SQ Project Team**

Medical Appeals Patient Advocacy Graph #2



Jan-07

9. CLINICAL SPACE

PROJECT LEAD: MANI SUBRAMANIAN

There are multiple construction and renovation projects underway at San Quentin. Most all of these subprojects will be ongoing through 2007 and 2008. Attached is a table which shows each outstanding project with the current status.

VANIR
CONSTRUCTION MANAGEMENT, INC.

San Quentin State Prison
Project Status Report Matrix

Status as of: Jan 19, 2007

Project No.	Description	Procurement	Budget	Completion	Stage	% CMP	Issues
1	Personnel Building	D-B-B	$2,100,000	Nov-07	Concept design	90	None
2	Parking						
	a. Entry Parking	P. O.	$60,000	Jan-07	Complete	100	None
	b. Rock Crusher	P. O.	$80,000	Nov-06	Complete	100	None
	c. Tower 1	P. O.	$85,000	Jan-07	Construction	98	Address Institution Concerns
3	Relocate Excercise yard	D-B-B	$980,000	May-07	Const.Docs	95	None
4	Medical Warehouse	D-B	$1,800,000	Dec-07	Concept Design	20	None
5	TTA Renovation	D-B	$1,400,000	Apr-07	Construction	2	None
6	North Block Ventilation	P.O	$200,000	May-07	Procurement	60	None
7	Cell Block Sick Call Units						
	a. Rotundas (East & West)	D-B-B	$2,000,000	Dec-07	Concept Design	80	Address Fire Marshal Concern
	b. North, AC, Gym				On Hold	0	Need to define scope
8	Medical Modular Bldgs	D-B	$5,000,000	Nov-07	Concept design	50	None
9	Remodel Medical Records		$0		On Hold	0	Awaiting Records Director
10	Remodel Existing R & R	Change Order	$150,000	Mar-07	Procurement	50	None
11	New Central Health Bldg.	D-B	$141,993,000	Apr-10	Concept Design	40	None
12	Vacate Neumiller			May-10		0	None
13	Interim Modulars						
	a. Facility Staff	P.O	$50,000	Jan-07	Furnishings	90	None
	b. Medical Admin	P.O	$150,000	Feb-07	Furnishings	70	Telecom Connection
	c. R & R Mental Health	P.O	$70,000	Mar-07	Construction	70	None
			$156,118,000				

Legend	
D-B-B	Design-Bid-Build
D-B	Design-Build
P.O.	Purchase Order
C.O.	Change Order to Existing Contract

Notes

1. Some budgets are very conceptual & are intended to provide an order of magnitude cost for the projects.

10. Facility Maintenance

Project Lead: Joe McGrath

Most of the objectives for this subproject were accomplished. Casual union laborers were hired and completed various facility improvements at San Quentin. A pest control contract was also secured for the Institution. Although, not part of the initial pilot project, the ventilation problems in the North Block and the asbestos issues in the Neumiller building became the focus of the Facility Maintenance staff. Both of these matters are still being addressed.

Monitoring of the outstanding facility issues should continue through 2007, including some analysis of long-term maintenance plans and the staffing necessary to sustain acceptable facility standards.

10	FACILITY MAINTENANCE Team Oversight: Joe McGrath	Start Date	Completion Date	Responsible Party
	Ensure facilities and physical plant is maintained through preventative maintenance with timely responses to ongoing repair needs.	**7/5/2006**	**11/2/2006**	**T. Atkinson**
10.1	**Evaluate existing facility maintenance system and implement a facility health care maintenance plan, including the following:** Availability of supplies and necessary equipment Small repairs Painting Review existing, pending work orders The need for a specific health care facility maintenance team Preventative maintenance and repair	**7/5/2006**	**7/19/2006**	**T. Atkinson & M. O'Byrne**
10.2	**Take digital photographs of the SQ medical areas for documentation purposes**	**7/19/2006**	**8/3/2006**	**Lt. Rodriguez**
10.3	**Establish a contract for pest control**	**7/21/2006**	**9/1/2006**	**D. Sallade**
10.3.1	Evaluate pest control contract and determine if the contract should be extended indefinitely	9/1/2006	10/3/2006	D. Sallade & Team
10.4	**Evaluate and improve long-term facility maintenance staffing levels**	**post - 1/16/2007**	**post - 1/16/2007**	**T. Atkinson**
10.4.1	Determine most effective work schedule for casual (union) labor (Wed. - Sun. 2-10 p.m.)	7/19/2006	8/2/2006	T. Atkinson
10.4.2	Hire 6 casual (union) staff to begin repairs on the infirmary	7/21/2006	8/4/2006	T. Atkinson

10.5	**Begin facility improvements**	**7/21/2006**	**ongoing**	**T. Atkinson & M. O'Byrne**
10.5.1	Establish tool room and material storage area	7/21/2006	8/18/2006	T. Atkinson & M. O'Byrne
10.5.2	Obtain hazardous materials training for new staff	7/21/2006	9/1/2006	T. Atkinson & M. O'Byrne
10.5.3	Fire Block between floors at core borings	7/21/2006	10/26/2006	T. Atkinson & M. O'Byrne
10.5.4	Patch holes in walls and ceilings	7/21/2006	9/1/2006	T. Atkinson & M. O'Byrne
10.5.5	Replace missing fire sprinkler escutcheons	7/21/2006	10/4/2006	T. Atkinson & M. O'Byrne
10.5.6	Paint the interior as needed	7/21/2006	ongoing	T. Atkinson & M. O'Byrne
10.6	**Determine what long-term major repairs are needed in medical areas at SQ (i.e. replace ceiling tiles where needed, replace and standardize lighting or replace light diffusers, install new floor tile where needed)**	**8/18/2006**	**ongoing**	**T. Atkinson**
10.6.1	Evaluate the level of staffing required to maintain repairs completed and to continue with long-term repairs	8/18/2006	10/3/2006	VANIR & T. Atkinson
10.7	**Address the ventilation problem in the North Block and clean the area**	**9/7/2006**	**10/3/2006**	**VANIR**
10.7.1	Hire an engineer to review and provide a solution for the HVAC problem	9/20/2006	10/4/2006	VANIR
10.7.2	Develop a plan to clean the North Block (including steam washing the cell fronts) and reengineer the HVAC	9/7/2006	9/21/2006	T. Atkinson
10.8	**Determine if SQ requires a transformer and new feeders and distribution lines**	**8/18/2006**	**10/3/2006**	**VANIR, T. Atkinson & D. Marshall**
10.9	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

