

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

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

January 15, 2010

California Prison Health Care Receivership

Vision:

As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

Mission:

Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and integrate the delivery of medical care with mental health, dental and disability programs.

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Section 1

Executive Summary

In closing the final reporting period for the year, there is much that prison healthcare stakeholders and advocates can showcase as accomplishments. While faced with unprecedented budget challenges and managing a diverse stakeholder process system, progress has continued toward attaining the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights of progress include the following:

- The Receiver's Medical Classification Team has finalized the classification system and Reception Centers will begin utilizing the system on January 20, 2010 with newly arrived inmates. The Non-Reception Centers are scheduled to begin utilizing this system during the 1st quarter of 2010.
- Patient-inmate access to health care has markedly improved and, through our ongoing collaborative efforts with the Department of Corrections and Rehabilitation (CDCR), we are projecting that control of the Health Care Access Units can be transferred back to CDCR as early as next fiscal year, with a target for July 2011.
- Utilization Management (UM) – Critical to successful implementation of UM is staff leadership. The lead Nurse Consultant position was filled in September by Grace Dodd. Under Ms. Dodd's leadership interviews for UM nursing consultants have been initiated. By filling these positions, we will further enhance implementation and accountability for application of the UM system.
- The new Episodic Care Processes were tested at Mule Creek State Prison in October 2009, and the results have directly contributed to the development of draft policy to be released by December 31, 2009. The rollout of the New Episodic Care System is projected for the 1st quarter of 2010.
- Following the rollout of the Primary Care Model, the Receiver's staff conducted compliance evaluations at each institution, and each achieved 100 percent compliance with implementation requirements.
- A Request for Proposal (RFP) to obtain a medical services network from a Preferred Provider Organization (PPO), as allowed under SBX4 13, was released on October 20, 2009. A Bidders Conference was held on November 12, 2009. The selection will be announced during the next reporting period.
- Medical invoice processing activity has continued to be streamlined for efficiency through the use of Third Party Administrators (TPA) and system enhancements. The Two-Year Post Audit identified billing discrepancies which resulted in recovering \$368,835 and triggered approximately \$5.6M in voluntary provider refunds.
- Significant gains have been made to meet our medical care staffing goals filling 87 percent of nursing positions and 87 percent of physician positions. (Note: Percentages have been adjusted from the prior reporting period to account for additional nursing and physician positions to be filled that were authorized in the 2009/2010 budget.)

- Quality Improvement Programs – To ensure a healthcare delivery model that is compliant, efficient and sustainable administratively and at the institutions, the Quality Improvement Program continues to lead efforts that provide for a multi-level system of checks and balances. While this report addresses all of the efforts, we highlight the ongoing audit activity by the Office of the Inspector General (OIG) and California Prison Health Care Services (CPHCS) to evaluate performance and identify opportunities to improve delivery systems; the results of the Rand study which has proposed 79 indicators to measure access to care and clinical performance, which will be incorporated into processes and systems; and the newly formed interdisciplinary Quality Management Committee charged with enterprise coordination and evaluation of the programs.
- Implementation of a pharmacy wholesaler agreement tailored to address the specific and evidentiary medical needs of patient-inmates has generated an estimated cost avoidance of \$38.9M through October 2009. This coupled with improvements in pharmacy operations, based on inspection results, and the successful rollout of the GuardianRx pharmacy operating system to 29 institutions, continues to drive policy enhancements and efficiency gains at each institution.
- Upgrades to Avenal State Prison are in the final stages of completion with staff moving to the new buildings December 2009. Construction has also been completed at San Quentin. Planning activities and legal responses for the Consolidated Care Center in Stockton are proceeding in coordination with vested stakeholders.

While we continue to make strides in many important areas that bring us closer to the goal of providing a constitutional level of healthcare within California’s correctional system, the momentum of these efforts has clearly been affected by the State’s budget and fiscal crisis. The budget and fiscal crisis is likely to continue for the foreseeable future, and the Receivership is doing everything it can to reduce expenditures without cutting into core healthcare areas. However, productivity has been impacted throughout the organization, and coupled with some staff turnover, certain projects and initiatives have been delayed in their implementation. Due to these factors, this report will reflect extensions on some of the objectives and action item dates to fulfill the goals.

Moreover, although the Administration has made some proposals to the Legislature to reduce prison population and overcrowding (in part to address the state’s budget crisis), so far, those proposals have not been fully embraced by the Legislature and none of them has yet been implemented. CDCR’s prisons remain significantly overcrowded, and the lack of adequate facility space and appropriate beds for medical and mental health purposes continues to impede efforts to improve care.

Format of the Report

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

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

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

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

RTPA Matrix

In an effort to provide timely and accurate progress reports on the RTPA to the Courts and other vested stakeholders, we are introducing a new format that provides activity status by enterprise and by institution, as appropriate to the activity and coordination.

The Enterprise Project Deployment worksheet and the Institution Project Deployment worksheet provide an illustration of the progress made toward each goal-objective-action outlined in the RTPA and the Tri-Annual Report. The Enterprise Project Deployment worksheet captures projects specifically assigned to the Receiver for broad administrative handling, analysis or testing. The Institution Project Deployment captures the status of all other activity by institution. Similar to the Percent Completed Worksheet, reporting will reflect activity that is completed, on schedule, delayed or not progressing, with corresponding dates. The Tri-Annual Report will continue to provide a narrative status report.

Due to the size of the document, the Matrix is included as [Appendix 1](#).

Section 2

The Receiver's Reporting Requirements

This is the thirteenth report filed by the Receivership, and the seventh submitted by Receiver Clark Kelso.

The Order Appointing Receiver (Appointing Order) filed February 14, 2006 calls for the Receiver to file status reports with the *Plata* court concerning the following issues:

1. All tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion of each task and metric.
2. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.
3. Particular success achieved by the Receiver.
4. An accounting of expenditures for the reporting period.
5. Other matters deemed appropriate for judicial review.

(Reference pages 2-3 of the Appointing Order.)

<http://www.cphcs.ca.gov/docs/court/PlataOrderAppointingReceiver0206.pdf>

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

Section 3

Status of the Receiver's Turnaround Plan Initiatives

Goal 1. Ensure Timely Access to Health Care Services

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation.

This Action has been completed.

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

The Reception Center redesign is planned to occur after completion of Action 1.1.3 in January 2010. Re-evaluation of the reception center processes, established in Action 1.1.1, and statewide implementation of the new processes at each of the major reception centers is expected by January 2011.

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

During this reporting period, the Medical Classification System was finalized, including approval of the policy and the Medical Classification Chrono; system training of key staff; and preparation of Local Operating Procedures by Institutions. On January 20, 2010, all Reception Centers will begin using the Medical Classification System on all newly arrived inmates.

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

Non-reception center institutions will begin using the Medical Classification System during the first quarter of 2010. The Regional Leadership Teams will then begin assessing institutional compliance with the system.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on healthcare access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution.

This Action has been completed.

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

Health Care Access Units (HCAU)

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

Collaborative Efforts

The Corrections Services Field Operations Unit worked extensively with CDCR to reach a consensus regarding a sufficient number of additional HCAU custody staff to adequately provide access to care. These efforts sought to increase efficiencies, in view of the current fiscal issues in California, while satisfying the remaining access to care custody staff resourcing at the 33 CDCR adult institutions. This consensus with CDCR, which included a substantial increase in the number of proposed HCAU staffing from CDCR's original custody staffing reviews, was reached in October 2009.

Corrections Services continues to collaborate with CDCR mission changes and in the implementation of the short, intermediate and long term bed projects. Corrections Services continues to work with CDCR and the adult institutions to ensure that healthcare operations are not interrupted.

The Receiver is continuing to work with CDCR by reviewing operational processes and staffing resources to ensure that together healthcare in prisons is safe, efficient, patient-centered, timely, efficient and equitable.

Operational Assessments

To facilitate this process, an accelerated schedule for conducting Institutional Operational Assessment reviews has been developed.

Previously, institutions were scheduled to have the Operational Assessment reviews completed by June 2010. In order to ensure the assessment instrument adequately measures intended objectives, the process review completion timeline has been extended to December 2010. Although much work remains, overall healthcare access at the institution level is on track to meet this goal.

Monthly Health Care Access Quality Report (AQR) - Data Collection Instrument

During this reporting period, AQR data stabilization continued along with the overall coordination of custody and clinical staff in an effort to track patient-inmate movement to

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

healthcare services. September's AQR indicated 90 percent of all patient-inmates that received ducat(s) for a healthcare appointment(s) were seen by a clinical provider. Specific to custody performance, the number of inmates *Not Seen Due to Custody* represented 1.24 percent of the total number of ducats, slightly lower than 1.3 percent recorded in [June 2009](#).

Updates to the AQR during this reporting period, include the addition of Personnel Post Assignment System (PPAS) Timekeeper's Monthly Overtime and Expenditure Report information. The new data elements record the hour and dollar figures under billing codes .08 - Medical Costs (Med Guarding), and .16 - Medical Transportation, costs that are billed to the Receiver.

The addition of those PPAS data elements and results from the testing phase for the input of AQR data into COMPSTAT necessitated further modification of the COMPSTAT data collection tool. AQR and COMPSTAT staff continues to work toward the goal of integrating the report into COMPSTAT within the coming months.

Corrections Services Field Operations Unit has established quarterly meetings with the Division of Adult Institutions, Associate Directors. On the agenda for these meetings are AQR trends, changes and updates, as well as discussions and development of other Field Operations functions and their association within elements of the DAI.

Refer to [Appendix 2](#) for the Executive Summary and Health Care Access Quality Reports for September – November 2009.

Buses

From April 2009 through September 2009, ten (10) buses for patient-inmate transportation were distributed statewide. Efficiencies will include a reduction in the number of medical transports and backlog appointments as a result of up to 21 inmates per trip traveling to specialty appointments. Additionally, the buses allow sister institutions (HDSP/CCC) (CTF/SVSP) to utilize the same providers and batch the appointments together to make a more efficient process for both CDCR and the providers.

The Emergency Response Vehicle prototype has been completed and delivered to Avenal State Prison to complete a 4-month pilot of the unit. The Emergency Response Committee will be including the overall effectiveness of the unit into its evaluation process. All modifications will be addressed through that committee and the Corrections Services Unit. At the conclusion of the pilot, the department will assess the effectiveness, cost and purchasing of additional vehicles for all institutions.

Fair Labor Standards Act (FLSA) Validation

Since Fiscal Year 04/05, Medical Guarding and Transportation expenses have increased at a rate of approximately 48 percent each year. In order to determine the cause for increase and validate Medical Guarding and Transportation expenses, Corrections Services began FLSA validation at all CDCR institutions in December 2009. The FLSA validation process includes a review of

FLSA's and other billing documentation to validate overtime and temporary help expenses charged to CPHCS for 5 separate points in time at all 33 institutions. Target date for completion is March 31, 2010. The FLSA validation process will assist in confirming expenses charged and custody resources needed as part of fully implementing the Health Care Access Units.

Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System

Action 1.3.1. Work with CDCR to accelerate the development of the Strategic Offender Management System with a scheduling and inmate tracking system as one of its first deliverables.

A centralized system for the scheduling and tracking of healthcare appointments, coordinated with all other appointments for patient-inmates, is an essential element of providing timely access to care. General offender scheduling and movement control within the 33 existing CDCR prisons and the planned new long-term healthcare facilities will be handled by the Strategic Offender Management System (SOMS). SOMS will include four informational components for each offender that is critical to the success of the prison healthcare system: a unique lifetime identification number; demographic information; continuous real-time location; and a comprehensive master schedule and scheduling prioritization protocol.

After the decision in summer 2009 to incorporate the healthcare scheduling functionality into SOMS, a CPHCS team of Subject Matter Experts from all areas (Medical, Nursing, Mental Health, Dental, Allied Health and Telemedicine) participated in a series of requirements definition and validation workshops. The result of these sessions culminated in the Electronic Offender Management Information System (eOMIS) Prototype and the General System Design Document which will be the foundation for the development of the healthcare scheduling system.

In conjunction with the system design activities, efforts to plan for deployment, change management, training and communication have begun. The deployment of the system will occur in phases, with the three women's institutions going first in July 2010. After a stabilization period, the roll-out will proceed to men's institutions that currently do not use technology for scheduling and then on to the remaining institutions. Roll-out of healthcare scheduling to all institutions is scheduled to be completed by the end of 2011.

Change management and training activities have been initiated beginning with the documentation of the future state business processes for scheduling, utilizing the new system. These baseline documents will provide for the development of training and user acceptance testing materials. They also serve to determine the gap between current practices and future practices in the scheduling process, thus allowing the change management team to assess the effort that will be required for training of the end users.

Communication activities included an article in the *Lifeline* newsletter and an overview PowerPoint presentation for statewide distribution and participation of the project team in various statewide calls. Feedback on the system received to date has been overwhelmingly positive.

