

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

**REQUEST FOR PROPOSALS
FOR CORRECTIONAL HEALTH RECORDS
PROFESSIONAL MANAGEMENT SERVICES
FOR CALIFORNIA ADULT PRISON FACILITIES**

April 4, 2008

PROPOSALS DUE:

June 3, 2008

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I. REQUEST

The Receiver of the California Department of Corrections and Rehabilitation's ("CDCR") prison medical system is requesting proposals for professional management services to assist the Department of Correctional Healthcare Services ("DCHCS") in addressing staffing and organizational issues relating to the effective processing and management of inmate health records. The contract awarded by the Receiver will be a service agreement with either the California Prison Health Care Receivership Corporation ("CPR") or CDCR.

II. BACKGROUND

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

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

The CDCR mental health and dental systems are also under court supervision as a result of two additional inmate class actions: *Coleman v. Schwarzenegger* and *Perez v. Tilton*, respectively. To avoid duplication of effort, certain health care initiatives that support the entire health care system are being coordinated by the *Plata*, *Coleman* and *Perez* courts. To facilitate such coordination, the courts have agreed that the Receiver will be responsible, in addition to his management of the medical system, for the oversight and implementation of certain mental health and dental support functions, including health information management.

While the problems identified by the courts and the Receiver reach into almost every element of the medical care system, it is without question that the health information management (HIM) system is inadequate to meet the needs of the

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confined adult population. The *Plata* Court has found that “[t]he medical records in most CDCR prisons are either in shambles or non-existent.” FFCL, at p. 20.

As stated by the Court:

The amount of unfiled, disorganized and literally unusable medical records paperwork at some prisons is staggering. At California Institution for Men (CIM), the records were kept in a 30 foot long trailer with no light except for a small hole cut into the roof and were arranged into piles without any apparent order. Conditions are similar at other prisons as well. At some prisons, medical records are completely lost or are unavailable in emergency situations.

At CIM, the use of temporary medical records creates a confusing and dangerous situation for practicing physicians who often have access to little or none of a patient’s history. The Court observed first-hand at CIM that doctors were forced to continually open new files on patients simply because the doctors could not get access to the permanent files. As a result, the risk of misdiagnosis, mistreatment, and at a minimum, wasted time, increase unnecessarily.

Id., at p. 21 (internal citations omitted). Simply put, “the CDCR medical records system is ‘broken’ and results in dangerous mistakes, delay in patient care, and severe harm.” Id.

The court monitors in *Plata v. Schwarzenegger*, *Coleman v. Schwarzenegger*, and *Perez v. Tilton* voiced some of the following additional concerns:

- CDCR lacks a uniform and standardized health information system.
- The health records departments need better trained and more appropriate staffing.
- A uniform priority system for filing does not exist in all institutions.
- At several institutions each yard has a separate health records unit.
- Duplicative forms are filed in the health record in multiple sections.
- Loose filing is not being completed, resulting in incorrectly packaged health records and delays in treatment. In some facilities the amount of loose filing exceeds 8 feet.

CDCR appears to have no functional centralized oversight or management of health care recordkeeping in any of its 33 prisons or parole offices, where records are also kept. Medical recordkeeping, although quite variable from prison to prison, appears, in the Receivership’s experience, to be problematic, with frequent anecdotes about:

- lost or missing charts;
- misfiled documentation;

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- stacks of unfiled paper documents dating back months to years;
- hundreds of conflicting and redundant forms that are poorly understood by clinicians

The above problems have been compounded by an increase in the number of new forms implemented without uniformity throughout the 33 prisons. For example, in response to several lawsuits filed since 1993 relating to medical, mental and dental programs, the CDCR has created or is developing more than 30 new forms to document compliance. These new forms increase the workload of health records staffs, which must ensure the documents are properly incorporated in the Unit Health Record (UHR). Additionally, there has been a dramatic increase in the pulling and filing of health records for visits and court monitor reviews. The result is a backlog in the updating of the UHRs, and a proliferation of loose documents.

Additionally, efforts to protect inmate privacy and ensure compliance with privacy laws present additional challenges. The probability of unauthorized release of confidential inmate health information is increased by the lack of an effective system for maintenance of health records, posing a serious risk of a breach in privacy. Moreover, the above factors have concurrently affected the transfer and receipt of documents by Parole and Community Services Division and Archives. The consequences of error can be significant, with public safety impacted and the ability of CDCR to comply with federal mandates compromised.

The processing of a UHR involves many individual yet interconnected activities, including record retrieval, concurrent record maintenance, transcription and filing of loose documents, and follow-up. The staff required for coding, analysis, release of information, retrieval, indexing and confidentiality must be specially trained and knowledgeable in all aspects of an efficient and standardized health records management system. In addition to the health record uses within the prisons, the records are also kept in the parole offices and used by paroles seeking treatment in the community.

The current system of health records management, however, is not efficient and standardized according to best practice and industry standards, and the current allocation of health records staff is insufficient to meet these responsibilities and challenges. The existing health records management staff in the institutions are overwhelmed. While changes in the provision of health care have resulted in increased clinical staff, there has been no concurrent augmentation of qualified and registered health records staff.

Furthermore, CDCR is in the initial planning stages for system-wide computerized patient information systems for all inmates. If these systems are to be implemented in a timely and efficient fashion, paper-based health records processes and clinical documentation at all CDCR facilities will first need to be standardized and streamlined.

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As part of its information technology initiatives, the Receivership recently engaged the consulting firm Just Associates to assess CDCR's processes and systems for patient identity management. A by-product of this assessment was documentation of and recommendations for health information management in California's prisons. Just Associate's white paper is attached to this RFP as Appendix A.

III. ANTICIPATED SCOPE OF SERVICES

A. General Scope of Services

CDCR seeks to contract for health records management and staffing functions to transition the current HIM operation to one based on best practices and standards in the industry applicable to the correctional environment.

Because CDCR's healthcare records are multi-disciplinary, the contractor must pay particular attention to any unique healthcare records requirements of mental health, dentistry, and services for the disabled, in addition to overall medical care. The contractor will meet these diverse needs by working through a committee with representation from CDCR's medical, dental and mental health staff as well as the *Plata*, *Coleman*, and *Perez*, and *Armstrong* courts.