11. IT, Communications & Power

Project Lead: Mani Subramanian

Most of the objectives of this subgroup were accomplished but have been further developed following the appointment of the Receiver's CIO. San Quentin hired a Staff Information Systems Analyst to support health care, and San Quentin acquired much needed permissions to maintain and support the current medical systems. With the recent assistance of John Hummel, San Quentin recently began to make great progress in identifying several IT solutions to provide needed network connectivity for the medical systems and staff. Now that several solutions to the networking issues have been identified, implementation of the solutions can begin as soon as possible to provide critical data access, communications, and expedient IT support.

Monitoring of this area should continue through 2007 to ensure continued improvements are made.

	IT, COMMUNICATION, & POWER Team Oversight: VANIR	Start Date	Completion Date	Responsible Party
11	**Ensure that information technology resources and communication and power capabilities are improved to a level that enhances communication and assists healthcare staff in providing medical care and assists healthcare administrative staff in performing necessary administrative support functions.**	**7/5/2006**	**11/2/2006**	**T. Atkinson & D. Marshall**
11.1	**Evaluate IMSATS for long-term solution**	**7/27/2006**	**10/26/2006**	**D. Marshall & Team**
11.1.1	Obtain a system summary from Quan Vu on the IMSATS	8/2/2006	8/4/2006	D. Marshall
11.1.2	Obtain the set of plans for the HCMS project	7/27/2006	7/27/2006	D. Marshall
11.2	**Install phone lines and computer drops in SQ clinics as necessary**	**8/18/2006**	**10/3/2006**	**T. Atkinson & M. Hussein**
11.2.1	Initiate communication with Francine Pogue and Jeff Atkinson regarding telecom issues.	7/27/2006	8/3/2006	J. McGrath
11.2.2	Obtain a grid from Tel-Com that indicates where the lines are to be dropped (for the clinic project)	7/21/2006	7/27/2006	J. McGrath
11.3	**Replace or increase the capacity of the network communication between SQ, EIS, and the internet**	**7/27/2006**	**unknown**	**D. Marshall**
11.3.1	Provide a summary of data line drops to HCM & DON	7/27/2006	8/3/2006	D. Marshall
11.4	**Secure remote access to the CDCR network for the SQ IT staff so that support can be provided remotely when IT staff is not on-site**	**7/28/2006**	**7/28/2006**	**D. Marshall**
11.5	**Compose a request regarding DDPS access (F4 function)**	**7/20/2006**	**7/24/2006**	**D. Marshall**
11.6	**Secure additional SISA position for overall IT support**	**7/20/2006**	**8/18/2006**	**L. Buzzini**
11.7	**Improve the Personnel Office for expedited on-site hiring processes**	**7/19/2006**	**pending Recruiting modular**	**L. Buzzini**
11.7.1	Acquire online testing capability from SPB for all clinical classes (LVN has priority)	7/19/2006	9/1/2006	L. Buzzini
11.7.2	Purchase and install a computer with internet access in the SQ Personnel Office	7/19/2006	9/1/2006	D. Marshall
11.7.3	Purchase and install a live fingerprint scanner	7/19/2006	8/31/2006	L. Buzzini & SQ Personnel
11.8	**Acquire local area network connectivity for Procurement Tracking System**	**8/10/2006**	**9/1/2006**	**D. Marshall**
11.9	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

12. Sanitation & Janitorial

Project Lead: Linda Buzzini

The objectives for this subproject have not yet been accomplished. Of all areas at San Quentin, this one had the least effective beginning; however, San Quentin recently hired a competent individual from Napa State Hospital who will implement a high quality environmental services program. The new staff person will be responsible for the vocational program, and a custodian will operate the implementation (e.g. on-the-job work by the inmates) of the overall program. The previous San Quentin custodian recently vacated her position, so the Institution will now need to fill that vacancy.

Monitoring of this subproject should continue through 2007 while the environmental services program is being developed and implemented.

12	SANITATION & JANITORIAL Team Oversight: L. Buzzini	Start Date	Completion Date	Responsible Party
	Ensure all clinical space is clean, sanitary and meets with customary and accepted medical practice standards.	**7/5/2006**	**11/2/2006**	**B. Welch**
12.1	**Evaluate the following:** Whether there are appropriate hand washing facilities for all clinical personnel. Biohazard disposal processes Supplies, equipment and staffing Alternatives for securing janitorial maintenance (e.g., contract, in-house, vocational training program for inmates)	**7/5/2006**	**7/19/2006**	**B. Welch**
12.2	**Establish an Environmental Services Program at SQ that includes janitorial services and bio-waste management**	**9/7/2006**	**10/3/2006**	**T. Roberts & K. Mitchell**
12.2.1	Define the Environmental Services program and provide a description to the Receiver's Team regarding how the program will function	9/7/2006	9/21/2006	T. Roberts
12.2.1.1	Determine what services are necessary in the medical areas	9/7/2006	9/21/2006	TBD
12.2.1.2	Create a schedule regarding what needs to be cleaned and how often	9/7/2006	9/21/2006	TBD
12.2.1.3	Determine if contractors will be needed to augment the Environmental Services program	9/21/2006	9/21/2006	TBD
12.2.2	Secure an instructor for the program	9/21/2006	10/3/2006	T. Roberts
12.2.3	Evaluate previously developed curriculum and update as necessary	9/7/2006	9/21/2006	T. Roberts
12.2.4	Obtain necessary supplies and tools	9/21/2006	10/3/2006	T. Roberts
12.3	**Order and install foot pedals on all sinks in medical clinic areas**	**7/19/2006**	**8/7/2006**	**B. Welch**
12.4	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

13. Custody & Clinical Relations

Project Lead: Joe McGrath

Most of the objectives for this subproject were accomplished. Three sessions of the "Promoting a Positive Corrections Culture" training were completed and a "values statement" was composed by the participants and distributed to all Institution staff following the training. Unfortunately, the final summary and course analysis has not yet been compiled and provided to the Warden; this report is critical and is expected to be forwarded to the Warden and the Receiver's group by INSERT DATE. Though the report is not complete, one critical finding is that civil service medical staff were underrepresented in each of the three courses due to the large volume of registry staff at the Institution. Even considering the lack of clinical presence however, San Quentin staff contend that rolling out this training to the entire Institution is valuable, and Captain John Day will recommend course expansion to the Warden in the course report.