During the next few months, planning activities for the new scheduling systems will continue on multiple fronts. By growing the project team and assigning dedicated leads for change management, deployment, infrastructure and training, CPHCS will ensure that the deployment of the new scheduling system will be a success.

Objective 1.4. Establish a Standardized Utilization Management System

Action 1.4.1. By May 2010, open long-term care unit.

As of October 30, 2009, the California Medical Facility Outpatient Housing Unit (OHU) Section 6.00 funds were approved by the Department of Finance authorizing the Department to use Inmate Labor to proceed with this project. Section 6.00 of the budget act allows support money to be utilized for construction projects. The scope of this project is to convert a 200 man dormitory into a 72 bed Outpatient Housing Unit. The construction adds exam rooms, nurse's stations, medication and general storage rooms, and an additional staff restroom. These additional OHU beds will be used to reduce the number of aberrant bed days that CDCR is currently encountering. Aberrant bed days are the days an inmate remains in a community hospital, discharged, awaiting placement back into a correctional institution. The cost of one discharged inmate in a community hospital bed is estimated at \$4,052 per 24 hour period. This cost includes guarding and administrative fees. The OHU project is estimated to save \$27 million per fiscal year.

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

To maximize the impact of the Utilization Management (UM) department, clinical activities are field coordinated rather than centralized. By directly coordinating with institutional leadership, we are providing a reporting mechanism that drives accountability at the institutional level for oversight of the specialty referral activity, institutional bed occupancy and community hospital utilization, while maintaining enterprise coordination through the regional offices and headquarters.

Current central components of the UM department include:

- Oversight of specialty referral management – implementation was completed in June 2009 and continuous quality improvement activities are ongoing.
- Oversight of institutional bed availability – regular infirmary bed rounds occur in 2/3 of the regions and the Northern Region bed rounds are planned for early 2010.
- High volume community hospital bed management – hospital rounds with attending staff at high census hospitals to monitor appropriate utilization and discharge scheduling are ongoing.
- Telemedicine referral policies and processes – as the capacity of institutions to expand telemedicine services increases, transition of services from off-site to telemedicine will begin.
- Case Management of high cost, high risk patients with institutional staff, beginning with hospital case management.
- Education and outcomes reporting to Headquarters and Regional Leadership.
- Development of guidelines and assessment of new technology.

UM continues to participate in the activities below:

- Claims Third Party Administrator (TPA) Payment System
- Development of a Claims Based Medical Outcomes Reporting Library
- Network Initiatives to Improve Specialist and Hospital Coverage
- Contract Initiatives to Improve Specialty Coverage in key areas and specialties

The Nurse Executive position has been hired, and, under her leadership, interviews for regional UM nursing leads have begun. Supervisory case management should commence in early 2010. This staff will be responsible for the mentoring, monitoring and training of the institutional nursing staff. Institutional bed management, community hospital discharge and case management training are planned. Their goals will be optimal institutional OHU and Correctional Treatment Center (CTC) vacancies, and the oversight of timely care and discharges of the acute community hospitalized patients. The UM nursing teams will be field based, and work in collaboration with the Physician Advisor teams. Once hospital case management is mastered, and patient data sources are developed, individual patient and patient population case management will be introduced.

As CPHCS refines its plans regarding placement of inmates in institutions that are appropriate for their medical and nursing needs, UM departmental activities will include the identification and transfer of sicker, high cost patients to those institutions close to effective specialist networks and quality hospitals with efficient care and locations. It has been shown that a small percentage of high acuity patients generate a large proportion of potentially avoidable medical costs (588 high acuity patients generated over \$139M in medically related costs, according to claims information from FY 2008/2009). By placing these patients, as resources permit, in institutions with closer proximity to medical resources, it is anticipated that some of the transportation, guarding and transfer costs for care can be mitigated.

Goal 2. Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services

Objective 2.1. Redesign and Standardize Access and Medical Processes for Primary Care

Action 2.1.1. By December 2009, complete the redesign of episodic care processes, forms, and staffing models.

This action has been completed.

A test of the new Episodic Care Processes and forms began in Facility A at Mule Creek State Prison in October 2009. The test was successfully built on the structures and processes established by the Primary Care Model. Redesign of the CDCR 7362 “Health Care Services Request Form” was completed. The draft policy based on the redesign and the test site experience was completed by December 31, 2009.

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

Roll-out of the new Episodic Care System to all institutions is anticipated for the first quarter of 2010. It is anticipated that the system will be implemented at all institutions by July 2010.

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

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

This action has been completed.

The Primary Care Model was implemented at all institutions during the previous reporting period. During this reporting period, each institution was evaluated by an on-site compliance evaluation team using a standardized methodology. All of the 33 institutions achieved 100 percent compliance with the implementation of the Primary Care Model.

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

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

This Action has been completed.

Action 2.3.2. By July 2009, develop and implement certification standards for all clinical staff and training programs for all clinical and custody staff.

This Action has been completed.

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

This Action has been completed.

Objective 2.4. Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality

Action 2.4.1. By June 2009, establish standard utilization management and care management processes and policies applicable to referrals to specialty care and hospitals.

This Action has been completed.

Specialty Referral Management and InterQual Outcomes

Areas of operational focus that continue include:

- Institutional compliance with UM processes and policies;
- Reduction of medically unnecessary referrals so that access to specialty care is optimal;
- Monitoring of backlogs and compliance with processing timelines, especially in specialty areas where network access challenges exist;
- Audits for over utilization and potential under-utilization;
- Ensuring physician and nursing inter-rater consistency in clinical decisions.

Outcomes

Specialty referral outcomes have met the Receiver’s goal of 100 Referral for Specialty Services per One Thousand Inmates (RFS/K*) as illustrated in Table 1.

Table 1

RFS total		North	South	Central	Statewide	RFS/K*
Baseline FY 08/09						25,000
April	2009	4,525	6,674	10,023	21,222	137.19
May	2009	3,479	5,647	7,482	16,608	104.38
June	2009	3,578	4,978	8,124	16,680	109.67
July	2009	4,905	4,245	6,600	15,750	102.89
August	2009	3,875	3,708	6,477	14,060	92.46
September	2009	3,811	4,018	6,869	14,698	98.15
October	2009	3,995	4,131	6,933	15,059	97.85
November	2009	3,261	3,549	5,629	12,439	81.19

Ongoing on-site audits continue to be performed by the UM staff to ensure that denials are not “overdone” and that decreasing utilization is medically safe and appropriate.

Challenges and Threats

Personal, direct and continuous UM physician advisor and nursing support continues to be essential to sustain the improvements achieved. As these processes are relatively new to

CPHCS, leadership continues to engage staff in change management activities to ensure both continuity and sustainability for improved handling of Specialty Care and Hospitalization.

SBx4 13 has produced some volatility in specialty network coverage, particularly in key surgical specialty areas. Procedures to monitor access and availability are being developed, in cooperation with Regional Leadership teams, and will be a priority so that timely information regarding the need for alternative access strategies can be communicated and managed.

Infirmiry/Community Hospital Bed Access

A statewide and institutional census reporting system and daily monitoring of hospital and institutional census bed occupancy began in October 2009.

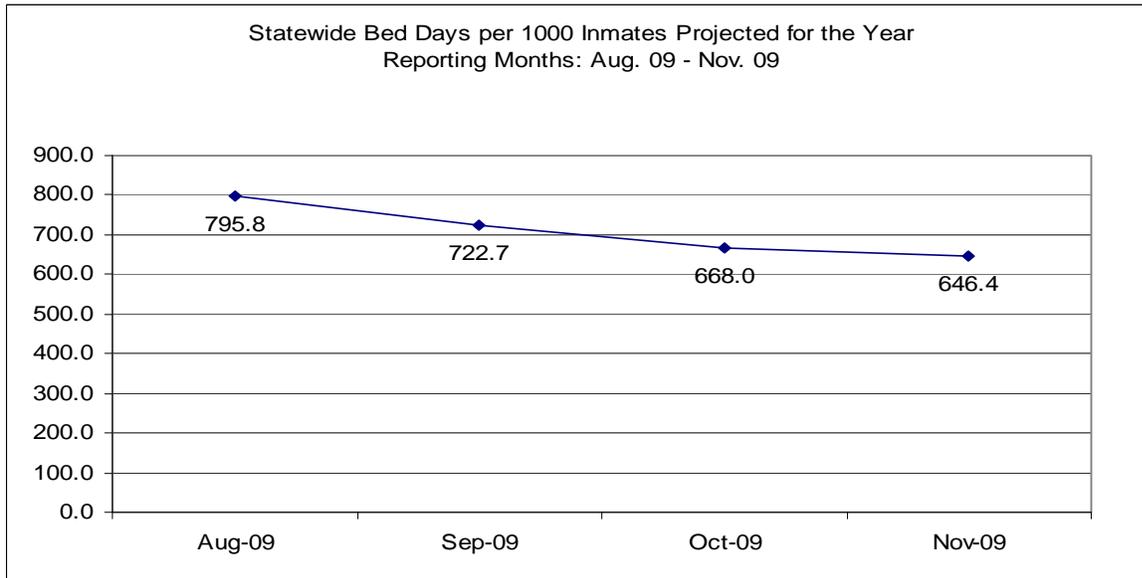
Regular clinical rounds on patients in institutional infirmiry beds and high volume community hospital beds are required and institutional compliance will be monitored.

While improvements in patient transfers and institutional bed vacancies have resulted, significant challenges continue. Hospital aberrant bed days (patients who have no clinical reason to stay in the hospital, but have no suitable, safe destination to return to) remain. Until enough additional beds are available, so that all hospitalized patients can return to safe institutional beds in a timely fashion, optimal hospital utilization outcomes will not be possible and unnecessary hospital days will continue to accrue and add to medical costs.

Table 2.

Community Hospitals							
Institution	Total Admits	Total Discharges	Total Census Days	Average Daily Census	Average Length of Stay	Inmate Population	Bed Days per 1000 Inmates Projected for the Year
STATEWIDE TOTALS							
Sep-09	1,107	1,129	9,206	302	8.32	152,870	722.7
Oct-09	1,027	1,060	8,567	261	8.18	153,906	668.0
Nov-09	1,004	995	8,253	275	8.22	153,203	646.4

Table 3.



Community hospital lengths of stay reflect both a high acuity patient population and lack of institutional beds that patients can return to. While the situation is not amenable to significant improvement until additional institutional beds are available, the UM team has begun clinical monitoring of patients at 10 of the top high volume hospitals, statewide, so that the hospital census can be managed to the maximum degree possible under the current circumstances. Daily census review and collaborative discharge planning efforts with hospital case management are ongoing.

In addition to the root causes of high community hospital utilization described above, it has been found that other drivers of utilization that can be improved are common. These include: unaligned incentives to discharge promptly among community hospital attending staffs, lack of hospital case management and discharge planning, and some institutional inattention to community hospital patients.

Daily concurrent rounds at high volume hospitals are now conducted by the UM physician advisor staff. Institutional responsibility for tracking their community hospital patients and maintaining telephonic access with their high volume community hospitals and attending staffs will be mandatory. IT links to hospital medical records departments for institutional tracking of patient progress are being developed.

As UM impact on hospital bed utilization increases, benchmarks for hospital bed utilization will be established and monitoring of institutional performance will begin, similar to the process used to manage referrals.

Case Coordination

Reports have been developed to identify the top high cost patients, statewide, who generally represent the highest acuity medical patients, at risk for frequent hospitalizations and multiple specialty referrals. The team has implemented processes to identify these patients and, through Regional leadership, share them with institutional clinical staff. The initial goal is to improve continuity of care and access to coordinated specialty care. While it is not known what impact improved clinical case coordination of these patients care could have on costs, it is intuitive that coordinated. Care coordination would mitigate lapses in continuity of treatment, and facilitate better primary care communication with outside specialists. Many of these patients are located in remote areas and would benefit from transfer in the future, as resources expand, to locations with expanded specialty and hospital coverage.

Telemedicine

Standardized referral review processes, using InterQual, have been implemented for all initial telemedicine requests. Working with the telemedicine team, additional analysis to determine which specialty areas would benefit from additional telemedicine access is planned (see Objective 5.5 for more information). It is hoped that a shift from off-site specialty referrals to on-site telemedicine referrals, as telemedicine space/equipment capacity grows, will result in additional cost avoidance for transportation and guarding, and result in improved access to care.