Based on the high level goals and objectives mapped out in the Detailed Scope of Service section, the contractor will:

1. Identify industry standards and best practices in paper based health records management;
2. Identify and analyze gaps between best practice and current HIM practice in the CA prison system;
3. Provide a road map for the system-wide adoption of procedural, physical infrastructure, and technological approaches that will optimize the organization and maintenance of records, retrieval, distribution, and release of information, while ensuring the privacy and security of the records, within the 24-month contract period;
4. Take appropriate and specific steps to close the gap between current HIM operations and best practice.
5. Establish an effective management system that ensures standardized HIM practice in the CA prison system. It is envisioned

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that the contractor will provide a Sacramento headquarters and a senior management team for the duration of the contract, supplemented, as necessary, with a team of managers, supervisors, technical, and clerical staff. Ideally, interim and temporary staff will be hired using established state personnel processes.

6. Create and implement training programs to ensure state employees charged with maintaining and organizing medical records adhere to all best practices and regulatory requirements.
7. Within 6 months, develop a formal plan approved by CDCR's Plata Human Resources division to transition leadership and management to a self-sustaining, permanent team of state employees.
8. Lay the foundation, by optimizing how the paper based system is implemented and participating on appropriate work groups, for an eventual transition to computerized information systems.

B. Detailed Scope of Services

1. Establish effective leadership and management oversight over CDCR's health record services
 - a. Establish a centralized HIM leadership and management team structure and lines of authority to the medical/dental record departments in the 33 prisons as well as other record storage sites.
 - b. Staff the centralized HIM senior management team until such time as CDCR has the appropriate personnel and organization structure to provide its own management.
 - c. Work with Receivership and CDCR leaders to establish and implement centralized management oversight committees, including a HIM Committee, Forms Committee, and Security, Privacy, and Audit Committee.
 - d. Participate in ongoing forums with other professional staff, including physicians, dentists, nurses, pharmacy, imaging, and laboratory staff for the purposes of implementing a continuous improvement program.
 - e. Develop a HIM strategic action plan in concert with the HIM Committee and communicate the plan and roadmap to all constituents.

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2. Establish the integrity and continuity of the health record by establishing policy and procedures regarding:
 - a. Patient Identification and Location Management: In conjunction with Information Technology leadership, develop, implement, and manage master patient index and bed tracking systems among various prisons, across multiple illness episodes, across various domains of care (i.e., medical, mental health, and dental) and across multiple incarcerations.
 - b. Integration of Records: Establish policies and procedures to integrate the components and volumes of the health record (inpatient, ambulatory, psychiatric, dental, rehab, hospice, etc.) into an integrated record system.
 - c. Record Documentation: Through the use of the centralized HIM Committee, and in accordance with applicable federal and state laws and regulations as well as applicable accreditation agencies, establish a single, uniform policy on record documentation for each illness episode (ambulatory, inpatient, psychiatric, dental, long term care, and hospice). This will include establishing policy about which documents must be dictated and transcribed and which must be directly entered into electronic record systems.
 - d. Uniform Chart Organization (Order): Through the centralized HIM Committee, establish uniform rules for a single chart order for the entire prison system as well as how information will be organized when the health record must be divided into multiple volumes.
 - e. Forms Control: Through the use of a centralized forms committee, inventory all existing forms, establish a single form numbering system, standardize forms, develop a procedure to bar code forms as they are printed, and develop a management and approval process for introducing / retiring forms.
 - f. Chart Clean-up: Through the centralized HIM Committee, establish policies and procedures to clean-up health records, eliminating redundant and non-health care related information from the record.
 - g. Chart and Document Retention: Policies to be established regarding chart and document retention which satisfy legal

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and regulatory standards as well as business requirements while incarcerated and until released from parole.

3. Establish the security and confidentiality of the health record by establishing policy and procedures regarding:
 - a. Health Information Privacy: Through the use of the centralized Information Privacy and Security Committee, and in accordance with applicable federal and state laws and regulations as well as applicable accreditation agencies, establish a single, uniform policy on record privacy, covering all illness episodes (ambulatory, inpatient, psychiatric, dental, long term care, and hospice). This will include establishing policy about patient privacy, appropriate and inappropriate access and release of information from the health record, and accounting for disclosures.
 - b. Health Information Security: Through the use of the centralized Information Privacy and Security Committee, in accordance with applicable federal and state laws and regulations as well as applicable accreditation agencies, and in concert with Information Technology leadership, establish policy on information security, covering paper and electronic records.
4. Establish policies and procedures, and management control over HIM processes across the CA prison system, including:
 - a. Filing Systems: The design of the paper chart filing systems across prison system, including the file rooms, warehoused and basement record system, digit filing, the use of multiple volumes, receipt and filing of orders, the results of diagnostic testing, loose sheet filing, chart thinning, and receipt of records following an illness episode.
 - b. Chart Retrieval and Movement: The retrieval of the charts when needed by a health care provider (including multiple volumes), the movement of charts between institutions and to parole, and the retrieval of an old health record if an inmate has returned to the system after parole and release.
 - c. Chart Analysis / Chart Deficiency: The effectiveness of chart deficiency systems to insure that records are appropriately completed after an episode of care.

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- d. Release of Records: The types of records released, to whom, and the quality of the service.
 - e. Coding: The coding of specified illnesses episodes using ICD-9-CM and CPT-4 diagnostic and procedure codes.
 - f. Transcription: Work with an ongoing CDCR initiative to centralize and modernize dictation and transcription to ensure the rapid and accurate transcription of dictated health reports for filing into electronic and paper record systems.
5. HIM Organization and Staffing: Develop the structure of the HIM organization at the local and headquarters levels, the number of staff, job roles and job descriptions, recruitment, training, retention, compensation, and standards for staff productivity.
- a. Evaluate the effectiveness of HIM teams (management and staff) at each of the facilities.
 - b. Establish an HIM organizational structure for the CA prison system, at the central organization level and within each facility and the lines of authority between the central organization and the facilities.
 - c. Develop roles, performance standards, job descriptions, salary ranges, and career paths for each HIM function.
 - d. Assist CDCR's Plata Human Resources division in recruiting managers and staff for each location.
 - e. Develop a training program for the HIM functional areas that ensures understanding and compliance with established policies and procedures and builds to the HIM credentialing of selected staff members.
 - f. Develop and implement a plan to transition management control from the contract team to a CDCR team over the life of the contract.
6. Evaluate the physical infrastructure of the 33 prison health record departments and take appropriate steps to remediate.
- a. Functions: Identify the functions to be performed in custody areas and those that could be performed in administrative areas outside of secure areas.