Jayne Russell is working with San Quentin staff to create a joint orientation for clinical and custody staff. This orientation was intended to be part of the original pilot; however this effort could not be completed effectively until now. (Joe to get completion date). Additional items not included in the original pilot but which are necessary are completion of a "Values and Culture" training for San Quentin supervisors and implementation of a Plata Ombudsman. The supervisory training is being conceptualized currently, and the function of an ombudsman position is being reviewed and considered. Estimated implementation of both of these items is unknown at this time.

Monitoring of this subproject should continue through 2007.

13	CUSTODY/ CLINICAL RELATIONS Team Oversight: J. McGrath	Start Date	Completion Date	Responsible Party
	Prepare and implement a plan to improve relations between health care and custody staff for the betterment of medical health care delivery, including the following elements:	**7/5/2006**	**11/2/2006**	**Capt. Day**
13.1	**Establish a mechanism of communication between Specialty Svs., Transportation, R&R, clinics, OHU, and TTA (i.e. shift reports)**	**8/3/2006**	**10/3/2006**	**J. Robinson**
13.2	**Provide "Promoting a Positive Corrections Culture" course**	**7/19/2006**	**11/14/2006**	**Capt. Day**
13.2.1	Determine general and specific issues (e.g., reception, transportation, incident reporting, professionalism)	7/19/2006	7/28/2006	
13.2.2	Contact the course instructors and schedule course date	7/19/2006	7/28/2006	
13.2.3	Contact the course developer (Carol Falherty-Zonis) and schedule her participation	7/19/2006	7/28/2006	
13.2.4	Order O.C.I. survey materials	7/19/2006	8/1/2006	
13.2.5	Schedule the course location (off-site)	7/19/2006	8/4/2006	
13.2.6	Identify staff to participate in first course session	8/24/2006	9/21/2006	
13.2.7	O.C.I. survey at least 250 SQ staff	9/26/2006	9/27/2006	
13.2.8	Order materials, refreshments, lunch for group session (CPR to pay for lunch & refreshments)	8/24/2006	9/8/2006	
13.2.9	Conduct first course session (three days)	10/3/2006	10/6/2006	
13.2.10	Evaluate course outcome	10/10/2006	10/10/2006	
13.2.11	Identify staff to participate in second course session	10/12/2006	10/12/2006	
13.2.12	Conduct second session (one day)	10/18/2006	10/18/2006	
13.2.13	Evaluate course outcome from second session	10/20/2006	10/20/2006	
13.2.14	Identify staff to participate in third course session	10/26/2006	10/26/2006	
13.2.15	Conduct third course session (one day)	11/2/2006	11/2/2006	
13.2.16	Evaluate course progress	11/3/2006	11/3/2006	
13.2.17	Complete report to Warden, SQ staff, and Receiver	11/3/2006	11/14/2006	
13.3	**Develop and implement joint orientation for custody and healthcare staff based on findings of training as well as general information necessary to healthcare and custody staff**	**7/19/2006**	**unknown**	**J. Russell, Capt. Day & T. Church**
13.4	**Convene team building activities and implement employee recognition**	**9/1/2006**	**ongoing**	**Dr. Saylor & Warden**
13.5	**Metrics (staff survey)**	**9/15/2006**	**TBD**	**SQ Project Team**

14. Organizational Structure

Project Lead: Linda Buzzini

Some of the objectives for this subproject were accomplished; however most are ongoing due to the complexity of implementation. A proposed organizational structure/chart, developed by the Receiver's group and Mercer, was submitted to the Receiver for review. This model is temporarily in place at San Quentin, and some of the positions associated with the organizational structure have been filled (i.e. Giselle Matteson as the Chief of Support Operations). Career Executive Assignments are proposed for nursing and other clinical management positions throughout the State, and implementation of these positions will occur at San Quentin as soon as approval is obtained. A care management model was proposed for San Quentin but has only been partially implemented, as full implementation of this care structure requires more analysis and approval by the Receiver.

Monitoring implementation of the new healthcare structure at San Quentin should continue through 2007.

14	ORGANIZATIONAL STRUCTURE Team Oversight: L. Buzzini	Start Date	Completion Date	Responsible Party
	Ensure that the organizational relationship of clinical and administrative personnel enables the efficient delivery of quality medical care.	**7/5/2006**	**11/2/2006**	**J. Robinson**
14.1	**In conjunction with a health care organizational consultant, develop prototype organizational structure, as a result of the study, and evaluate feasibility of application at San Quentin**	**8/1/2006**	**8/15/2006**	**L. Buzzini & Team**
14.1.1	Consider implementing a clerical and analyst pool to enhance productivity and to provide consistent supervision to staff	8/1/2006	8/15/2006	L. Buzzini
14.2	**In conjunction with a health care organization consultant, develop duty statements and MQs for top 3-layers of SQ's healthcare structure**	**8/15/2006**	**9/1/2006**	**L. Buzzini**
14.3	**In conjunction with a health care organizational consultant, study organization needs and research organizational models for application to CDCR's health care system**	**TBD**	**TBD**	**L. Buzzini**
14.4	**Implement a Care Management structure (with an RN as a case manager for a population of patients who will coordinate with Spec. Svs., transportation, OHU etc.)**	**8/3/2006**	**11/2/2006**	**J. Robinson**
14.4.1	Develop and provide a detailed written plan to Receiver's staff	8/3/2006	10/4/2006	Dr. Kanan & J. Robinson
14.4.2	Initiate staffing movements necessary to implement this model (move RN to day shift; move OTs)	8/16/2006	10/3/2006	J. Robinson
14.4.3	Coordinate with Mercer to ensure this model is incorporated in the Mercer study	8/16/2006	8/18/2006	J. Robinson
14.4.4	Implement and train staff on Care Management processes	8/3/2006	11/2/2006 and ongoing	J. Robinson
14.5	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