Referrals for Specialty Services

The following are charts that contrast the total referrals for specialty services (RFS) generated vs. the total RFSs run through the InterQual system for the northern, central and southern regions during the September 2009 through October 2009 timeframe (See Tables 4, 5 and 6 below). This program requires all RFS's to be run through the InterQual system. While the majority of RFS's are captured in this report, the following contribute to reporting exceptions: 1) the ratio between total referrals and InterQual data is closely related to system training needs and delayed reporting, captured in the following month; and 2) the difference in volume of RFS referrals is related to a number of factors including patient acuity mix, specialty network practices and requests, provider familiarity with UM processes, provider staff turnover, strength of the institutions primary care model, and the acuity of physician reviewer oversight. (Note that these differences mirror referral practices in the civilian sector.) As UM becomes more engrained into institutional processes and reviewers gain familiarity with the InterQual system, we anticipate minimal differences among the regions.

Table 4

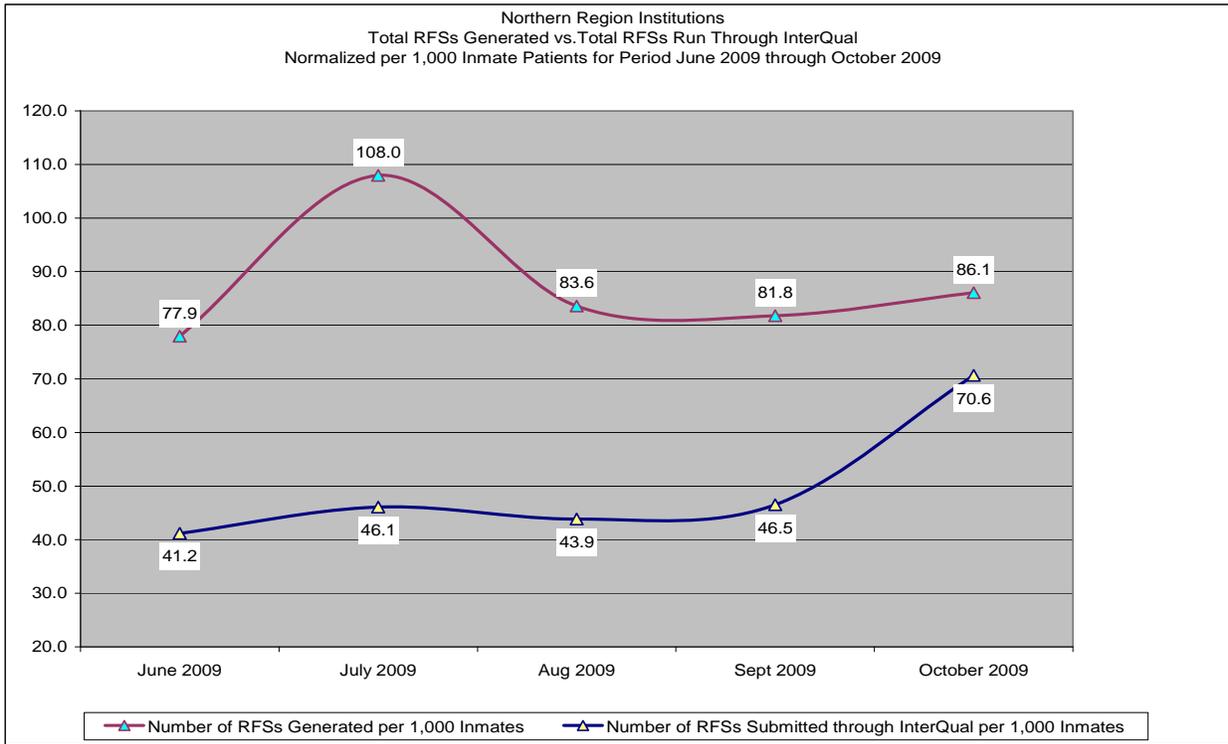


Table 5

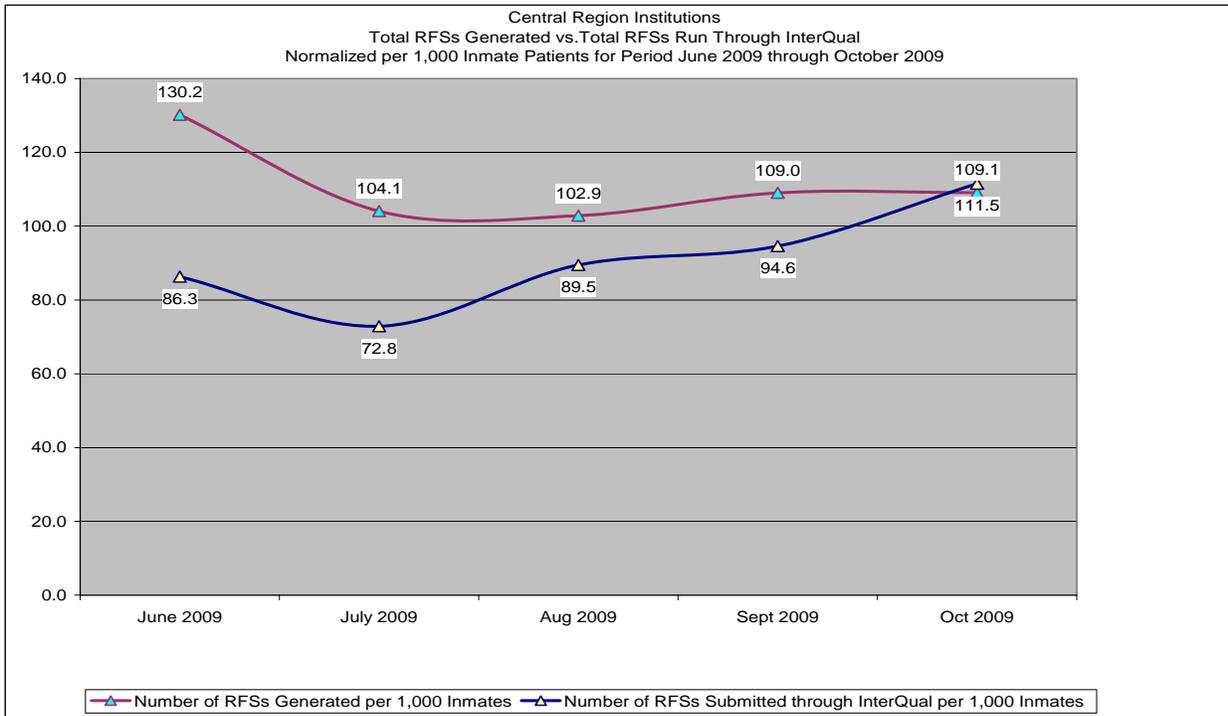
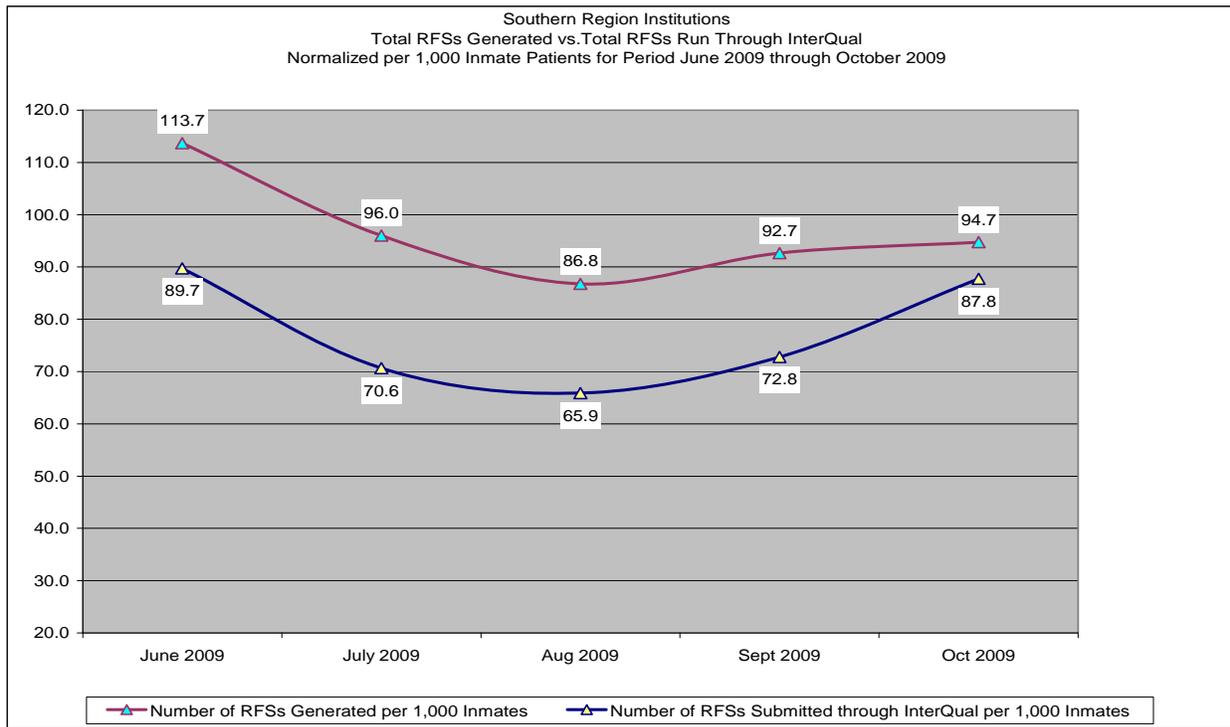


Table 6



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

This action item is ongoing. Progress during this reporting period is as follows:

ProdÁgio Contract Processing System

Implementation of an upgrade to an automated contracts process system is scheduled to take place in January 2010. This upgrade will deliver enhanced processing features including auto-filing of contract documents, and an analyst time-tracking feature. This additional functionality will aid in effective contract processing until CDCR’s Business Information System (BIS) system is implemented for direct medical contracts (see “CDCR’s BIS Integration” below). A number of medical contract staff participated in Train-the-Trainer and User Acceptance Testing of the upgrade features in December 2009.

CDCR’s BIS

CPHCS is continuing its participation in work groups and demonstrations organized by the CDCR BIS Team. In addition, CPHCS will begin the process of defining how Medical Contracts will integrate BIS into its business process.

Streamlining Medical Contracting and Aligning Resources to Achieve Performance Goals

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

to care. From August 17, 2009, through December 9, 2009, 100 new negotiated contracts and 20 amendments to negotiated contracts were executed for hospitals and specialty physician services. In addition, competitive bid efforts initiated in the previous reporting period resulted in 36 competitively bid contracts and 18 amendments to competitively bid contracts for a variety of services.

The Request for Proposal (RFP) to obtain a medical services network from a PPO, as allowed under the new legislation (SBX4 13 which amended Penal Code section 5023.5), was released October 20, 2009. The Bidder's Conference was held on November 12, 2009. The selection will be announced during the next reporting period.

During the reporting period, CPHCS Medical Contracts initiated or completed the following contract negotiations with ambulance providers: ten in the Northern Region, two in the Central Region, and seven in the Southern Region. A total of 24 ambulance contract negotiations were initiated and 19 ambulance contract negotiations were completed. There were seven invitations to bid advertised and two bid openings during the reporting period.

Medical Contracts continues to work closely with the Receiver's Emergency Medical Services Liaison, county Emergency Medical Services throughout the state, and ambulance associations and providers to enhance customer relations and emergency medical contract processes.

Hospital Rate Negotiations

Since the passage of SBx4 13, staff has successfully negotiated statutory rates (including the exempted administrative days) with 24 hospitals. Thirty nine (39) contracts have been executed with hospitals that have agreed to the new rate structure. Only one long term hospital partner, Community Regional Medical Center in Fresno, has discontinued service due to the lower rates. However, there are a couple of hospitals, including the three University of California (UC) hospitals, which are continuing to see patients without a contract in place at the non-contracted rate of 100 percent of Medicare. While concerns about the rates have been raised by these hospitals, CPHCS will continue to work with the providers to execute service contracts at the statutory rates stipulated in SBx4 13 to ensure a consistent and equitable rate of reimbursements for services rendered by agreement/contract for all providers. See [Appendix 3](#) for the California Hospital Map, a color coded map indicating coverage throughout the State.

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

Medical Invoice Processing Days

During this reporting timeframe, the number of invoices processed per day has increased. This has resulted in a decrease in the number of invoices waiting to be processed. With that, we expect to see a decrease in overall days to process in the first quarter of 2010. Due to the transition of a subset of the invoices to the TPA as discussed in the next section, metrics on both areas will be reported in the next Tri-Annual Report to the Court.

Contract with the Third Party Administrator (TPA)

The full transition of claims submitted on industry standard forms (hospital, physician, and ambulance) to the TPA began on October 5, 2009 for dates of service September 1, 2009 forward. The electronic interface between the TPA, BIS and the State Controllers Office is successful and working smoothly. The average days to process for the TPA claims will go live January 7, 2010.

The eligibility interface between the TPA and the Offender Based Information System is expected to go live in early 2010. This will reduce the TPA processing time by several days. Additionally, a Provider Web Portal, that will allow providers to access their explanation of benefits information directly, will be included with this interface. This will help reduce operations workload further by shifting payment inquiry research to providers through this portal.