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- b. Filing Systems: Evaluate the paper filing system for capacity, efficiency, and compliance with appropriate fire and safety codes. Describe recommended active and inactive file system requirements.
 - c. Staff Areas: Evaluate the staff areas for adequacy and work flow efficiency.
 - Describe standard office layout requirements for HIM function, including standard office space, electrical, telephone, and network requirements.
 - Describe the standard compliment of equipment and office tools for HIM functions and staff, such as desks, telephones, mobile phones, computers (desktop and laptops), and network connectivity.
 - c. Potential Solutions: Generate a list of potential solutions, including document imaging, with associated budgets as interim solutions until a full EMR is implemented.
 - d. Implementation: With regard to HIM functions and workflow, advise and coordinate with all ongoing construction projects, including the Facility Improvement Program, the 5000 bed construction program, and the re-entry facility construction program.
7. Evaluate the HIM automation infrastructure of the 33 prison medical record departments and take appropriate steps to remediate.
 - a. HIM Automation Systems: Evaluate the adequacy of the current HIM automation systems (such as chart tracking, deficiency analysis, abstracting, etc.) as an integrated solution to manage existing paper HIM processes across the entire California prison system. These evaluations should assume 4-7 years until a full EMR can fully replace paper processes.
 - b. Potential Solutions: Based on these evaluations, generate a list of potential HIM automation solutions, with associated budgets as adjuncts to the HIM solutions.
 - c. Implementation: With the approval of the Receiver, develop a plan and implement selected solutions to remediate the HIM automation solution.

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8. Establish management controls over HIM processes by:
 - a. System- Wide Metrics: Developing and implementing metrics within the health record areas to monitor, evaluate, and analyze department and individual performance.
 - b. Standards: Using the metrics, set performance standards for each of the operational areas and incrementally modifying these standards as performance improves.
 - c. Audits: Conducting audits and management visits to ensure compliance with established policies and procedures.
 - d. Problem Solving and Remedial Action: Taking appropriate remedial action when performance does not meet established standards

IV. Deliverables:

The deliverables required will be stipulated in conjunction with the approved work plan and associated staffing plans and schedules. The total duration of the contract is expected to be 24 months. At the Receiver's discretion, this contract may be extended as required.

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

A. Key Deliverables:

The contractor shall provide the following deliverables to the Receiver:

1. Deliverable One: Regulatory Analysis and Best Practices.

By the end of four weeks, the contractor shall provide identify and provide a regulatory and best practices review on each of the dimensions listed in the Detailed Scope of Service.

The regulatory analysis, at a minimum, shall address federal regulations such as HIPAA, California healthcare regulations such as Title 22 as well as those relevant from the following California state agencies: Department of Health Services; Department of Managed Care; Department of Mental Health, and Department of Corrections and Rehabilitation. In addition, the regulatory analysis should address relevant standards (as they pertain to health records) established by accrediting agencies such as the JCAHO,

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the National Commission on Correctional Healthcare, and the American Correctional Association. Reference should be made to other correctional systems and the Federal Bureau of Prisons.

Best practices standards should be focused on paper-based systems and standards presented should be grounded with the type of institution from which it is derived (e.g.; other correctional system, government based public health, academic medical center, or for-profit system).

2. Deliverable Two: HIM Assessment

Within two months, complete an assessment of CDCR's health information management systems:

- a. The contractor shall work with the CDCR staff and, at a minimum, make onsite assessments of at least 8 prison facilities, 2 parole offices, headquarters, and the central health records archive storage unit at the Army Depot in Sacramento to create a general impression the current state of HIM operations.
- b. Within 2 months, a written report shall be prepared documenting the site visits, addressing the dimensions listed above as well as the transport system to move records between facilities as well as to community health facilities. The report should give an overview of findings, patterns, and trends, and provide an unvarnished assessment of the existing system.

3. Deliverable Three: Remediation Road Map.

By the end of the fourth month, the contractor shall make recommendations to close the gap between current practice of the HIM services within the California prison system and best practice on each of the dimensions listed above.

The written report shall be organized by each of the topic areas listed in the Detailed Scope of Services (above) and list practical recommendations (and alternatives) to improve each. Each recommendation, within a topic area, shall detail its priority, time required to achieve, and staffing and resource support required. Recommendations should be considered in light of ongoing Receivership healthcare information technology projects, such as a clinical data repository that will be available in 2008.

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The Receivership will evaluate this report and must approve the overall plan or specific actions to proceed to the next deliverable. If the Receivership is not satisfied with the overall products of the first three deliverables, continued work on the project may be terminated.

4. Deliverable Four: Master Project Plan.

Within a month of receiving approval and direction from the Receivership on the Remediation Plan, the contractor will prepare a master project plan for phased implementation, outlining recommended tasks and actions, key deliverables and milestones, implementation plans by site, critical paths, required state and consultant staffing resources, and other equipment and infrastructure requirements.

The master plan will include a Service Level Agreement (SLA) to consist of consulting staff requirements, experience, credentials, rates, scope of service (including hours, schedules, roles, and responsibilities), methods of tracking consultant time and activities, timing and basis for invoicing, and issue resolution mechanism.

The Receivership must approve the SLA and Master Plan to proceed to deliverable five.

5. Deliverable Five: Management of HIM Operations per the terms and conditions of the approved SLA.

Approved action steps will be implemented during this step, based on the deliverables submitted during the first three steps.

A monthly report will be required, outlining the original plan, findings, progress made, metrics, and any suggested plan modifications.

6. Deliverable Six: Management Transition Plan

Within 6 months of assumption of management of HIM Operations (Deliverable 5) the contractor will map out a plan to transition management of the HIM branch from the contractor to a permanent management team. The plan will provide month-by-month road map of steps to be taken, with time line, and budget to fully transition management while ensuring that accomplishments are not eroded.

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Over the second half of the contract, the vendor will provide a monthly status of that transition, including accomplishments, issues, set backs, and potential solutions.

7. Deliverable Six: Management Transition

No later than 24 months after the initiation of this contract, the vendor will complete its transition of all HIM functions and roles back to a permanent CDCR management team.