15. STAFFING

PROJECT LEAD: LINDA BUZZINI

The objectives for this subproject have been accomplished and, in most cases, are ongoing. San Quentin was granted delegated authority for all local employee classifications and now does not rely upon CDCR's Headquarters' Personnel Services for this testing function. Many new positions were authorized and filled at the Institution which relieved some areas that were severely impacted. All Office Assistant positions were updgraded to Office Technicians to recruit staff with a higher skill level. Class specifications for the Medical Records Director was modified and the position was recently filled. The class specs for social workers were also modified to create a position to assist with development of public health programs; however, this position is currently vacant. Staffing ratios with relief factors were created for San Quentin and included all clinical and support functions. San Quentin implemented post and bid for nursing on January 19, 2007, and the Receiver's group coordinated with the nurses' union on this modified staffing program. A relocatable building will be placed on grounds by November 2007 for Personnel Services and recruiting and will greatly assist in the ability of San Quentin to appropriately receive possible job candidates, interview in a designated area, and expeditiously complete the hiring processes locally. A Live-Scan fingerprinting machine was purchased and will be utilized to expedite the hiring process, as well, in the new relocatable building.

Monitoring of staffing matters and Personnel Services should continue until the relocatable building is fully operational (through 2007) so the Receiver's group can assist with full implementation of this critical function at San Quentin.

15	STAFFING Team Oversight: L. Buzzini	Start Date	Completion Date	Responsible Party
	Ensure qualified, competent and committed clinical and administrative support personnel are present in adequate numbers for delivery of quality medical care and support activities.	**7/5/2006**	**11/2/2006**	**J. Robinson & K. Mitchell**
15.1	**Implement temporary reporting relationships**	**7/21/2006**	**7/21/2006**	**Dr. Saylor**
15.2	**Improve SQ staffing levels by filling vacancies and increasing staffing levels**	**7/19/2006**	**ongoing**	**K. Mitchell**
15.2.1	Acquire delegated testing to be administered on a continuous testing basis for all clinical classes and for the following additional classifications: Materials and Stores Supervisor I and II; Health Records Technician I, II (specialist and supervisor), and III; Property Controller II; Custodian, Plumber, Electrician, Office Assistant, and Office Technician.	7/19/2006	7/28/2006	L. Buzzini
15.2.2	Acquire delegated testing for Office Technician on an open and promotional basis	8/22/2006	9/7/2006	K. Mitchell & S. Duveneck
15.2.3	Hire immediately the following positions: 5 Office Technicians, 1 Health Records Technician III; 2 Health Records Technicians II, 6 Health Records Technicians I, 1 Property Controller II, 1 Warehouse Worker, 1 Materials & Stores Supervisor II, 1Staff Information Systems Analyst, 2 Janitors, 1 Registered Nurse, 1 Associate Personnel Analyst, 1 CEA III, 1 attorney (for the Patient Advocacy and Correspondence Program), and 1 locksmith.	7/21/2006	11/2/2006	K. Mitchell & L. Buzzini
15.2.4	Upgrade all Office Assistant positions in SQ medical departments to Office Technician	8/10/2006	9/1/2006	K. Mitchell
15.3	**Expedite hiring at SQ**	**7/19/2006**	**10/3/2006**	**K. Mitchell**
15.3.1	Identify HQ Personnel Office liaison to report to SQ to assist in giving initial exams	7/21/2006	8/2/2006	S. Duveneck
15.3.2	Acquire local delegation to approve all out of class assignments	8/10/2006	10/3/2006	K. Mitchell
15.3.3	Acquire local delegation to approve Training and Development assignments	8/10/2006	10/3/2006	K. Mitchell
15.3.4	Acquire local delegation to approve Temporary Appointments Authority (TAU)	8/10/2006	10/3/2006	K. Mitchell
15.3.5	Acquire local delegation to approve Hiring Above Minimum (only to be exercised after receiving case by case approval from the Receiver's Office	8/10/2006	10/3/2006	K. Mitchell
15.3.6	Acquire local authority to reclassify all positions regardless of difference in salary	8/10/2006	10/3/2006	K. Mitchell
15.4	**Implement 'post' positions for clinical personnel**	**8/3/2006**	**10/5/2006**	**J. Robinson**
15.4.1	Determine staffing levels for each work site by classification and shift	8/3/2006	10/3/2006	J. Robinson
15.4.2	Determine which positions should be considered post positions	8/3/2006	10/3/2006	J. Robinson