Two-Year Post Audit

Viant has performed their audit of the two largest laboratory providers and their initial findings will be presented to staff in January 2010. In addition, they continue to contact providers for recovery based upon their findings of duplicates and hospital bill audits. As of December 8, 2009, their recovery effort has netted \$368,825 in refunds. Their payment for this effort is 27 percent of that amount. In addition to Viant's recovery efforts, as of December 8, 2009, staff has received approximately \$5,647,671 in voluntary provider refunds. These voluntary refunds are in part due to staff identifying duplicates and overpayments as part of their data cleanup and have been contacting providers directly for refunds. In addition, providers are sending duplicates and overpayments back to balance their Accounts Receivable due to their knowledge of the audit.

TPA/Contract Medical Database (CMD) Interface

The TPA to CMD interface workgroup has adopted system requirements and has met regarding initial design and development of that interface. The interface will push down utilization and expenditure data from the TPA into the CMD. This is necessary to be able to accurately report on the effect of the cost containment initiatives as well as prepare for contract medical budget projections. This interface (Phase 1) is expected to roll out by the end of February 2010. The second phase of this project will be to expand the data elements not currently collected by CMD to include clinical line item detail.

Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1 Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

Action 3.1.1. By January 2010, fill 90% of nursing positions.

As of November 30, 2009, which is the most recent reporting period available, approximately 87 percent of the nursing positions have been filled statewide (this percentage is an average of six State nursing classifications). It should be noted that while there is a decrease in the percentage of filled nursing positions since the 12th Tri-Annual report, this is due to the fact that an additional 58.8 nursing positions were authorized in the 2009/2010 budget and are reflected in the November Human Resources Recruitment and Retention Report, adjusting the percent comparison.

More specifically, the goal of filling 90 percent of the Registered Nurse (RN) positions has been achieved at 18 institutions (54.5 percent of all prisons). Eleven institutions (33.3 percent) have filled 80 to 89 percent of their RN positions. The goal of filling 90 percent of the Licensed Vocational Nurse (LVN) positions has been achieved at 15 institutions (45.4 percent) and 14 institutions (42.4 percent) have filled 80 to 89 percent of their LVN positions. Twenty-two institutions (66.6 percent) have achieved the goal of filling 90 percent of their Psych Tech positions. Four institutions (12.1 percent) have filled 80 to 89 percent of their Psych Tech positions.

The following hiring-related initiatives continued during the reporting period: (1) focused recruitment continues statewide for LVNs and Psych Techs; (2) presentations at nursing schools statewide; and (3) online job postings. Nursing vacancies are posted on multiple websites including: www.ChangingPrisonHealthCare.org, www.Indeed.com, www.VetJobs.com, and several more. Each job posting often represents multiple vacancies at an institution. Additionally, staff recently negotiated a contract with www.Monster.com for job postings on that site. Staff has been assigned to monitor vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

At the following institutions: Richard J. Donovan Correctional Facility, California Correctional Institution, Wasco State Prison, Pleasant Valley State Prison, and California State Prison, San Quentin, nursing has experienced moderate turnover (11 to 19 percent) and moderate vacancies (11 to 30 percent vacant) as displayed in the Nursing Filled Percentage and Turnover Rate map in the November Human Resources Recruitment and Retention Report. A moderate vacancy rate (11 to 30 percent) exists at Chuckawalla Valley State Prison, California Men's Colony, Kern Valley State Prison, North Kern State Prison, Correctional Training Facility, California State Prison Corcoran, Substance Abuse Treatment Facility, Valley State Prison for Women, Sierra Conservation Center, Deuel Vocational Institution, California Medical Facility, and Pelican Bay State Prison. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September, October, and November 2009.

These reports are included as [Appendix 4](#). Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: (1) Physicians Filled Percentage and Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

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

Physician recruitment efforts continued to focus on “hard-to-fill” institutions during the reporting period. Most urban institutions have now hired their full complement of primary care providers. As of November 30, 2009, approximately 87 percent of physician positions are filled (this percentage is an average of all three State physician classifications). More specifically, 94 percent of the Chief Medical Officer (CMO)/medical executive positions are filled; 80 percent of the Chief Physician and Surgeon (P&S) positions are filled; and 87 percent of the P&S positions are filled. Eighteen institutions (54.5 percent) have achieved the goal of filling 90 percent of their P&S positions; 15 of these institutions have filled at least 95 percent of their P&S positions. Six institutions (18.2 percent) have filled 80 – 89 percent of their P&S positions. It should be noted that while there is a decrease in the percentage of filled P&S positions since the 12th Tri-Annual report, this is due to the fact that an additional 12.5 P&S positions were authorized in the 2009/2010 budget and are reflected in the November Human Resources Recruitment and Retention Report. While the Central Valley region, along with High Desert State Prison, Pelican Bay State Prison, and Chuckawalla Valley State Prison continue to be “hard-to-fill,” P&S hires have been made at the Substance Abuse Treatment Facility, High Desert State Prison, Chuckawalla Valley State Prison, California Correctional Institution, and California State Prison, Corcoran. Of special note, California State Prison, Corcoran has now filled 96 percent of their P&S positions.

Job postings continue to be placed online at the Department’s recruitment website, other online job boards, and recruiters continue to visit residency programs and other recruitment events. Additionally, staff has drafted a RFP for physician and executive search services. These services would be used to assist with staffing the “hard-to-fill” institutions.

A high vacancy rate (50 to 55 percent) and turnover rate (33 to 40 percent) exist at Pelican Bay State Prison, Salinas Valley State Prison, Chuckawalla Valley State Prison, and Avenal State Prison, as displayed in the Physicians Filled Percentage and Turnover Rate map in the November Human Resources Recruitment and Retention Report. A high turnover rate (16 to 33 percent) also exists at High Desert State Prison, Central California Women’s Facility, California Men’s Colony, Ironwood State Prison, and California State Prison, Los Angeles County. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September, October, and November 2009. These reports are included as [Appendix 4](#). Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: (1) Physicians Filled Percentage and Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

Objective 3.2 Establish Clinical Leadership and Management Structure

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

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

The Chief Executive Officer (CEO) examination was launched on December 24, 2008. Since the exam commenced, 339 CEO eligible applicants have been added to the certification list and four hires have been completed. Due to the severity of the State's fiscal crisis, the Department of Personnel Administration (DPA) has approved a reduction in the salary structure for the CEOs to more closely approximate that of the institutional wardens; however, a differential for hard to recruit or high cost areas and the performance incentive features were retained as additional means of compensation. The pool of CEO candidates is very competitive and interest remains high.

Strategically, CEO positions will be filled statewide and these individuals will then play a pivotal role in establishing the remainder of the clinical leadership structure. The interview and hiring process for all CEO positions is underway, and several hires are pending.

The Receiver's Nurse Executive examination was launched in September 2008. Since the examination commenced, 247 Nurse Executive eligible applicants have been added to the certification list and nine Nurse Executives have been hired.

The Receiver's Medical Executive examination was launched in December 2008. Since the examination commenced, 83 Medical Executive eligible applicants have been added to the certification list and nine Medical Executives have been hired.

On September 3, 2008, the State Personnel Board (SPB) approved a fourth Receiver's Career Executive Assignment (RCEA) classification, entitled Clinical Executive that is intended for the chief and assistant chief responsible for all licensed allied health disciplines. The civil service examination for this classification was released on November 4, 2009, and DPA has issued the pay letter. An organizational structure has been approved by CPHCS executive management and recruitment is in progress for five of the listed specialties: rehabilitation, laboratory, radiology, respiratory, and dietary services.

A fifth RCEA, Receiver's Health Care Administrator, that will be responsible for all medical administration subject areas that are not clinical in nature, is scheduled for approval by SPB on December 17, 2009. Prior to filling jobs covered by this classification, a salary study must be conducted and salaries approved by DPA.

In an October 2009 hearing, CPHCS staff reported to the five member SPB on the status of the delegation for the establishment of CEA positions. Staff noted that the delegation did not reduce the time or paperwork needed to establish CEAs. Given that the number of new CEA requests has diminished significantly, CPHCS staff requested that the delegation agreement be discontinued. Additionally, CPHCS currently has an arrangement with DPA whereby CPHCS

funds a position that is dedicated solely to CPHCS workload. This arrangement will be assessed on a continual basis to determine the ongoing need.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2010, establish statewide organizational orientation for all new health care hires.

Status of New Employee Orientation and Training

Health Care New Employee Orientation (HCNEO) was placed on hold regionally with the exception of Headquarters during February 2009. During this time CPHCS employees in the field (institution and regional) were directed to attend the local institution IST NEO until the statewide re-implementation could be coordinated. A recent audit, however, identified a large number of healthcare new hires who had not attended any orientation. The primary issue of inconsistency with the IST NEO from one institution to the next was instrumental in the development and roll-out of the HCNEO curriculum. The program will begin in January 2010 at the institution-level for all healthcare staff to include Medical, Dental, Mental Health, and support staff located in the field; and the curriculum is consistent statewide. Headquarters staff continues to receive training on a monthly basis in the greater Sacramento area. In addition, portions of the training continue for out-of-state patient-inmate providers via a computer-based training program. Success of this overall program relies heavily upon collaboration with CDCR and CPHCS staff locally and at Headquarters. The next tri-annual report will provide an analysis of how the training is being implemented and received.

Status of the Proctoring/Mentoring Program

Implementation of a proctoring/mentoring program was put on hold at the end of February 2009. The plan for proctoring and mentoring is being revised so that fewer resources are required to implement and maintain.

Action 3.3.2. By January 2009, win accreditation for CDCR as a CONTINUING MEDICAL EDUCATION provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education.

This action has been completed.

During this reporting period, the Continuing Medical Education (CME) courses (listed below) were conducted for a total of 40 sessions at various institutions throughout the department. These sessions were provided to 195 MDs and 247 non-MDs for a total of 3,354 hours of instruction.

- 2009 Program Guide Training (Mental Health)
- Advance Directives

At this time, the following eight CME courses are in various stages of development, review, approval and/or implementation.

- CPHCS Pain Management Guidelines
- Low Back Pain / Acute Joint Pain

- Do Not Resuscitate / POLST
- Diabetes
- Mental Health Assessment and Referral Project Training
- HIV Medicine for the Primary Care Provider
- CPHCS HIV Update 2009-2010
- Introduction to the MHSDS for Medical Staff

As a continuous effort to improve inmate-patient healthcare, the Office of Professional Education and the CME Committee continue to work with other programs to assess the educational needs of CPHCS/CDCR clinicians. To fully embrace the multi-disciplines within CPHCS/CDCR, in addition to physicians and surgeons, the CME Committee includes representatives from mental health, dental and nursing.

Goal 4. Implement Quality Improvement Programs

Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program

Action 4.1.1. By July 2011, establish sustainable quality measurement, evaluation and patient safety programs.

During this reporting period, RAND completed their in-depth analysis of correctional and free world health system quality measures. In October 2009, the principal investigators presented their findings to CPHCS executives. The final 79 performance measures, selected by a panel of national experts, were a mix of process and outcome measures that were virtually all based on evidence from research and/or accepted national standards (e.g., HEDIS measures). The Measurement and Evaluation Unit will focus analysis on outcome performance measures because of their immediate impact upon the health of our patients and the resources needed to care for them. The Unit will work with clinical leadership to embed the outcome measures into clinical guidelines and other decision support tools; professional development and training programs; and patient self-management tools. The intended result will be reduced patient morbidity and mortality and reduced resource burdens statewide.

The Measurement and Evaluation Unit also continued the development of a data collection and reporting infrastructure to support their analysis of outcome indicators. This included support for the Clinical Data Repository (CDR) and the development of accurate medical chart review capacity and methodologies. With this infrastructure in place, the primary care teams and management will be able to be more efficiently inform patient care. Unit staff continued their support of clinical staff in the implementation and evaluation of several system-wide initiatives. One example was the full implementation of the primary care model to all 33 institutions. Complementing these initiatives was a request by executive leadership for the Unit staff to lead a high priority data validation study on a number of “access to healthcare” measures. The findings from this study will be used to improve patient health oversight and prompt the refinement of the department’s data collection procedures.

Action 4.1.2. By July 2009, work with the Office of Inspector General to establish an audit program focused on compliance with Plata requirements.

This Action is divided into two phases. Phase I included program development and pilot implementation, and Phase II included statewide roll-out and implementation. Phase I is complete and Phase II is well underway.

As of the close of this reporting period, the OIG has completed five additional inspections at High Desert State Prison, California Correctional Center, North Kern State Prison, Kern Valley State Prison, and Folsom State Prison, respectively. The first year inspection results will establish a baseline that will provide an objective, clinically appropriate method to evaluate and monitor the progress of medical care delivery to patient-inmates within each institution. Once final inspection reports are issued, the inspection results for each institution will be available to be viewed on the OIG website (<http://www.oig.ca.gov>).