B. Other Expectations:

During the course of this engagement, the contractor will be expected to

1. Open and staff a field office in Sacramento for the duration of the project.
2. Lead a kick-off meeting for the project in Sacramento, CA.
3. Present a series of communications to the CDCR health records staff at all prisons, central office staff, and parole offices intended to give them a road map and gather suggestions and feedback from front-line personnel.
4. Present project deliverables and analysis by the project milestone dates and follow up with a presentation to the HIM Records Oversight Committee.
5. During the implementation phase, provide a monthly written report of progress, findings, metrics, issues, setbacks, and any suggested plan modifications.
6. Present monthly status on the budget and any issues or deviations from original projects.
7. Participate in professional committees established by the Receivership for coordination and direction of all health services.
8. Coordinate with and participate in other projects including the Clinical Data Repository project, the 10,000 bed project, and projects for improvement of laboratory and imaging services, among others.
9. Create and implement training and education programs to enable HIM staff to meet regulatory and quality standards for the organization and maintenance of health records.

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C. Organization and Direction

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

V. SELECTION PROCESS

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

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

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

The Receiver intends to negotiate and enter into a services agreement ("the Agreement") with the selected Respondent promptly upon selection. Prior to commencing the Services, the selected contractor must sign the Agreement and provide proof of insurance. The Agreement will include the General Terms and Conditions and Contractor Certification Clauses set forth at:

<http://www.documents.dgs.ca.gov/ols/GTC-307.doc> and
<http://www.documents.dgs.ca.gov/ols/CCC-307.doc>,

except that all references to the State of California or the Department of General Services will mean the California Prison Health Care Receivership Corporation. The Agreement is anticipated to be for a period of not more than thirty-six months.

VI. EVALUATION CRITERIA

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

1. Respondent understands the context of CDCR's medical service delivery issues by reviewing the website and being familiar with the Plan of Action, court reports and documents.

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2. Respondent's proven experience, capabilities and resources, at both the corporate and individual levels, in providing health records management services to health care systems, such as:
 - a. Large health care systems with multiple facilities and geographical distance.
 - b. Health care systems with limited or no infrastructure
 - c. Medical records systems that do not have strong, existing HIM management expertise.
 - d. Predominantly paper-based record systems (that is, no HIM management software) that do not have the immediate ability to computerize or even install computers.
 - e. Medical records systems within a criminal justice system.
3. Respondent demonstrates clear understanding of different health records systems and the unique requirements and needs of each, to include:
 - a. Inpatient records
 - b. Ambulatory Care records
 - c. Mental Health and psychiatric records
 - d. Dental records
 - e. Long Term Care and Rehabilitation records
 - f. Hospice records
4. Respondent demonstrates a clear understanding and knowledge of:
 - a. California laws, rules, and regulations regarding the management of health records.
 - b. Federal and state laws, rules, and regulations regarding the privacy and security of health information.
 - c. Specific rules and regulations regarding correctional facilities.
 - d. Relevant and helpful accreditation agency standards.
 - e. Computerized patient information systems, a long term approach to transitioning from paper to electronic solutions, and an appreciation of the intermediate steps that can be taken.

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5. Respondent demonstrates an approach to the unique challenges of the CDCR environment and record systems that:
 - a. Is strategic in nature and provides an overall approach to the entire CA prison system and not just a facility by facility approach.
 - b. Suggests creative approaches to immediately addressing and solving the institutional issues.
 - c. Represents a commitment of personnel with a diversity of experiences and solution approaches.
 - d. Provides proven systems, management techniques, and required expertise and resources designed to facilitate timely.
 - e. Shows the ability to facilitate stakeholder coordination and timely and effective decision-making.
6. The proposal must articulate a clear project approach and project plan that:
 - a. Clearly addresses the issues, goals, and objectives outlined under the Section labeled "Detailed Scope of Service".
 - b. Outlines high level tasks, milestones, and a projected time line.
 - c. Clearly allocates resources for each project phase and task.
 - d. Commits the contractor and specific individuals (with percent of time) to this project without appearing to be inflated.
7. The proposal must present a diverse, experienced, and qualified Core Team by:
 - a. Presenting the qualifications and experiences of each team member as compared to the selection criteria discussed above (items 1 to 5).
 - b. Demonstrating the availability and commitment of key staff.
 - c. Clearly identifying the key staff that will perform each of the phases and why their expertise is required.
8. Presents a reasonable budget and relative value of services provided.
9. Completeness and comprehensiveness of response to this RFP and compliance with the submittal requirements.

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10. Quality of oral interviews including technical analysis and presentation (if requested by the Receiver).
11. Legal actions that might affect Respondent's ability to perform as contracted.
12. Absence of any relationship that could constitute a conflict of interest or otherwise impede the ability of the Respondent to protect the interests of the Receiver.

VII. SUBMITTAL REQUIREMENTS

1. RFP Schedule

Event	Date
RFP Issued	April 4, 2008
Bidder's Conference (see Appendix B)	April 24, 2008
Deadline for questions regarding RFP	May 9, 2008
Responses to questions	May 23, 2008
Proposals due	June 3, 2008
Notification for interviews (estimated)	June 13, 2008
Interviews (estimated)	Week of June 23
Selection announced (estimated)	July 07, 2008
Estimated project start date (estimated)	August 04, 2008

2. Addenda

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

Addenda will be sent to all known applicants. If the Respondent did not receive this RFP directly from CPR, notify Stan Ketchum (Stan.Ketchum2@cdcr.ca.gov) by email of a request to receive any addenda by **April 18, 2008**.

3. Format

Proposals should be clear, concise, complete, well organized and demonstrate both Respondent's qualifications and its ability to follow instructions.

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8 (eight) bound copies of the Proposal should be provided, with all materials spiral bound into books of approximately 8-1/2" x 11" format, not to exceed sixty (60) single-sided pages total length. At least one (1) copy must contain original signatures and be marked ORIGINAL.

Pages must be numbered. We will not count, in the total, the graphic cover sheet, cover letter, table of contents, blank section dividers (tabs), explanations about legal actions, and a maximum of 12 resumes, which may be included in an appendix.

The entire Proposal shall also be submitted in electronic (pdf) format on CD or electronically by e-mail, organized in the same manner as the printed submissions.