15.4.3	Determine appropriate "relief factor" to each positions (i.e., 1.8 for RNs) to determine number of staff to hire to ensure coverage in post positions	8/3/2006	10/3/2006	J. Robinson
15.4.4	Based on 9/7/2006 presentation of staffing plan, develop a 3-phased implementation plan/roadmap for clinical personnel staffing plan (including PY's, post positions, and compliment of staff by classification)	9/7/2006	10/5/2006	J. Robinson
15.5	**Implement a strategy for post and bid for clinical & custody staff**	**8/3/2006**	**10/3/2006**	**L. Buzzini**
15.5.1	Identify source of all post/bid requirements	8/3/2006	10/3/2006	L. Buzzini
15.5.2	Evaluate impact of post/bid by classification, determine changes need to be made to various classifications, and consider legal implications	8/3/2006	10/3/2006	L. Buzzini
15.6	**Evaluate custody staff support**	**8/3/2006**	**8/31/2006**	**D. Meier**
15.7	**Evaluate the need for administrative and clerical support personnel by class, shift, work site**	**8/1/2006**	**9/27/2006**	**J. Robinson & Dr. Saylor**
15.7.1	Provide information to Mercer consultants for determination about where they fit into organizational structure	8/1/2006	8/9/2006	L. Buzzini & Dr. Saylor
15.8	**Evaluate enhanced technical support (e.g., telemedicine, training, orientation, information technology, facilities)**	**8/1/2006**	**8/9/2006**	**Dr. Saylor**
15.10	**Develop a medical staffing levels package with the Receiver's staff based on medical services and level of care**	**7/19/2006**	**post - 10/26/2006**	**J. Russell & Dr. Saylor**
15.10.1	Evaluate adequacy of staffing levels	8/3/2006	10/3/2006 and ongoing	Dr. Saylor & J. Robinson
15.10.2	Evaluate roles and responsibilities of clinical staff	8/1/2006	post - 10/26/2006	J. Russell & Dr. Saylor
15.10.3	Establish timekeeping and time accountability (e.g. administrative leave)	7/19/2006	post - 10/26/2006	J. Russell & Dr. Saylor
15.10.3.1	Implement staff sign-in/sign-out sheets	7/19/2006	8/18/2006	Dr. Saylor
15.10.3.2	Establish accountability and supervision of the sign-in/sign-out process (Dr. Saylor or designee) for HR, providers, clinic staff, clerical staff etc. (i.d. the area and develop process for various clinical areas)	8/1/2006	8/18/2006	Dr. Saylor & D. Meier
15.10.3.3	Establish accountability and supervision of overtime (OT pre-approved in writing)	8/1/2006	post - 10/26/2006	Dr. Saylor & D. Meier
15.11	**Develop a long-term medical staffing package (duty statements, adding posts, scheduling, etc.) based upon recommendations from an outside consultant**	**8/15/2006**	**post - 10/26/2006**	**L. Buzzini, J. Russell & Dr. Saylor**
15.12	**Metrics**	**9/15/2006**	**TBD**	**SQ Project Team**

16. SALARIES

PROJECT LEAD: LINDA BUZZINI

The objectives for this subproject were accomplished statewide, with the exception of laboratory services personnel. Salary adjustments for these classes are currently being analyzed.

16	SALARIES Team Oversight: L. Buzzini	Start Date	Completion Date	Responsible Party
	Ensure competitive salaries that support the recruitment and retention of competent and committed clinical and support personnel within 60 days.	7/5/2006	11/2/2006	L. Buzzini
16.1	Collect and analyze existing comparable salaries in the public and private sectors and recently completed studies and data from the DPA	7/5/2006	7/14/2006	L. Buzzini
16.2	Review pay differential data and court orders related to pay increases for various medical classifications	7/5/2006	8/4/2006	L. Buzzini
16.3	Propose salary ranges for review	8/4/2006	8/11/2006	L. Buzzini
16.4	Prepare a motion regarding salary increases	8/10/2006	8/24/2006	L. Buzzini
16.5	Implement	9/1/2006	9/1/2006	L. Buzzini
16.6	Metrics	9/15/2006	TBD	

17. Internal & External Communications

Project Lead: Rachael Kagan

The objectives for this subproject were accomplished and are ongoing.

17	INTERNAL & EXTERNAL COMMUNICATION Team Oversight: R. Kagan	Start Date	Completion Date	Responsible Party
	Ensure ongoing, accurate information about the project reaches all relevant audiences.	7/5/2006	11/2/2006	E. Messick
17.1	Develop and distribute initial communication regarding the San Quentin project	7/5/2006	7/5/2006	R. Kagan & E. Messick
17.2	Develop and distribute ongoing internal communication regarding San Quentin project, including patients	7/21/2006	10/3/2006	R. Kagan & E. Messick
17.3	Develop and distribute ongoing external communication regarding San Quentin project, including CDCR, other correctional facilities, elected officials, counsel (including the Prison Law Office and Attorney General's Office), the media and the public	7/5/2006	11/2/2006 and ongoing	R. Kagan & E. Messick
17.4	Metrics	9/15/2006	TBD	SQ Project Team

18. Plata Remedial Plan Requirements

Project Lead: ALL

No activities related to this subproject have been initiated to date.

18	PLATA REMEDIAL PLAN REQUIREMENTS Team Oversight: Receiver's Staff	Start Date	Completion Date	Responsible Party
	Evaluate which provisions of the (1) June 13, 2002, stipulation for injunctive relief, and (2) September 17, 2004, stipulated order re quality of patient care and staffing order and injunction (and/or policies or procedures required thereby), should be carried forward and which, if any, should be modified or discontinued due to changed circumstances.	11/2/2006	TBD	TBD

EXHIBIT 15

MAXOR℠
National Pharmacy Services Corp.

March 15, 2007

John Hagar
Chief of Staff
Office of the California Prison Receiver
450 Golden Gate Avenue
Law Library, 18th Floor
San Francisco, CA 94102

Re: California Department of General Services

Dear Mr. Hagar:

As Project Manager for the Receiver's CDCR pharmacy improvement initiative, I believe it is important to provide you an update on the status of Maxor's interaction with the Department of General Services (DGS). We have met with various DGS staff on 6 occasions—1/11/2007, the morning of 2/7/2007 (meeting included the Receiver's Chief of Staff), the afternoon of 2/7/2007, 2/22/2007, 3/1/2007 and 3/14/2007, and at this time, I offer the following facts, observations and opinions:

1. **Access to DGS contracts has been limited, incomplete and delayed; and a review of the contracts clearly indicate a need for improvement.**

Requests have been made since January 11, 2007 for complete copies all contracts for pharmaceuticals in which the CDCR participates. Some four weeks later, February 14, 2007, we received a list of the contracts. The complete (according to DGS officials) contracts were supplied to Maxor on February 16, 2007. Those contracts included three signed contracts (Roche, Astra Zeneca, and Lilly) by DGS, three notice of contracts awards with their attached requests for proposals (McKesson, Major and Apotex) completed in December 2006, the GPO agreement (General Purchasing Organization, officially entitled the Massachusetts Alliance for State Pharmaceutical Buying) with an accompanying MOU (Memorandum of Understanding) for

428 J Street, Suite 610 • Sacramento, California 95814
(916) 441-1089 • Fax (916) 441-0792

administration by Managed Health Care Associates (MHA); and, the contract for AmeriSource Bergen, the general wholesaler managing the purchases. The AmeriSource Bergen contract provided proved to be incomplete, as discovered during a later review of a proposed contract amendment, and after a Maxor request to DGS, the missing appendices were provided February 20, 2007—now 6 weeks after our initial requests for complete contracts.