The OIG activated its second team in December 2009. Inspections will proceed at a rate of one inspection per team each month. With two inspections per month, they are on target to complete medical inspections of all the institutions by fiscal year end, thus completing Phase II.

During this reporting period, the Program Compliance Section (PCS) completed six 180-day follow-up reviews at California Medical Facility, RJD Donovan Correctional Facility, Centinela State Prison, Deuel Vocational Institution, California Correctional Women's Facility, and California Men's Colony. The 180-day follow-up reviews focused on those areas where the institution stated corrective action of the OIG findings had been fully implemented. The PCS also completed its first 360-day follow-up review at California State Prison, Sacramento. The 360-day follow-up review focused on those areas not fully implemented and areas found to be non-compliant during the 180-day review. These follow-up reviews will provide the necessary monitoring to ensure progress continues towards a system of adequate medical delivery for patient-inmates.

Objective 4.2. Establish a Quality Improvement Program

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

Credentials Committee

During the reporting period of September 1, 2009, through November 30, 2009, the Credentials Committee reviewed 44 individual provider cases. Of the 44 cases reviewed, 16 were approved, 9 denied, 17 reviews resulted in either a Credential Alert or a Credential Bar, and 2 are pending a final determination.

Credential Applications

Within this reporting period, the Credentialing and Privileging Unit staff processed 508 credential applications. Of these, 373 were approved, 10 denied, 30 were closed due to being incomplete, and 95 files are pending completion.

Two-Year Reappointment Compliance

During the reporting period of September 1, 2009, through November 30, 2009, 220 civil service and 15 registry providers were notified to complete their two-year reappointment. Of these 235, 73 have been completed while 162 remain pending completion. Of the 162 pending reappointments, 57 are not due until January 2010, 9 are currently being processed by the Unit staff, leaving the remaining balance of 96 pending due to provider compliance.

The previous reporting period reflected that 230 reappointments were pending completion; however, further internal auditing shows a total of 280 reappointments that were pending completion. Of the 280, 82 have been completed leaving 198 still pending. Of those 198, 11 are pending completion by the Unit staff and 187 are pending provider compliance.

To date, 360 reappointments are pending completion with 78 percent due to provider non-compliance. The two-year reappointment credentialing requirement is a condition to continue providing clinical services to the Department. Due to the non-compliance of provider completion, the Unit management has addressed the need for regional and institutional management to administratively direct the providers to comply. Beginning January 2010, the Credentialing and Privileging Unit staff will provide monthly compliance reports to the Executive Leaders to assist in achieving statewide compliance.

Tracking of License and Board Certification Expirations

The reporting period for Licensure Expirations is September 1, 2009 through November 30, 2009. The Licensure Expiration process has yet to be completed for the month of December. During this reporting period 79 Notice of Licensure Expirations were processed and renewed. To date all monitored provider's license are current through November 30, 2009. There were no Board Certification Expirations during this reporting period. The tracking of expiring license and certifications is an on-going process with notifications being sent out regularly to ensure that the practitioners have active, current credentials and/or licenses at all times.

Backlog and Delays in Processing

The number of pending files is once again at an all time high. The furlough program continues to impact turn around times for completing provider files and activities. In an effort to decrease the turnaround timeframe for final committee decisions, the Credentials Committee resumed weekly meetings in November 2009.

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

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

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

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

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

This Action has been completed.

During this reporting period, the Policy Unit coordinated the development and statewide distribution of four new policies. Policy Unit staff also finalized 13 related medical forms, which institutions may now order through CDCR. A total of 11 policies were submitted to the Policy Unit during the period. One entire volume of the Inmate Medical Services Policies and Procedures was updated by the end of the reporting period.

Policy Unit staff identified a test institution site for statewide implementation of a policy tracking system and is coordinating implementation with Health Care Information Technology staff and the Project Management Office.

Action 4.2.3. By January 2010, implement process improvement programs at all institutions involving trained clinical champions and supported by regional and statewide quality advisors.

This Action has been combined with Action 4.2.1.

Objective 4.3. Establish Medical Peer Review and Discipline Process to Ensure Quality of Care

Action 4.3.1. By July 2008, working with the State Personnel Board and other departments that provide direct medical services, establish an effective Peer Review and Discipline Process to improve the quality of care.

This Action has been completed.

The Professional Practice Executive Committee (PPEC) and Peer Review Subcommittee met 13 times during the reporting period and have reviewed a total of 83 civil service referrals. The Peer Review Subcommittee closed 26 referrals following review or the successful results of training and/or monitoring plans, of which 13 new plans were implemented. The Governing Body approved six case closures of providers whose clinical practice was deemed to meet an appropriate standard of care following a peer review investigation.

In this reporting period, the PPEC summarily suspended the privileges of two providers, while three providers separated from State service following a referral. The Governing Body also issued Notices of Final Proposed Action under the new policy to revoke privileges and employment of one physician. Graphical displays of PPEC outcomes for the period September 2009 through December 2009 are presented in the Tables 7 and 8.

Table 7

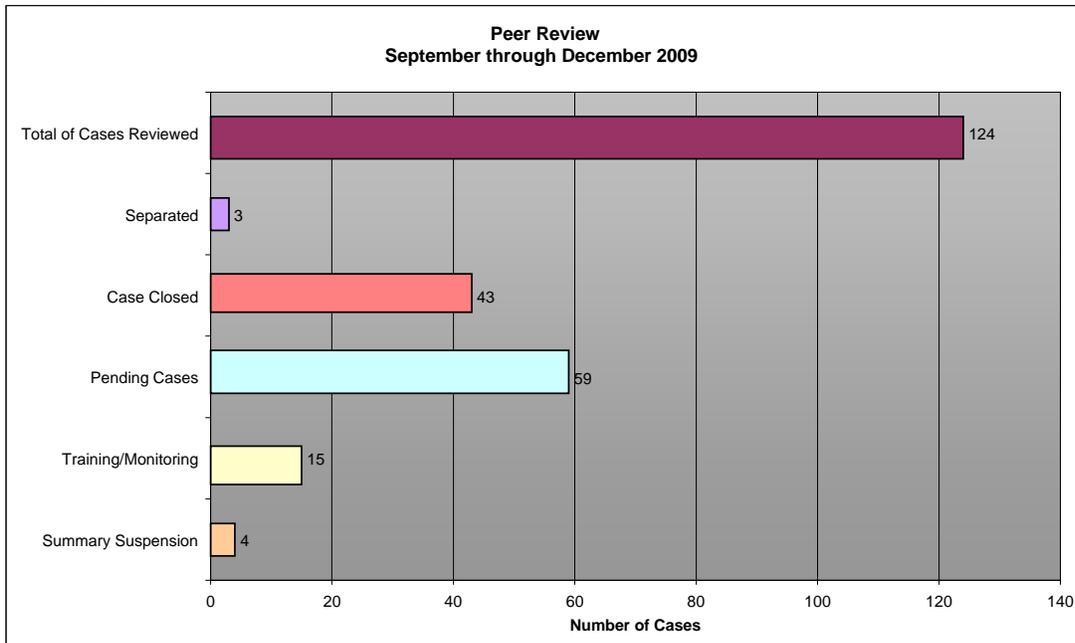
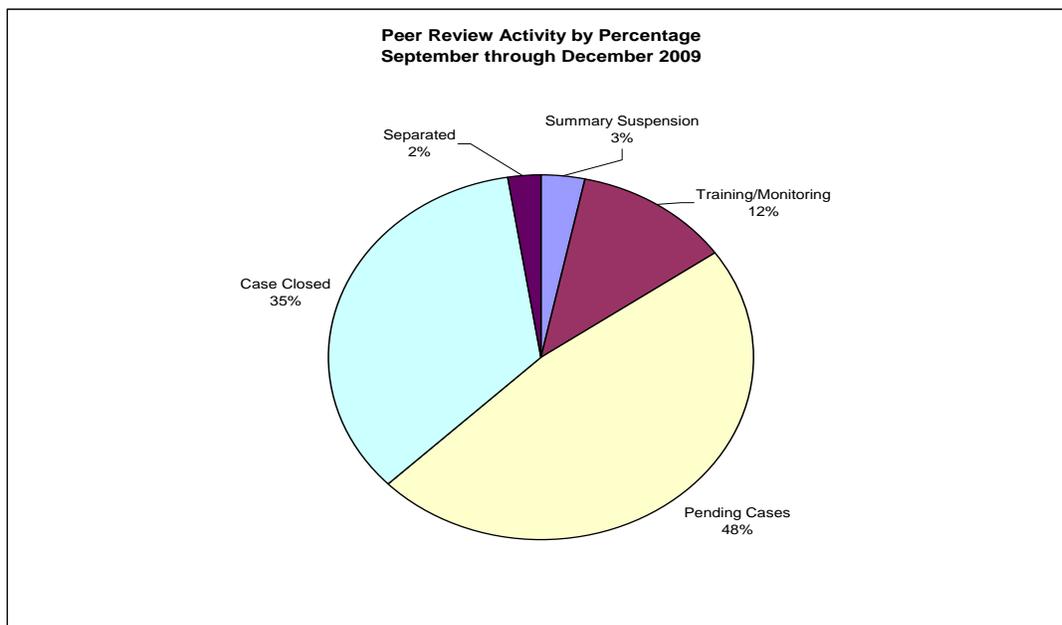


Table 8



Tables 7 and 8 Results Explanation:

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

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

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

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

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

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

While the PPEC’s primary charge is providing for patient safety, PPEC is also charged with supporting physician practice improvement. With an improving physician and mid-level workforce, the PPEC can increasingly focus efforts on remediation and practice improvement while still providing for increased patient safety. During this reporting period, the number of referrals and summary actions has decreased while case closures, training, and remedial activities have increased.

In a continued effort to ensure physicians are afforded their due process rights in a timely manner, CPHCS has taken affirmative steps to implement the entire disciplinary process including formal hearings. During this reporting period, there were no formal appeal hearings before a Judicial Review Committee. In the next reporting period, CPHCS will work collaboratively with SPB to transition the appeal hearing process from hearings at the Office of Administrative Hearings to the SPB.

In a healthcare organization, the Governing Body is the highest policy making body for the provision of healthcare. Consistent with community standards and healthcare organization, the Governing Body is responsible for the administration, direction, monitoring, and quality of healthcare services provided to inmate-patients within CPHCS and Division of Correctional Health Care Services (DCHCS) adult institutions. The Governing Body takes final action on recommendations from the PPEC regarding practitioners.

During this reporting period, the Governing Bodies for CPHCS and DCHCS were combined into one Governing Body. This merging brought together the medical Governing Body (responsible for the practice of physicians, nurse practitioners and physician assistants) and the mental health and dental Governing Body (responsible for the practice of psychiatrists, psychologists, licensed clinical social workers and dentists). The newly reconstituted Governing Body has met monthly since October to act on the recommendations of the PPEC.

Objective 4.4. Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations

Action 4.4.1. By January 2009, fully staff and complete the implementation of a Medical Oversight Unit to control and monitor medical employee investigations.

This action has been completed.

The Medical Oversight Program (MOP) has utilized an alternative operational approach that meets the key program objectives in an efficient and cost effective manner. The MOP has realigned clinical resources regionally, utilizing both CPHCS headquarters and regional clinicians as MOP team members in order to maximize the clinical resources. This approach was implemented to utilize physicians and nurses as subject matter experts in medical investigations while also utilizing their clinical expertise in a variety of initiatives for CPHCS.

During this reporting period, MOP has developed the first draft of policies that will govern the program operations. The policies will be reviewed by key stakeholders from CPHCS and CDCR for input prior to finalizing the draft during the next reporting period.

CPHCS clinicians and the Office of Internal Affairs are working collaboratively to develop a process for the MOP Chief Medical Officer (CMO) and MOP Chief Nurse to pre-screen “Confidential Request for Internal Affairs Investigation/Notification of Direct Adverse Action.” The aim of this endeavor is to ensure medical experts are involved in the review processes at the earliest stage necessary to expedite medical investigations.

MOP activations continue to review the most egregious of sentinel events. During this reporting period, the MOP was activated for eight cases. Four of these cases were submitted by institutional healthcare managers and four were called by the MOP CMO. The Medical Intake Panel convened and opened four cases for investigation, rejected nine cases for investigation, and five cases are pending further review. With respect to the disposition of cases reviewed by the Panel, four “Direct Actions” were referred back to the hiring authority, eight subjects were referred to Nursing Practice Review and one subject was referred to the PPEC.

Graphs of MOP outcomes for September - December 2009 are in Tables 9 and 10.