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

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

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

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

4. Contents

The Proposal must include the following items:

- a. A cover letter signed by an officer of the firm submitting the Proposal, or signed by another person with authority to act on behalf of and bind the firm. The cover letter must contain a commitment to provide the required Services described with the personnel specified in the submission. The letter should certify that the information contained in the Proposal is true and correct. Please also indicate the contact person(s) for the selection process along with contact information.
- b. Executive Summary: The Executive Summary must include a clear description of the primary advantages of contracting with your organization. It should also include a brief explanation of how the

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Respondent satisfies the evaluation criteria, and a brief statement that demonstrates Respondent's understanding of the desired Services.

- c. Demonstration of the Respondent's Qualifications: Please provide the following information:
- (1) Your company's name, business address and telephone numbers, including headquarters and local offices.
 - (2) A brief description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.
 - (3) A description of your company's prior experience related to correctional and healthcare facilities.
 - (4) A description of your company's prior experience in California.
 - (5) A description of your company's specific areas of technical expertise as they relate to this RFP.
 - (6) A description of your company's internal training and quality assurance programs.
 - (7) The proposer must demonstrate the capacity to bring forward sufficient qualified staff to provide operational support needed during the management phase of this engagement.
- d. Professional references: Describe previous work on no more than three projects of comparable scope and magnitude for which you provided similar types of services. Provide complete reference information including project name, location, client, total contract amount (and firm's amount if different), principal-in-charge, day-to-day technical project director/manager, key staff, date completed, client reference (name, current position and phone number), and a brief narrative of project description for each project identified and described above. **Experience may not be considered if complete reference data is not provided or if named client contact is unavailable or unwilling to share required information.**
- e. Qualifications of Technical Personnel: Submit current resumes for Key Personnel committed to this project and a statement regarding their local availability. Specifically describe previous related experience, its pertinence to this program, and provide references including the name, address and telephone number of a contact person who can verify the information provided. Provide brief description of referenced project(s), as well as any professional certifications, accreditation, special licensing or

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other qualifications which qualifies the professional to perform in their designated area of responsibility.

- f. Proposed changes to Scope of Services: Respondent should provide any proposed modifications to the objectives, deliverables and timelines identified in this RFP.
- g. Legal action: Respondent must provide a listing and a brief description of all material legal actions, together with any fines and penalties, for the past five (5) years in which (i) Respondent or any division, subsidiary or parent company of Respondent, or (ii) any member, partner, etc., of Respondent if Respondent is a business entity other than a corporation, has been:
 - (1) A debtor in bankruptcy;
 - (2) A defendant in a legal action alleging deficient performance under a services contract or in violation of any statute related to professional standards or performance;
 - (3) A respondent in an administrative action for deficient performance on a project or in violation of a statute related to professional standards or performance;
 - (4) A defendant in any criminal action;
 - (5) A principal of a performance or payment bond for which the surety has provided performance or compensation to an obligee of the bond; or
 - (6) A defendant or respondent in a governmental inquiry or action regarding accuracy of preparation of financial statements or disclosure documents.
- h. Default Termination: A disclosure of whether your company has defaulted in its performance on a contract in the last five years, which has led to the termination of a contract
- i. Conflict of Interest: Identify any existing financial relationships with other vendors that may be a part of your proposal, and explain why those relationships will not constitute a real or perceived conflict of interest.
- j. Cost Proposal: Provide a cost proposal for performing the Assessment and Master Plan Services:
 - (1) The cost shall include a table showing by proposed individual the number of hours proposed for each individual, the cost for the individual, and the total for professional services.

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- (2) Local staff is preferred. When staff must be provided from outside the Sacramento area, demonstrate controls to be established to limit travel and living expenses. Travel within the state to visit facilities will be at state rates.
- k. Management Services Phase of Project: Since the exact staff requirements can not be determined until after the assessment phase, please provide an estimate of the per person rate, from where staff would be obtained, and estimated living and travel expenses. This part of the project will not be approved until after the assessment and development and approval of the master plan.

5. Modification or Withdrawal of Proposal.

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

6. Public Opening

There will be no public opening of responses to this RFP. However, after a contract is awarded all Proposals may be available for public review. CPR makes no guarantee that any or all of a Proposal will be kept confidential, even if the Proposal is marked "confidential," "proprietary," etc.

7. General Rules

- a. Only one Proposal will be accepted from any one person, partnership, corporation or other entity.
- b. Proposals received after the deadline will not be considered.
- c. This is an RFP, not a work order. All costs associated with a response to this RFP, or negotiating a contract, shall be borne by the Respondent.
- d. CPR's failure to address errors or omissions in the Proposals shall not constitute a waiver of any requirement of this RFP.

8. Reservation of Rights

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

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- a. Reject any and all Proposals, or cancel this RFP.
- b. Waive or correct any minor or inadvertent defect, irregularity or technical error in any Proposal.
- c. Request that certain or all candidates supplement or modify all or certain aspects of their respective Proposals or other materials submitted.
- d. Procure any services specified in this RFP by other means.
- e. Modify the specifications or requirements for services in this RFP, or the required contents or format of the Proposals prior to the due date.
- f. Extend the deadlines specified in this RFP, including the deadline for accepting Proposals.
- g. Negotiate with any or none of the Respondents.
- h. Terminate negotiations with a Respondent without liability, and negotiate with other Respondents.
- i. Award a contract to any Respondent.

Inquiries in regard to this RFP should be addressed to:

**JUSTIN GRAHAM, MD MS
CHIEF MEDICAL INFORMATION OFFICER
501 J Street
P.O. BOX 4038
Sacramento, CA 95812-4038**

justin.graham@cprinc.org

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APPENDIX A: - JUST ASSOCIATES HIM WHITE PAPER

California Prison Health Care Receiver
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December 31, 2007

Justin Graham, M.D.
Chief Medical Information Officer
California Prison Receivership Inc.
Sacramento, CA

Dear Justin:

Just Associates has recently finished the report for the Patient Identity Assessment that the California Prison Receivership Inc. contracted us to complete. A focal underpinning of such an assessment is to document the flow of medical record/clinical information throughout the treatment of a patient, in this case California state correctional system inmates.

As we complete the information flow analysis, we often spend a great deal of time with the Health Information Department staff to identify issues they encounter with timely and accurate transmission of health care information. This frequently uncovers unknown issues with patient identity accuracy and often provides evidence to troubleshoot the likely causes of patient identity and patient tracking issues.