Failure to deliver the completed contracts to Maxor is important because:

1. The wholesaler stocks items and ensures timely delivery of those items to the facilities. The prices are generally set by the GPO, which, in most cases, has acceptable negotiated pricing for medications, but which may be improved through direct negotiations with individual manufacturers—both brand and generic. In the case of California, one GPO is utilized and supplemented by three brand manufacturer contracts and three generic wholesale house "contracts." This delay has prevented Maxor from monitoring and ensuring accurate pricing of pharmaceuticals for CDCR patients for at least 2 months. Monthly expenditures for CDCR medications, on the average, approximates $16 million, and, continued unfettered monitoring of accurate charges to CDCR amounts to continued months of potential savings.
2. Separate contracts negotiated by DGS (who has, in this case, instructed the wholesaler to load the negotiated prices first, rather than taking the best price available at the time of procurement) can provide substantial savings ***if such contracts are based on clinical need*** within a therapeutic class of medications. However, in the case of DGS contract management for CDCR purchases, there ***does not appear to be a concerted effort to identify the clinical need,*** nor associate it with a disease specific treatment guideline. This lack of effort is not surprising since DGS Pharmacy and Therapeutics Committee operates outside of the CDCR and has representatives from multiple state agencies, each with their own, individual needs.
3. Initial analysis of the contracts also noted that:
    - The three notice of contracts (McKesson, Major and Apotex) were signed 12/11/2006, and represent primarily suppliers of generic medications. In our opinion, these contracts represent equivocal long term savings to the State of California.
    - The three signed contracts (Roche, Astra Zeneca, and Lilly), while providing a reduction in pricing for three select brand medications,

contain terms we find unacceptable. For instance, these contracts assure free access on the CDCR Formulary with no restrictions to practitioners at a time when there was only one available clinical disease management guideline to assist practitioners in the appropriate utilization of one of these medications. In all probability, clinical practice was influenced by Formulary decisions outside of CDCR review.

2. **DGS has shown a lack of responsiveness to CDCR patient specific needs.**

Maxor and DGS have participated in six meetings with DGS officials on 1/11/2007, 2/7/2007 morning, 2/7/2007 afternoon, 2/22/2007, 3/1/2007 and 3/14/2007. Discussions have centered on the role of the reconstituted CDCR Pharmacy and Therapeutics Committee and the resultant role of the DGS sponsored Pharmacy and Therapeutics Committee and the Common Drug Formulary. From our initial meetings, Maxor has emphasized the need for an appropriate, correctional-based Pharmacy and Therapeutics Committee to deal with the unique situations, circumstances and patient populations in the correctional setting. During this process, DGS has requested assistance with one immediate contracting need (reclamation) and has proposed a revised "business proposal agreement" for vendors wishing to enter into negotiations concerning specific pharmaceutical items. DGS has requested a schedule of the therapeutic category reviews. That schedule was provided during a meeting on 3/13/2007 to DGS officials.

In our opinion, these meetings have devoted ***too much time to too little process resolution, and DGS continues to be unresponsive to current CDCR medication needs***. In our opinion, DGS should be, at a minimum, actively monitoring medication expenditures within CDCR and designing strategies responsive to CDCR patient needs. After careful study of those needs, DGS should be aggressively seeking more favorable pricing for known patterns of drug utilization pending further guidance from the CDCR Pharmacy and Therapeutics Committee, in the way of Disease Management Guidelines and Therapeutic Category Reviews.

3. **DGS continues to negotiate contractual terms without adequately considering input on CDCR-specific needs.**

DGS continues to request proposals and negotiate terms of contracts with various vendors since Maxor's contract initiation without regard to the utilization and need of CDCR patients and the direct inclusion of Maxor in those negotiations. ***Release of information from DGS to Maxor continues to be partial, and continued questions of confidentiality are invoked at every stage of the process.*** Of particular note is the upcoming expiration of the Roche contract. DGS stated in our most recent meeting that negotiations were occurring, yet details (conditions) could not be released due to confidentiality concerns that Maxor was not included in the original request for business proposal prepared by DGS.

In our opinion, the continued negotiations for contracts without regard to CDCR utilization, and the exclusion of Maxor from the negotiating table represents a serious obstacle to our effective and efficient management of the procurement, distribution and the resultant prescriptive practices within the CDCR.

4. **DGS Confidentiality Concerns Are Impeding Progress**

Maxor received verbal approval from the Receiver's Chief of Staff on February 7, 2007 to allow the Heinz Family Philanthropies to conduct an analysis of 340B pricing for the CDCR at no charge. This organization is committed to helping governmental entities address dwindling resources and increased demands. One of efforts that the organization has supported is 340B pricing—that is, medication pricing to disproportionate populations served by an entity. Designation as such an entity is not without multiple hurdles. The Heinz Family Philanthropies expertly evaluates the setting, estimates cost savings, and delineates the challenges to achieving 340B designation that the health care entity must overcome. Maxor internally estimates those savings to approximate $62 million annually for the CDCR population. It is our continued belief that such an evaluation by a reputable outside source would be of benefit to the state.

Maxor verbally requested from DGS on 2/7/2007 permission to release purchase data in an aggregate fashion to the Heinz Family Philanthropies—release of information in this manner does not release specific contractual pricing information, but rather combines multiple medications with similar, industry accepted grouping categories into a single group thus prohibiting specific drug

price identification. Because of prior contractual obligations to three vendors, DGS has chosen not to provide Maxor permission to release that data; choosing instead to supply these three vendors with letters of introduction to Maxor and requesting that we discuss the study with them individually.

In our opinion, these contracts were made by DGS, are administered by DGS and any concerns releasing the aggregate data is a direct byproduct of DGS decisions in their poorly conceived contractual negotiations. In actuality, no current vendors contracted by DGS have a compelling interest in participating in such a study—should 340B pricing become available, it could potentially reduce vendor pricing by 30%. As of 3/7/2007, this impasse has not been resolved—DGS continues to delay permission to release of the data. We should be allowed to engage the Heinz Family Philanthropies immediately and provide them with the aggregate data needed to conduct the analysis. Each day that the 340B pricing is not realized could represent a potential savings in excess of $160,000 daily in providing medications to patients in CDCR.