Table 9

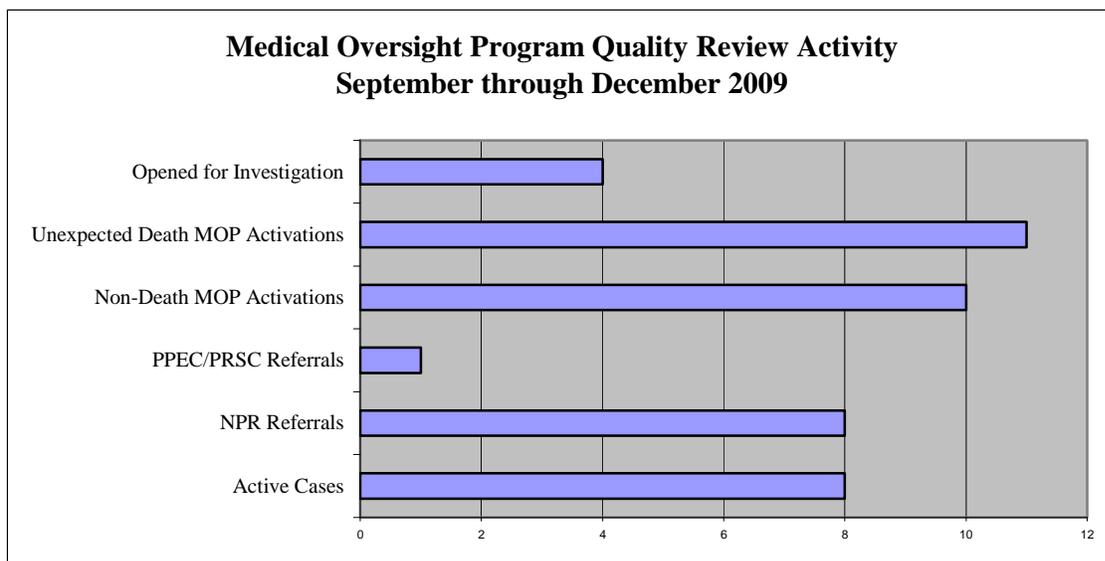


Table 9 Results Explanation:

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

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

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

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

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

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

Table 10

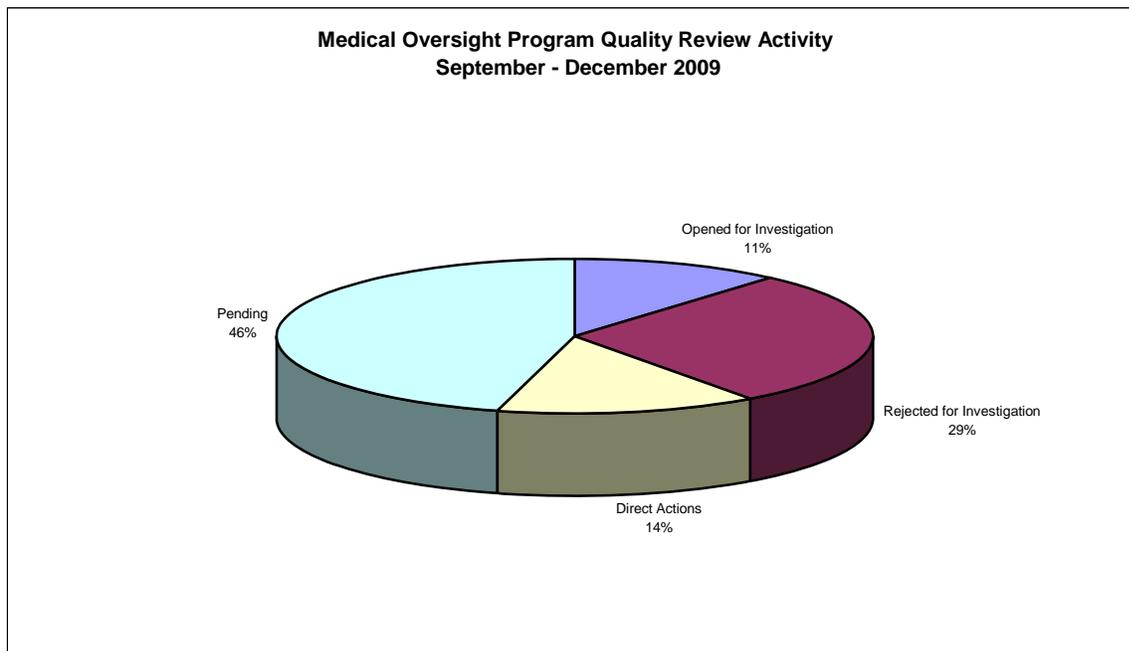


Table 10 Results Explanation:

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

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

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

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

Objective 4.5. Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative

Action 4.5.1. By July 2008, centralize management over all healthcare patient-inmate appeals, correspondence and habeas corpus petitions.

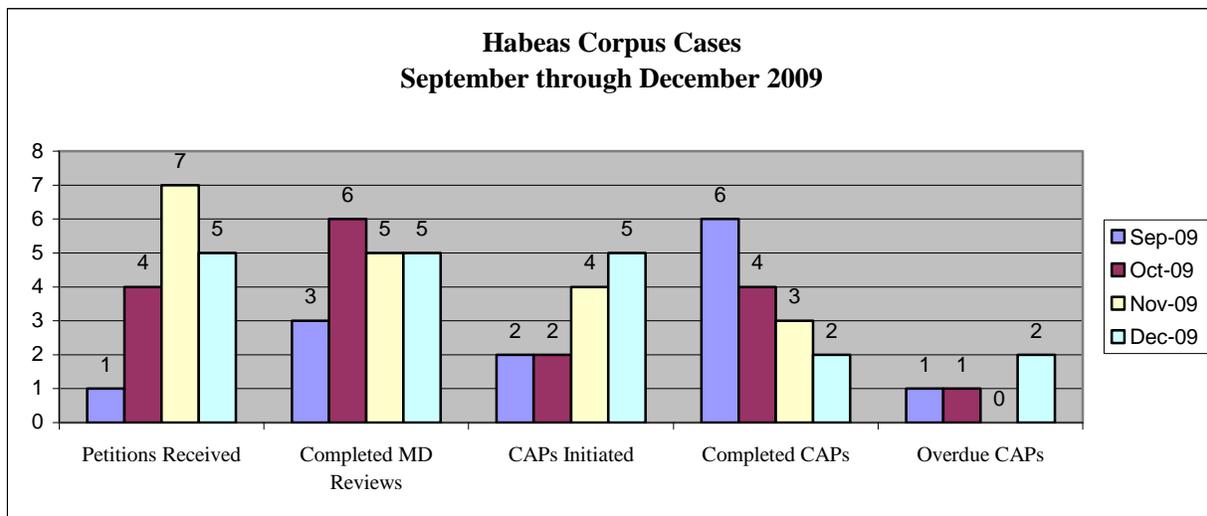
This Action has been completed.

Habeas Corpus Petitions

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

Table 11 displays the habeas corpus petitions for September through December 2009.

Table 11

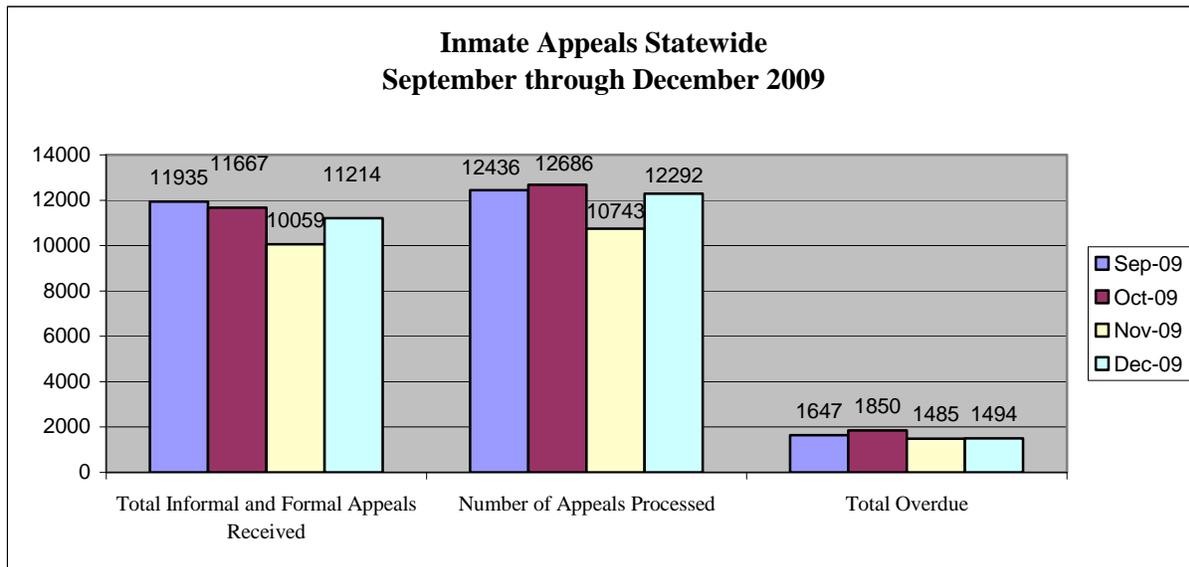


Institutional Health Care Appeals

During this reporting period, the monthly average of healthcare appeals received at institution healthcare appeals offices decreased from 12,369 during the prior reporting period to 11,220. The monthly average of all healthcare appeals processed at institutions decreased from 13,183 during the prior reporting period to 11,955. However, the monthly average of overdue appeals statewide increased from 1,467 during the last reporting period to 1,644.

Table 12 displays data related to Health Care Appeals Statewide for September through December 2009.

Table 12



Office of Third Level Appeals- Health Care

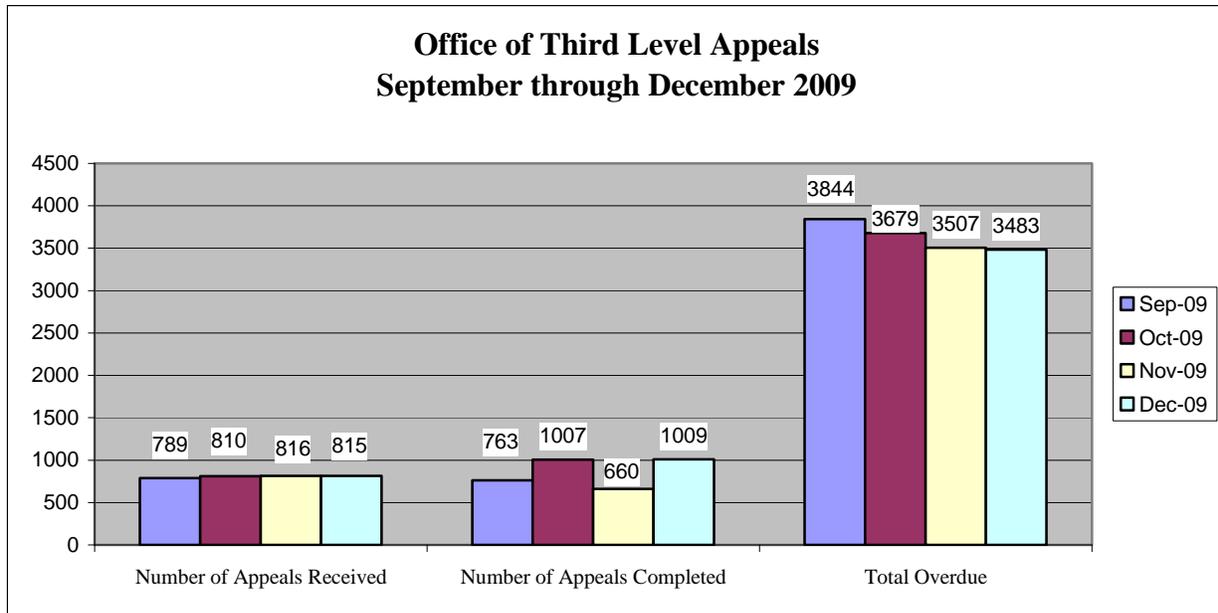
On August 1, 2008, the Office of Third Level Appeals (OTLA) began receiving all third level appeals regarding healthcare issues that were previously processed by CDCR. Due to the higher than anticipated volume and a necessary clinical review, there continues to be a significant and growing number of overdue appeals. In an effort to address this, a re-engineering analysis was recently completed to streamline the OTLA processes. Additionally, some staff have been redirected from other departments within CPHCS and overtime is approved to assist in alleviating the backlog of overdue appeals. A variety of significant OTLA work process improvements have been initiated since July 1, 2009, to continually increase the number of appeals closures with a goal to eliminate the overdue appeals by April 1, 2010. These efforts have significantly increased the number of appeals closure as evidenced below:

8/1/08 – 6/30/09 (11 months) of 3,765
 7/1/09 – 11/30/09 (5 months) of 3,741

Further, a new plan of action to process all of the overdue appeals will be initiated on January 4, 2009. All of the overdue appeals will be screened and triaged by management and clinical staff to determine if the lower level appeal response is complete and appropriate, and if so, the lower level responses will be adopted. However, if the lower level response is incomplete or inappropriate, staff will complete an abbreviated medical records review and clinical summary prior to completion of the response. Meanwhile, all new appeals will be processed to prevent any additional overdue appeals which will provide data to determine if the current staffing resources are sufficient to keep up with the incoming workload. Both action plans to address the backlogged appeals and new incoming appeals will involve a management and clinical “triage” review to identify administrative and critical/chronic care healthcare appeals.