As we have covered in our report, JA identified several critical and debilitating problems in the management of health information and we believed we would be remiss if we did not summarize these issues for you and provide you with our thoughts relative to HIM strategies for improvement. As you know, the medical record is currently all paper based, and moving toward an electronic health record requires strong leadership in the HIM arena.

Attached is an excerpt of our report relative to HIM findings as background to this letter.

Several key HIM strategies are suggested for CPR consideration. They include:

1. **HIM Leadership:** Strong leadership will be required in HIM to facilitate the transition from a paper-based medical record to an electronic health record. A Director level position in CPR would be appropriate and contracting for this position while recruitment occurs should be considered. Experienced and credentialed HIM professionals will be required to re-engineer operational processes and orchestrate plans for the future. This is probably the most critical step CPR could make relative to HIM and the transition to automation.
2. **Shift from “Medical Records” to “Health Information Management”:** The knowledge and skills that a strong HIM Leader will provide to CPR is that of

understanding the process of data and information capture at each point in the care continuum and how to most effectively transmit and display needed health information to each practitioner. Recruitment of HIM leaders should focus on identifying individuals that understand the concept of most effectively managing and utilizing health information and technology in support of patient care and operations.

3. **Best Practices:** Again, a strong HIM Leader will be able to set goals for implementation of HIM best practices and should provide the roadmap and interim steps required to make operational changes designed with HIM best practices in mind. Best practices relative to record retention, storage, retrieval, release of information, filing, chart deficiency, coding, abstracting, scanning and forms management need development using industry available best practices with modification for the correctional environment.
4. **Procedure Development:** Lack of standardized and well documented procedures for most of the HIM related tasks is rampant. All new staff are trained by other clerical employee creating even greater inconsistencies in processes. CPR's employment of experienced, credentialed HIM managers/consultants to scope, develop and write standardized procedures is needed. These HIM managers should then retrain all staff in each prison.
5. **Staff Training:** As more of the medical record becomes automated, higher skill levels will be required for staff supporting HIM. This is a strategic imperative that should be addressed as early as possible.
6. **Volume and Production Tracking:** Development of methodologies to track incoming workload and production completed is needed. There is very little of this occurring at present, and again, what was observed was inconsistent. There has been a significant number of additional HIM staff hired and it is not clear whether the added staff are making as significant of headway as maybe could be accomplished.
7. **HIM Automation:** At minimum, three HIM information systems will be required to augment the automation of the medical record. These include
 - a. **Document Management:** A document management strategy should be considered soon to enable scanning and indexing of key components/reports in the medical record for current inmates. Making these key documents available to TTAs and clinics inside each prison would reduce paperwork and medical record movements significantly.
 - b. **Chart tracking:** Implementing one chart tracking system and standardizing on one bar-code method will also significantly improve efficiency in R&R, clinics and TTAs, not only in HIM.
 - c. **Chart Deficiency Analysis:** A centralized system to allow the tracking of key documentation components that are not present in the patient's record and to facilitate online completion by the provider of deficiencies identified. (This needs to be coordinated with the Document Management strategy.
 - d. **Disease Registries/Chart Abstracting:** A centralized database, enabling tracking of critical "chronos" (consistently from prison to prison), chronic and communicable diseases is strongly recommended. Evaluation of the coding and classification system that should be used is

needed. These registry and abstracting systems exist in many fragmented databases, so compiling the requirements for these should be attainable. Feeding this data into the CDR should be considered regardless of the data capture methodology.

8. **MPI/Registration/Inmate Tracking (Bed Management)/Scheduling System(s):** Without these foundational, enterprise-wide applications, many of the patient care and HIM related improvements will be nearly impossible.
9. **Data and Data Flow Requirements:** The California prison system has many standard patient/clinical data requirements; however it also has many unique data requirements. Defining the standard and custom data requirements for patient identity, inmate location and health status/care needs should be accomplished quickly to ensure any automated medical or clinical applications acquired by CPR are able to support the unique characteristics of correctional facility based health care.
10. **Conduct Privacy and Security Assessment:** The privacy and security of the various data points to be captured will need to be considered as the data capture system and storage requirements are defined. For instance, understanding physical security issues for an inmate when attempting to schedule a clinic visit or outside specialty appointment is critical. Allowing clinical information to be readily available to clinicians “behind the wall” is highly needed, but must be protected to ensure correctional staff are not allowed access to the inmate’s electronic health record or data. How correctional security data is captured and stored for health care staff use must be architected carefully. And how much clinical information correctional staff are allowed access to must also be carefully defined.

Centralized dictation and transcription is not addressed as this initiative is already underway in the CPR.

Justin, these were some of the high level observations we made that were related to HIM. Each of them requires additional focused attention and there are likely areas we did not cover or catch as we weren’t focusing on HIM during our assessment.

Please feel free to comment and question!

Respectfully,

Beth Haenke Just, MBA, RHIA

HIM Overview

The Health Information Management departments (HIM) share similar functions across all the visited facilities. Core services include Unit Health Record (UHR) retrievals for patient care, UHR transfers for inmates being transferred either in and out of the institutions, release of information, loose sheet filing, coding & census for inpatient and specific outpatient treatment units and transcription of either dictated physician reports or “chronos”. Although an evaluation of the HIM functions was not the primary purpose of the consulting visit, the basic functions performed by members of this department are impacted greatly by proper identification of both the inmates and the reports contained within the Unit Health Record. Inmate or patient identification is a core building block of the existing systems, tools and processes used to provide HIM services to the institution.

Every department uses DDPS and OBIS, although access in some is quite limited with only one workstation with these programs available to the entire department. In addition Lanier dictation and CADDIS (Census and Discharge Date Information System) were used consistently, although what was tracked in CADDIS varied from prison to prison. There were two chart tracking systems observed, MEDCATS and CRIS (Complete Integrated Record System), although not all of the prisons had a chart tracking system. Both MEDCATS and CRIS include barcodes for the UHR, however it is not clear if the barcode labels are standardized so that they may be interchangeably read. The MIMAS system (Medical Writing & Chrono Tracking System) was used in two of the HIM departments to assist with chrono tracking. Although MIMAS is a helpful tool to track basic information regarding the inmates, each workstation is stand-alone so that the data contained does not link to another MIMAS workstation and is viewable to just one individual at a time. MIMAS is synchronized daily with DDPS, as are MEDCATS and CRIS. At CSP Sac, MEDCATS is updated via ARTS which has been synchronized with DDPS. CADDIS information is manually entered.