DGS continues to present obstacles to the accomplishment of our project's objectives through limited access to contract negotiations, repeated assertions of prior confidentiality requirements, and restricted access to certain medications for CDCR patients without regard to current utilization and existent disease management guidelines. In this way, we believe that DGS seriously impedes access of inmate patients to the benefits and safeguards of contemporary pharmacy management systems, including effective and cost savings procurement procedures, distribution and contemporary disease management processes. As a result, Maxor requests that we be allowed to become the contract negotiator under the purview of the CPR contracting office for CDCR pharmaceuticals procurement. Only in this way can we assure a timely and responsive system to CDCR patient needs given the current state of DGS responsiveness.

Glenn G. Johnson, M.D.
Maxor CPR Project Manager

EXHIBIT 16

State of California • Arnold Schwarzenegger, Governor
State and Consumer Services Agency
DEPARTMENT OF GENERAL SERVICES
Office of Legal Services
707 Third Street, Suite 7-330 • West Sacramento, CA 95605
(916) 376-5080 • Fax (916) 376-5088 • www.dgs.ca.gov

March 16, 2007

Glenn G. Johnson, M.D.
Maxor National Pharmacy Services Corp.
Maxor California Prison Receiver Project Manager
428 J Street, Suite 610
Sacramento, CA 95814

Re: Confidentiality of Contracts Provided to Maxor

Dear Dr. Johnson:

At the meeting on March 14, 2007, issues were raised regarding the ability of Maxor National Pharmacy Services Corporation (Maxor) to disclose confidential information to the Heinz Foundation. Below is a chronology of events relating to this item and the Department of General Services' (DGS) efforts to facilitate Maxor's pursuit of its project.

On May 10, 2006, prior to conducting its audit, Maxor agreed to abide by the terms of the Nondisclosure and Confidentiality Agreement with respect to the contracts and information the State provided to it with respect to the pharmaceutical contracts. Prior to signing this agreement, Maxor was made aware of the injunction against the State from releasing certain portions of the Roche contract and negotiated the release of that information with Roche's attorneys. (Exh. A, B, and C). As a result of this agreement, Maxor was provided with an unredacted copy of the Roche contract. (Exh. D).

On or about February 8, 2007, the DGS Pharmaceutical Program Consultant, Greg Doe, initiated discussion with Maxor's Rick Pollard regarding the Heinz Foundation project mentioned by Mr. Hagar at a joint meeting on February 7, 2007. In an email, Mr. Doe requested information concerning what Maxor was proposing to release to the Heinz Foundation, and if there was a written proposal, so that if there were any confidentiality issues to be resolved, that process could begin. (Exh. E). On February 9, 2007, Mr. Doe received an email regarding aggregate pricing, but the DGS had no information about the Heinz Foundation or what they were going to do with the data. (Exh. F).

On February 13, 2007, Mr. Doe requested the level of information proposed to be released, such as individual pricing and whether it may be possible to reverse engineer the actual cost of the drugs.[1] (Exh. G). Maxor discussed release of aggregate pricing,

[1] The DGS has previously asked Roche for permission to release aggregate pricing information in other contexts and Roche has denied such permission, instead offering that the requestor work with them directly to determine if a confidential sharing agreement might be arranged.

but the DGS still had no information about the Heinz Foundation, how they would be using the information, and whether they were subject to any confidentiality arrangement—information the vendors would presumably need to evaluate the request.

On February 14, 2007, DGS legal conferred with Maxor by phone in response to Maxor's request for status. The DGS again inquired if Maxor could provide a description of the project, so the DGS could in turn advise the vendors of the purpose and conditions for which their pricing information was being sought, and to enable the vendors to make an informed decision whether to grant such permission. Maxor indicated it was reluctant to prepare a white paper. The DGS suggested that an expeditious solution (already underway) would be for the DGS to put Maxor directly in contact with the vendors, so Maxor could explain its plans, and the vendors in turn could make any necessary inquiries and directly provide permissions to Maxor, if they agreed to the release. It was the DGS's understanding from that conversation that this arrangement was agreeable to Maxor and that Maxor stated it was simply waiting for the green light to make such contact with the vendors. (Exh. H).

Accordingly, on February 16, 2007, the DGS sent letters to AstraZeneca, Roche Laboratories, and Eli Lilly advising them Maxor would likely be contacting them. At the same time, the DGS provided Maxor the names, telephone numbers and email addresses of the three pharmaceutical companies to facilitate direct contact with these companies. (Exh. I).

As is evident from this chronology, the contractual information was shared with Maxor pursuant to the Nondisclosure and Confidentiality Agreement previously reached with the DGS. Further, Paragraph 8 of Maxor's own contract with the California Prison Health Care Receivership Corporation sets forth Maxor's agreement, in pertinent part, to maintain the confidentiality of:

> "all financial, statistical, personal, technical and other data and information relating to State operations, which are designated confidential by the State and made available to carry out this Agreement, or which become available to Contractor in order to carry out this Agreement, shall be protected by Contractor from unauthorized use and disclosure." (Exh. J).

The information Maxor seeks to provide to the Heinz Foundation, for whatever purposes, is confidential information provided to Maxor consistent with its agreement that the information would remain confidential. (Exh. A and J). To the extent Maxor wants to release the confidential information to other third parties, the DGS has provided Maxor with the names of the companies to which the confidential information belongs, in order to facilitate Maxor's work.

The DGS believes that by providing the vendor contact information, Maxor could proceed directly to the companies that own the information. Maxor could directly describe to these companies the purpose and any conditions surrounding the proposed release—information which is not known to or under the direction or control of the DGS.

Since the DGS does not own the confidential information, the DGS has no ability to grant the permission Maxor seeks. The DGS provided Maxor the most expeditious way to obtain such permission by facilitating direct contact between Maxor and the vendors.