Table 13 displays data related to OTLA for September through December 2009.

Table 13



Action 4.5.2. By August 2008, a task force of stakeholders will have concluded a system-wide analysis of the statewide appeals process and will recommend improvements to the Receiver.

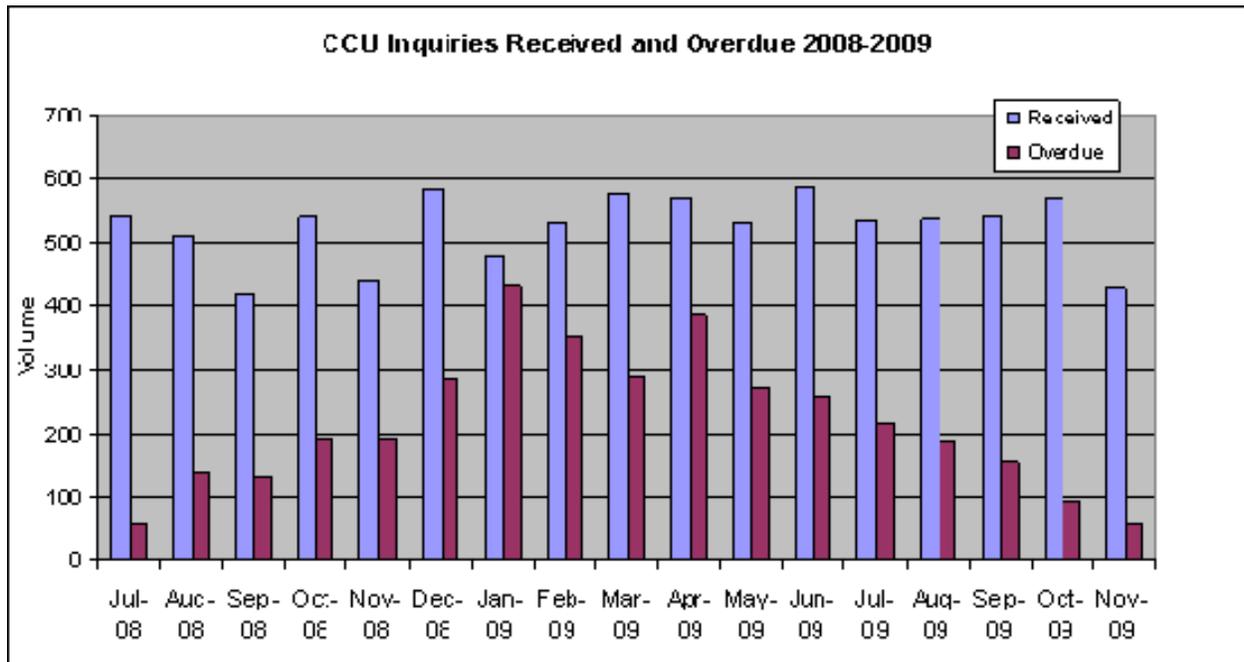
This Action has been completed.

Controlled Correspondence and Litigation Support Unit (CCLSU)

Additional staffing for a new Controlled Correspondence team to address the increased workload has been added. Overdue responses spiked in January 2009 to a high of 430, but with the increased staff and a limited amount of overtime, overdue responses have trended downward for the past seven consecutive months to 61 overdue cases by the end of November 2009. In addition, policies and procedures were reviewed and revised to streamline CCLSU processes. At the current rate of progress it is anticipated CCLSU will eliminate their backlog by the next reporting period. The CCLSU Executive Summary Reports for September - November 2009 are attached as [Appendix 5](#).

See Table 14 regarding the tracking of CCLSU incoming inquiries and overdue responses.

Table 14



Objective 4.6. Establish Out-of-State, Community Correctional Facilities (COCF) and Re-entry Facility Oversight Program

Action 4.6.1. By July 2008, establish administrative unit responsible for oversight of medical care given to patient-inmates housed in out-of-state, community correctional or re-entry facilities.

This Action has been completed.

During this reporting period, CPHCS’ Field Support Division (FSD) staff continues to work collaboratively with the Corrections Corporation of America (CCA) on finalizing policies and implementing monitoring tools related to the systemic issues identified in the July 2008 Remedial Plan, which came as a result of the May 2008 visit to Tallahatchie County Correctional Facility (TCCF) in Mississippi. While the initial implementation of the approved policies and monitoring reports were to be implemented at TCCF, CCA began implementing them at all five facilities currently housing California patient-inmates. Therefore, discussions related to rolling out the Remedial Plan to the remaining facilities are no longer required.

During this reporting period, the following policies were approved for implementation by CCA, CCA 13-58, Medical Records; CCA 13-70, Pharmaceuticals; CCA 9-18, Transportation Procedures; CCA 13-86, Transfer/Release Screening & Follow-up; CCA 13-34, Emergency Medical Response; CCA 13-37, First-Aid/Spill Kits; and CCA 13-74, Privacy of Protected Health Information.

As CPHCS clinical leadership provides input into the pending policies, there has been a need for additional revisions and continued discussions with CCA staff to resolve the outstanding issues so that we can finalize the remaining policies. The pending policies are CCA 13-06, Chronic Care & Disease Management; CCA 13-47, Infection Control; CCA 13-56, Credentialing, Privileging, & Licensure, and CCA 13-52, Continuous Quality Improvement, which includes policies related to peer review, mortality and morbidities, sentinel events, medical incidents and medical investigation.

Current Activities

The following provides an overview of the current activities FSD staff is involved in related to ensuring CCA compliance with the Remedial Plan developed in July 2008.

1. CPHCS Clinical Performance Appraisals of CCA Primary Care Providers

In August 2008, CPHCS clinical staff began completing Clinical Performance Appraisals (CPAs) of all CCA Primary Care Providers (PCPs) providing care to California patient-inmates. The reviews are to ensure that appropriate care is being provided by the CCA staff providing medical care to our patient-inmate population. CCA has also begun the process of generating CPAs on their providers. FSD staff is working with CCA and CPCHS clinical leadership to finalize the CCA policy related to this requirement. It is anticipated that the policy will be finalized during the next reporting period. FSD staff is in the process of developing a report to track the status and outcome of this process. It is anticipated that the information will be available during the next reporting period.

2. Weekly Physicians Collaborative Update on COCF Patient-Inmates

In November 2008, FSD staff initiated a weekly conference call with all CCA Physicians providing care to the California patient-inmate population, including CCA Regional Medical Directors. The purpose of these calls is to review patient-inmates with significant changes in their medical condition resulting in complex, serious and/or unstable conditions to ensure appropriate care is being provided and to determine whether or not the change in their medical condition is so significant that the patient-inmate is no longer eligible to be housed out-of-state. These calls continue to occur on a weekly basis. FSD staff is in the process of developing a report which will provide an overview of the outcomes of these calls. It is anticipated that the information will be available during the next reporting period.

3. CPHCS Review of Credentialing Information of CCA PCP Candidates

In November 2008, CCA began forwarding CPHCS clinical staff copies of all required credentialing material for potential candidates for hire by CCA. Implementation of this process ensures that CCA is hiring PCPs who have the appropriate credentials based on CPHCS requirements to provide care to the California patient-inmate population. FSD staff is working with CCA and CPCHS clinical leadership to finalize the CCA policy related to this requirement. It is anticipated that the policy will be finalized during the next reporting period.

4. Post Audits of Patient-Inmates Transferred Out-of-State

To ensure that the appropriate patient-inmates are transferred out-of-state, Registered Nursing staff assigned to FSD began the process of conducting post audits of the Unit Health Record (UHR) for all patient-inmates transferred out-of-state. The post audit consists of reviewing the patient-inmate's UHR and the screening documents completed by field nursing staff reflecting COCF eligibility.

In instances where it is found that a patient-inmate has been inappropriately transferred out-of-state, a list containing pertinent information regarding the discrepancy is forwarded to the CMO of FSD for review and determination regarding the action to be taken (either the patient-inmate is to be returned to California or he remains at the out-of-state facility). To date, no patient-inmates have been returned as a result of this review.

5. Establishment of Monitoring Reports

In April 2009, staff assigned to FSD developed and implemented seven Monitoring Reports that ensure compliance with Plata policy requirements for specific systemic issues that were identified during the visit to TCCF in May 2008. The initial reports were manual and generated a significant workload increase for both CCA and FSD staff. In October 2009, FSD staff, with the assistance of Information Technology staff, began the process of automating these reports and we anticipate having executive management reports for CPHCS and CCA management by January 2010.

The reports are required to be submitted on a daily, weekly or monthly basis and are as follows:

Daily Reports (Next Day)

1. Transportation Monitoring Requirements
2. Watch List Monitoring Requirements

Weekly Reports (Due Every Tuesday)

1. Intake Screening Monitoring Requirements
2. Specialty Care Referrals Monitoring Requirements
3. Hospital Stay and Emergency Department Visits Monitoring Requirements

Monthly Reports (Due the 5th of each month)

1. Sick Call Monitoring Requirements
2. Chronic Care Monitoring Requirements

Upon receipt of these reports, Nursing Consultants within FSD review the reports for their assigned facility to ensure compliance. When discrepancies are noted, they take the appropriate steps to ensure it is clarified and/or resolved to ensure compliance with policy requirements.

6. COCF Reception Center Transfer and Screening Process

While it was anticipated that CPHCS and CDCR would roll-out the COCF Reception Center screening and transfer process at the remaining Reception Centers, this did not occur during this reporting period. With the scheduled implementation of the new medical classification system at the Reception Centers in January 2010, there is no longer a need to report on this issue.

7. Clinical Staffing Levels at CCA Facilities

FSD and CCA staff developed a matrix to assist CPHCS clinical leadership with identifying the specific number of clinical and nursing staff providing care to the California patient-inmate population at each of the five CCA facilities. This information has been submitted to CPHCS clinical leadership for their review, modification, and/or approval of the staffing levels identified. It is anticipated that this issue will be resolved during the next reporting period.

8. Compliance Audits Beginning January 2010

FSD has established an audit schedule for 2010 and 2011. Two on-site visits will be conducted of each facility by June 30, 2010. Effective July 2010, an on-site visit will be conducted at each facility a minimum of three times per year. Any significant issues that impact this schedule will be documented in future reports.

The audits will consist of three components:

- A. Review of the roll-up of the Monthly Monitoring Reports for the three month period prior to the on-site audit.
- B. Electronic Medical Record Review, which is required to be completed at least two weeks prior to the on-site audit.
- C. On-Site Facility Audit.

Information obtained from the audit will be presented in a final report, which will be distributed to CPHCS, CDCR and CCA executive management staff. CAPs will be required to address any areas of deficiency.

Community Correctional Facilities

During the last reporting period, an update was provided regarding the seven CCF contracts that would be expiring by June 30, 2011. However, at this time, funding has not been identified to support the contract renewal process. Additionally, due to population concerns, CDCR has made a decision to move forward with closing three of the CCFs that are expiring on June 30, 2010. A 60 day notice has been served, with a closure date of December 25, 2009 (close of business).

Also during this reporting period, FSD staff conducted site audits at four CCFs. The remaining CCFs are tentatively schedule to be reviewed between January-March 2010. As reports are finalized, FSD staff will work with the facilities and CDCR to ensure Corrective Action Plans are developed to bring the impacted facilities into compliance.

Goal 5. Establish Medical Support / Allied Health Infrastructure

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

During this reporting period, implementation of the pharmacy services *Road Map to Excellence* continued to move forward and show progress. The *Road Map* gives priority to achieving improved patient safety and health outcomes, developing an evidence-based pharmacy practice and increasing cost-efficiency. Progress during this reporting period is detailed below.

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

The CDCR Pharmacy and Therapeutics (P&T) Committee continued its monthly meetings to review utilization trends, address formulary issues, and review and approve pharmacy policies and procedures. During these meetings, the members of the P&T Committee reviewed monthly reports including the pharmacy dashboard, monthly metrics summary, the pharmacy inspection grid, a review of pharmacy cost center trends and reviewed medication error reports. After initial development work, additional review of pain guidelines was deferred by the committee to the Clinical Guidelines Committee.