The UHR is filed in a color-coded folder in modified terminal digit order using the CDC# as the medical record number. The last two number of the CDC# are color-coded and provide the first grouping of numbers, and then the records are filed in alpha/numeric order. Records of inmates currently in residence are supposed to be located onsite. When records are missing, research must be completed in OBIS to determine where the inmate was previously housed and the records requested from that location. The outpatient and clinic record is kept separately from what is considered an “inpatient” record and identified by a different type of folder. While the UHR travels with the inmate to his new location, the “inpatient” record remains at the treating facility. This would appear to create an issue with continuity of care from one facility to the next, although portions of this record are copied and placed in the UHR. Records of inmates who have been paroled or who have fully completed the terms of their sentence and have been discharged are sent to the Army Depot Health Record storage. The records of inmates who die while incarcerated are kept locally for a period up to 10 years. Copies of these records are created and sent to Sacramento for review. The death records are housed onsite so that they are available for any legal proceedings regarding this inmate.

Staffing of the HIM departments was comprised of Health Record Technicians I and II, Medical Transcriptionists (although this position goes by the term Medical Transcriber which actually describes the machine used for transcription purposes, not the individual performing the task), and Office Assistants and Technicians. During the assessment just two professionally credentialed HIM staff, both RHIT (Registered Health Information Technician-two year degreed individuals) were encountered. No RHAs (Registered Health Information Administrator-4 year degree) were identified as being employed by CDCR. These individuals may have been considered Health Record Technician III. Coding staff members questioned indicated previous experience at local medical facilities or background in the medical billing industry. Salary levels for HIM staff members start at ~\$25,000 per year and top out for the highest classification at slightly over \$53,000. These salary levels are dramatically lower than comparable salaries within the local medical communities, especially for the technical and management positions.

A well thought through strategy for document management is needed. While scanning all of the old charts would be ill advised, a 'go forward' strategy needs some prompt consideration. There is evidence of the use of many common forms across facilities, which is a good starting point that many hospital systems lack when beginning an imaging project. There is however, a proliferation of non-standard forms in use that have been created to address facility unique needs or in answer to needs created by the various healthcare lawsuits. Bar-coding of forms is a logical step that reduces the need for manual indexing. A policy to image and make available via the network pertinent documents from the UHR as an inmate returns from parole or has a new incarceration would certainly improve availability of historical medical information to caregivers.

ICD-9 CM Coding & Census

All the correctional facilities were consistent in using the CADDIS system both to track inmates who were housed in the inpatient and outpatient treatment units within the facilities as well as those who had been admitted as an inpatient to a medical facility outside the prison. CADDIS is an MS Access database. Inmate information is manually input into the database by HIM staff. The census of each unit is tracked as a separate entity. When an inmate is transferred between treatment units, he is discharged from one and admitted to the second. There was inconsistency with the way inmates who were sent to the community Emergency Department were recorded. At one facility, the consultants were informed that whenever an inmate was absent from the treatment unit at midnight, they were considered discharged and had to be readmitted when they returned. A second facility indicated that if the inmate returned to the original unit from the outside ED by the next morning that a unit discharge was not done.

Routine ICD9 coding was done at all locations, however the information coded and the methodology used to arrive at the codes was very inconsistent. One institution indicated that they coded the admission diagnosis; another indicated the discharge diagnosis was used. Some enter just one code; others code every diagnosis available

to them. All of the facilities appear to be using out-dated ICD9 coding books. One facility was using a 1999 edition, with the most recent edition seen still a couple of years out of date.

It was difficult to understand the purpose of the ICD9 coding that is in place. The consultants were informed that the facilities code the visits to the community facilities and that this information is provided via a download from CADDIS to the HCCUP (Health Care Cost Utilization Program) and the information is used to validate the bills from the community facilities prior to payment. It was not understood how the coded data from the internal treatment units was used, nor by whom. If the data is aggregated at the Sacramento location, its validity must be questioned for the following reasons:

1. Coding practices are not consistent from facility to facility;
2. Coding is completed by staff with minimal or no coding credentials;
3. Coding resources are outdated;
4. Coding is completed only for a small portion of the prison population, negating the ability to use the coded data for disease tracking and monitoring for the larger population.

Upon questioning HIM staff regarding a Master Patient Index in one institution, the staff member responsible for coding indicated that a manual index was kept on 3x5 index cards that contained pertinent information for this inmate and each treatment episode. The card were completed by hand and stored in a small filing cabinet. Another institution indicated that they used DDPS as the MPI while a third indicated that the MPI could be printed directly from CADDIS. Unfortunately, when he attempted to do this at our request, he was unable to produce the report successfully.

Transcription

While all the facilities visited have a Lanier dictation system, the technology varied greatly in age and also in the way it was used by the physicians. Documents are transcribed using MS Word. The general impression is that transcription is staffed, but not fully utilized. Few reports were routinely dictated by the medical staff, with some of the most frequent dictators being outside clinicians who are brought in for the specialty clinics. Some of the HIM department managers are attempting to increase utilization by educating the medical staff regarding the available services. When questioned about his use of the dictation system, one medical staff member related that it was his perception it would take too long to find a phone (one wasn't readily available in the treatment room), dictate the report, wait for the results to be typed, review it for accuracy, sign it and then send it to be filed in the medical record. It was more efficient to simply write the pertinent information in the patient's UHR at the time they were being treated. It is clear that promoting use of a dictation system will require a carefully planned approach that takes these barriers into consideration.

At two sites, the medical transcriptionists were responsible for typing chronos into MIMAS (Medical Writing and Chrono Tracking System). MIMAS is again an MS Access database. Information from the various types of Chronos are typed into MIMAS which then serves as a secondary repository for this information. The information contained

on chronos are used daily by many various correctional facility staff, both medical and custody. Unfortunately, while this information is stored electronically, it is retrievable ONLY at the workstation used to input it as the system is not networked. When asked regarding the purpose of the value of using MIMAS when it was not accessible throughout the institution, the consultants were told that its use saves time as the department receives many telephone calls requesting the information stored in this system. It is less time consuming and generally more successful to look it up in the system than to try to find the physical UHR and retrieve the information from the handwritten chrono. MIMAS was also used at VSWP to track obstetrical patients. Tracking was very manual and required re-entry of data when the inmate was transferred to a community medical facility for some portion of their care and then returned to VSWP.