Concurrent with this letter, we will also be providing to Maxor, out of an abundance of caution, an additional set of true and correct copies of each of the pharmaceutical contracts requested by Maxor to continue ensuring Maxor has what it needs to conduct its work.

If you have any questions, please feel free to contact me at (916) 376-5115.

Sincerely,

KATHLEEN YATES
Senior Staff Counsel

cc: Robert Sillen, Receiver
John Hagar, Chief Deputy
Jared Goldman, Esq.
Andrea Hoch, Legal Affairs Secretary
Louis Mauro, Chief Deputy Legal Affairs Secretary
Jon Wolff, Supervising Deputy Attorney General
Paul Mello, Esq.

EXHIBIT 17

EDMUND G. BROWN JR.
Attorney General

State of California
DEPARTMENT OF JUSTICE

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March 1, 2007

VIA FACSIMILE & U.S. MAIL

Jayne Russell
Acting Health Care Project Officer
California Prison Health Care Receivership Corporation
1731 Technology Drive, Suite 700
San Jose, CA 95110
Facsimile: (408) 453-3025

RE: *Perez v. Tilton, et al.*
United States District Court, Northern District of California, Case No. C 05-05241 JSW

Dear Ms. Russell:

This letter follows up on our February 22, 2007 meeting regarding revisions to the dental program's current reception center processes at San Quentin State Prison (SQSP). As indicated at this meeting, the California Department of Corrections and Rehabilitation (CDCR) is willing to consider, on a pilot basis, modifications to the dental program's currently existing reception center processes at SQSP.

To expedite this process, we have requested the Court experts in this matter prepare a report recommending short-term modifications to the dental program's reception center processes due to the space constraints currently faced at SQSP's reception center. The Court experts anticipate a draft of this report will be completed by March 9, 2007. CDCR will then require sufficient time to review the Court experts' recommendations and to internally decide whether any revision(s) to the dental program's current reception center processes at SQSP would be appropriate.

We understand that time is of the essence in this process. At the February 22, 2007 meeting, you requested that CDCR definitively respond within one week regarding whether the dental program would modify its reception center processes at SQSP. As illustrated above, this time line is simply not feasible. CDCR is committed to working with you on this issue and will provide you with its decision after having an ample opportunity to review the Court experts' report and the merits of revising the dental programs existing reception center processes at SQSP. However, to the extent there are upcoming *Plata* imposed deadlines that could potentially impact

dental care at SQSP's reception center, please feel free to contact me and I will communicate these deadlines to my clients.

Please do not hesitate to contact me if you have any questions or would like further clarification regarding the foregoing. Thank you.

Sincerely,

CHARLES J. ANTONEN
Deputy Attorney General

For EDMUND G. BROWN JR.
Attorney General

cc: William Kuykendall, DDS
Peter Farber-Szekrenyi, Dr. P.H.
Joseph D. Scalzo, DDS, CCHP
Jay Shulman, DMD, MA, MSPH
Alison Hardy, Esq.
Rochelle East, Esq.
Michael Stone, Esq.

EXHIBIT 18

California Prison Healthcare Receivership Corp.

Balance Sheet

As of January 31, 2007

(Unaudited)

	January 2007	June 2006
ASSETS		
Current Assets		
Cash in Bank	$ 3,803,431	$ 2,072,487
Prepaid Insurance	29,619	41,138
Prepaid Rent/Other Deposits	0	121,402
Total Current Assets	**3,833,049**	**2,235,027**
Property, furniture, and equipment:		
CPR Headquarters	392,208	31,437
Held on behalf of CDCR	3,836,886	0
Total Property, furniture, and equipment:	**4,229,094**	**31,437**
Other Assets:		
Security Deposit	177,472	176,222
Total Other Assets	**177,472**	**176,222**
TOTAL ASSETS	**$ 8,239,615**	**$ 2,442,686**
LIABILITIES AND FUND BALANCES:		
Current Liabilities		
Accounts Payable	$ 373,363	$ -
Accrued Expenses	103,058	39,000
Payroll-Payable	207,534	98,274
Total Current Liabilities	683,955	**137,274**
Fund Balances:		
Contributed Capital -State of California	11,524,102	2,752,547
Net Expenses - Prior year	(447,135)	(447,135)
Net Expenses - Current year	(3,521,307)	0
Total Fund Balances	**7,555,660**	**2,305,412**
TOTAL LIABILITIES AND FUND BALANCES	**$ 8,239,615**	**$ 2,442,686**

California Prison Healthcare Receivership Corp.
Statement of Expenses
For the period ending January 31, 2007
(Unaudited)

	January 2007	June 2006
Operating Expenses:		
Salaries/Wages & Related	$2,272,114	$327,969
Legal & Other Professional Fees	1,004,185	90,929
Office Expenses	33,943	621
Rent	106,057	6,470
Insurance	25,384	8,120
Telephone	21,111	997
Travel	133,557	15,627
Other Expenses	32,460	0
Total Operating Expenses	**$3,628,811**	**$450,733**
Other Income		
Interest Earned	$107,503	$3,599
Total Other Income	$107,503	$3,599
Net Expenses	**$3,521,308**	**$447,134**

PROOF OF SERVICE BY MAIL

I, Kristina Hector, declare:

I am a resident of the County of Alameda, California; that I am over the age of eighteen (18) years of age and not a party to the within titled cause of action. I am employed as the Inmate Patient Relations Manager to the Receiver in *Plata v. Schwarzenegger*.

On March 20, 2007 I arranged for the service of a copy of the attached documents described as APPENDIX OF EXHIBITS FOR RECEIVER'S FOURTH BI-MONTHLY REPORT on the parties of record in said cause by sending a true and correct copy thereof by pdf and by United States Mail and addressed as follows:

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CDCR
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Little Hoover Commission
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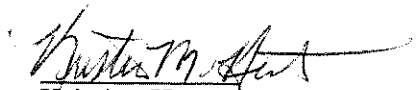
Sacramento, California 95814

MICHAEL BIEN
Rosen, Bien & Asaro
155 Montgomery Street, 8th Floor
San Francisco, CA 94104

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on March 20, 2007 at San Francisco, California.



Kristina Hector