It is noted that CPR is investigating improving transcription services by centralizing this function. The change to centralized dictation is non-trivial. It represents a significant change in terms of the relationship between the providers and the transcriptionists. The face-to-face communication and personal familiarity that was once the norm will quickly become a thing of the past. This has been a short term dis-satisfier with other organizations that have gone through the same transition. A strong communication plan coupled with a "help desk" function will be critical to the success of the transition.

Locater Systems

As with other HIM functions, the tools used to assist with chart location are varied across the six institutions visited. There are three automated locater tools used: CRIS (Complete Integrated Record System) used at CMF, MEDCATS used at CSP SAC, VSWP and Wasco, and C-File Tracking (used by the Army Depot Health Record Center). The other two facilities, Folsom and DVI did not have an automated tracking system, but relied on manual outguide systems for record location. Both CRIS and MEDCATS use bar-coding technology, however it is unknown if the barcodes are compatible. Chart location could certainly be simplified by using standard technology along with an integrated state-wide system. It is also logical to consider standardizing the barcode technology so that the codes are compatible with the system used by the Central Records Department to track the C-files, CRAFTS (Case Record Automated File Tracking System).

Loose Sheet Filing

Keeping up with loose sheet filing has traditionally been the bane of HIM departments throughout the nation. The correctional system is no different in this regard, except for the lack of technologically advanced tools that eliminate the need for filing. Although not a primary objective of this engagement, inquiries were made regarding the volume of loose filing as this impacts delivery of care to a specific individual. Most of the departments had some sort of backlog, and were taking steps to reduce the volume. The process at VSWP in particular demonstrated innovative thinking. At this facility, those dropping off loose sheets to be filed were asked to place them in the proper terminal digit grouping – CDC#s ending 00-09 went in one bin, those ending in 10-19 in a second bin, etc. This initial sorting enables those filing to eliminate one step in their process. Common issues shared across the facilities include:

- Volume of incoming loose filing ranged from minimal to 4 feet per day. Routine volume statistics were unavailable, although some facilities were attempting to capture this important information.
- Receipt of large volumes of filing from areas that provide this information monthly.
- Lack of adequate identifier information on the loose sheet to find the correct inmate.
- Receipt of loose filing after the UHR has been transferred to another location.
- Inability to locate the UHR that should be onsite.
- Receipt of reports that belong in the C-file.

The transitory nature of the UHR contributes to the loose filing backlog, especially at the reception centers where most inmates are transferred to their mainline facility within 90 days. The backlog problem is clearly demonstrated when one looks at the history of the DORM (Discharge Offenders Record Management) system. This large scale project to image inmates' records originally included plans to image the Unit Health Record. While the scanning of UHR related documents has now been halted, approximately ~6.5M loose sheets were scanned into the system, dating back to the early 1990s. This effort was apparently undertaken as a first step in the imaging process and was to match the huge volume of loose sheets sent to the North and South storage areas with the appropriate inmates' records. Unfortunately, the lack of appropriate identifying information on the documents, including the inmate's key identifiers as well as the form identifiers resulted in minimal benefit to the delivery of healthcare. While an imaging system for the UHR likely would be a viable part of future plans for an EHR, the implementation would need to include the ability to scan current, pertinent documents from the UHR so that they are immediately available to caregivers at a different location.

Health Information Management Issues

As with the scheduling area, many of the issues common to the HIM departments center on lack of connected data and the tools with which the employees work.

- Lack of integration of the departmental computer applications causes the need for many more manual processes to be used.
- Inability to access the core systems DDPS and OBIS due to limited workstation with these programs installed.
- Small number of professionally credentialed staff means that best practices of the profession are not in common use.
- References for ICD-9 coding range in date from 1999 through 2005 editions.
- Data collection via CADDIS that has little benefit to the organization while important epidemiological issues such as chronic disease tracking are ignored.
- Severe lack of space in some institutions for HIM functions
- The practice of keeping the UHR separate from designate outpatient and inpatient treatment area records is questionable from a continuity of care perspective.

The current record retention practice of keeping hardcopy UHR volumes stored onsite at the location of the inmate puts significant demand on already crowded office space.

This contributes to less than optimal working conditions and, no doubt, contributes to high staff turnover. For example, at VSPW the active UHR's are kept in the filing area in a designated filing space. The older volumes for current inmates are kept at the other end of the department in what was once office space. Similar practices were observed at several facilities. The scanning and subsequent destruction of inactive volumes could free up significant space. There would be immediate benefits including improved working conditions for staff and reduced demands for capital construction.

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APPENDIX B: - BIDDER'S CONFERENCE

Please check the Receivership website for updates regarding this conference, including distribution of associated presentations, on April 23, 2008. (http://www.cprinc.org/projects_rfp.htm)

The bidder's conference will be held Thursday, April 24, 2008 from 1:00 - 3:30 p.m. at the Health Records Center. The Health Records Center houses the Unit Health Records (UHR) not located on-site at the prisons. The conference consists of:

- A formal presentation of the need followed by questions and answers (approximately one hour).
- A walkthrough of the health records center affording potential bidders with an opportunity to observe the records in their natural state. After the tour, a selection of the records will be briefly available for review to help bidders better understand the volume, contents and condition of the records.
- *Note: Due to patient confidentiality bidders must sign confidentiality form in order to review the patient records made available. These will be provided for signature at the time of the tour.*

The Health Records Center is located at:

Sacramento Army Depot
8300 Valdez,
Sacramento, California
Contact phone (for directions only): (916) 229-0475

Dial in information for those who will be conferencing in for the presentation and question and answer period from 1:00 to approximately 2:00.

- Call-in information:
 - Phone number: **800-895-0231**
 - Conference ID: **BIDDERS**
- The conference call will be moderated by Intercall.
 - A live receptionist who will ask callers to indicate which firm they work for, provide an email address, and indicate the number of on that line).
 - At the end of the Question and Answers the moderator will allow phone participants an opportunity to ask questions.
 - ***Note: Please call in approximately 15 minutes before the start of the conference to allow the moderator time to gather the information.***

In order to accommodate planning for the conference, please an email send by April 21 indicating the number of people anticipated to attend from your organization. Also include in the email the number of people planning to dial in so that we can be sure to reserve sufficient number of lines. We will accommodate all people who ultimately attend, but do need an estimate prior to the event.