During this reporting period, the P&T Committee also reviewed and discussed initiatives to address prescription duration and over-the-counter and non-pharmaceutical utilization. Clinical pharmacy support has been provided to ongoing UM initiatives.

The P&T Committee selected Ventolin HFA as the preferred formulary inhaled albuterol product. Discounted pricing for this product has been established and is now being tracked as part of the targeted contract savings. All updates to the formulary are distributed to provider and pharmacist staff, posted to the CPHCS intranet and are made available through the online Epocrates web service.

The P&T Committee has also been working collaboratively with nursing leadership to align nurse protocols with CDCR formulary. The committee approved several changes in protocol medications to eliminate any conflict with CDCR formulary. The protocols were referred to the Guidelines Committee to complete the process.

Coordination with UM was conducted to establish an appropriate level of intravenous services based on facilities' ability to compound IV admixtures in a safe manner. Solutions developed include the use of additional premix products and outsourcing depending on facility need and capability.

The Clinical Pharmacy Operations Specialists (CPOS) continued to provide in-service to facility staff on Pharmacy Policy and Procedure on a regular basis. During this reporting period, topics covered included Ch.8 - CDCR Drug Formulary, Ch. 9 - Prescription Requirements, Ch. 19 - Medications Brought into a CDCR Facility by Patients, Ch. 20 – Floor Stock Orders, Ch.25 - Inspection of Medication Storage Areas, Ch. 31 - Use of Tricyclic Antidepressants, Ch.35 -

Therapeutic Interchange, and Ch.38 - Prescription Turn-Around Time. In addition, CPOS discussed non-formulary approval and utilization with providers and leadership staff based on purchases and utilization data in Managed Care reports and provided in-service to facilities on the Hepatitis C medication algorithm.

A formal Pharmacotherapy Management Consult (PMC) and process has been rolled out to several facilities, along with a pilot project to extend the duration of certain medical prescriptions to twelve months. By the end of December, CPOS will have presented PMC to Medical leadership at Central California Women’s Facility, Chuckawalla Valley State Prison, Mule Creek State Prison, California State Prison, Corcoran, California Substance Abuse Treatment Facility and California State Prison, Sacramento.

Extensive emphasis continued on training and implementation of enhanced performance monitoring metrics in coordination with healthcare leadership. These activities included additional report refinement and training of staff and the Pharmacist-In-Charge (PICs) on newly defined clinical performance metrics. A Mental Health (per member per month) cost metric was added to the Pharmacy Dashboard. Additionally, prescription related metrics relating to non-formulary prescriptions and prescriptions per inmate are being compiled on a regular basis for inclusion in the Facility Monthly Management Reports.

As displayed in Table 15, through November 2009, Maxor has documented cost avoidance of \$18,626,941 thus far in calendar year 2009 from the use of targeted contracting strategies linked to P&T Committee decisions.

Table 15

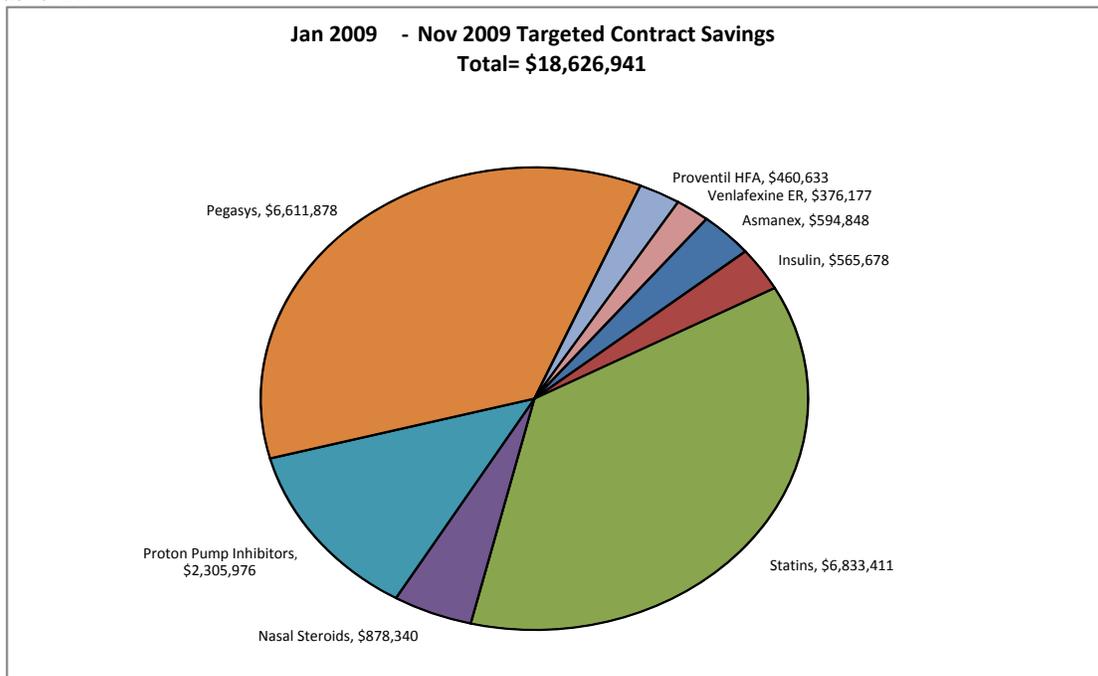


Table 15 Results Explanation: These categories represent specific P&T Committee initiatives targeting particular drugs or drug classes. Savings calculated by comparing purchases using the actual targeted contract rate to the pre-targeted contract rate.

Targeted contracts, order management activities and the implementation of a wholesaler agreement tailored specifically to address the pharmaceutical needs of the CDCR healthcare system continue to contribute to savings as displayed in Tables 16 and 17. In CY 2009, through the month of November 2009, over \$44.8 million in expenditures were avoided when compared to prior historical trends.

Table 16

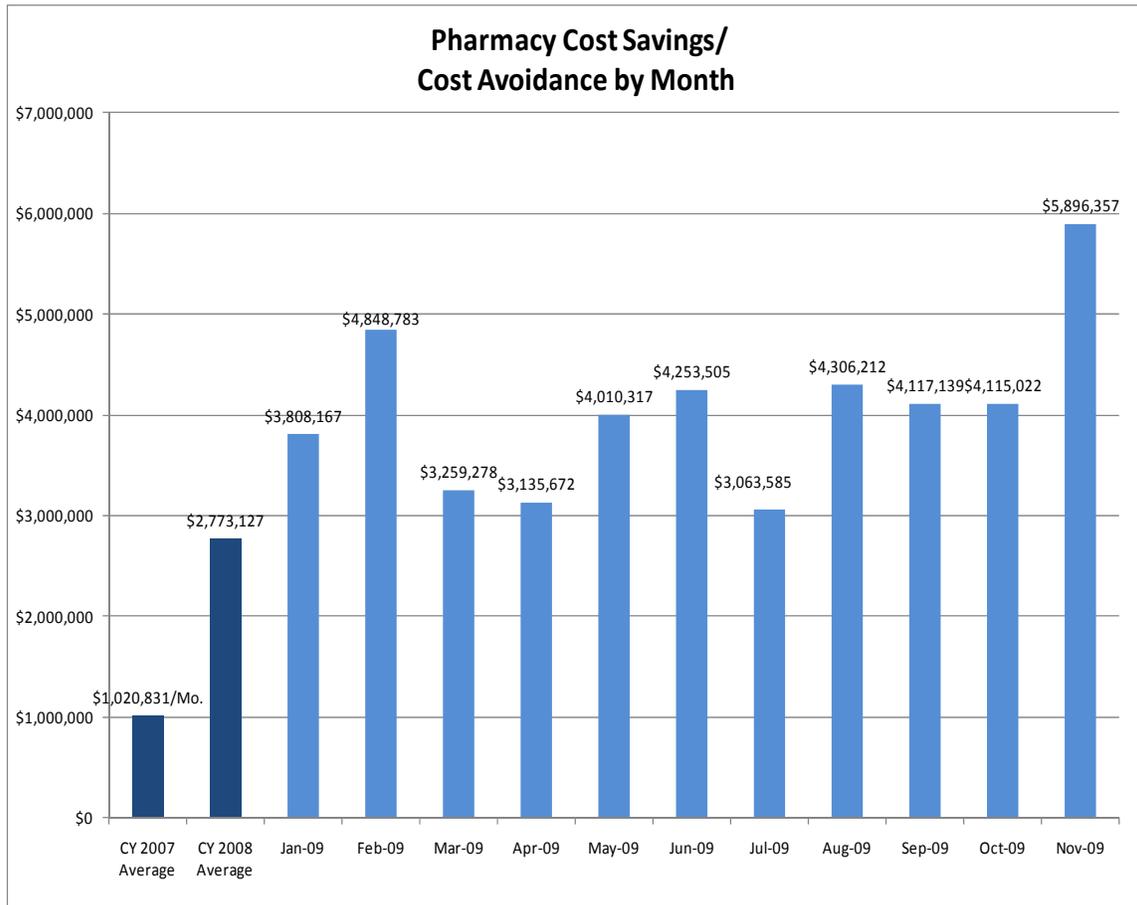


Table 16 Results Explanation: Cost savings/cost avoidance calculated based on comparing actual wholesaler purchases to prior historical trend line (also based on wholesaler purchases). Data pulled monthly from Wholesaler Purchase data. Maxor began managing pharmacy purchasing in April-May 2007.

Table 17

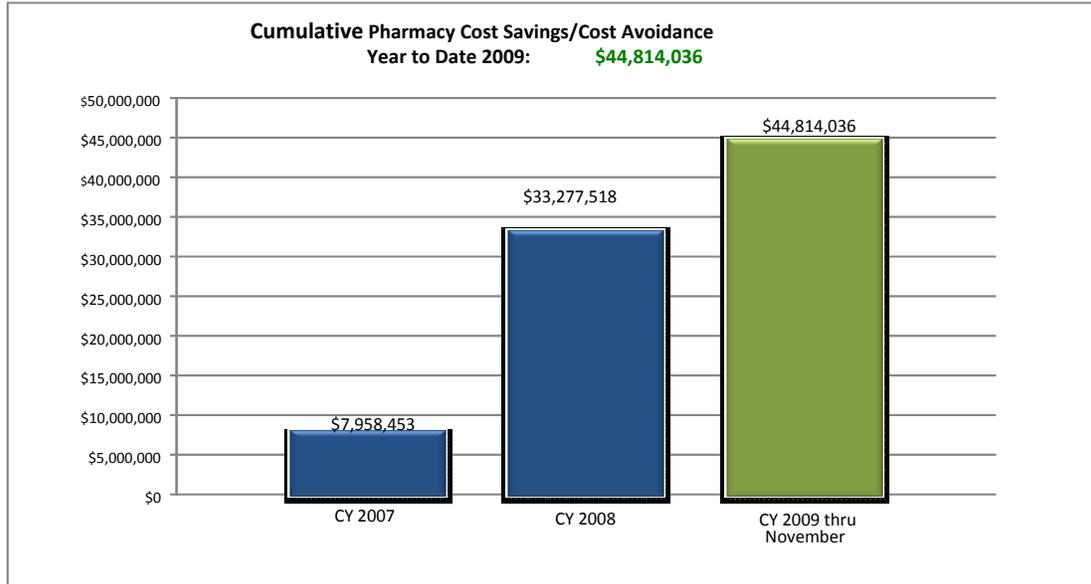


Table 17 Results Explanation: Savings/Cost Avoidance is calculated by comparing actual wholesaler purchases to prior wholesaler purchase trend line. Maxor began managing pharmacy purchasing in April-May 2007.

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

Pharmacy Policies and Practices

During this reporting period, the P&T Committee approved proposed changes to the pharmacy policies and procedures manual and completed its annual review and update of the policies. Following P&T Committee approval, the policies were sent for final review by the new policy and program evaluation department. In addition to reviewing and updating all existing pharmacy policies, two additional new policies were developed and approved. Chapter 41, Specialty Pharmaceutical Purchasing and Chapter 42, Prescription Quantity Standards were approved. A new draft policy and procedure was prepared to address quantity limits on certain groups of drugs and define packaging quantities for the planned central fill facility. This policy (Chapter 42) was approved by the P&T Committee in December 2009.

Additionally, pharmacy leadership has continued to focus on implementation of policy and procedures at the facility level to ensure compliance. To aid in this effort, a renewed emphasis was placed on the use of the *MC Strategies* online training and assessment tool to provide in-service training. Expectations were established with a targeted goal of a 95 percent completion rate. Facilities deficient in compliance are required to submit a written plan of action to bring training compliance up to the targeted levels. Also during this reporting period, two revised *MC Strategies* lessons were deployed and two new lessons (Ch. 19 - Medications Brought into a CDCR Facility by Patients and Ch. 20 - Floor Stock Orders) were released to PIC and pharmacy staff. The *MC Strategies* completion rate system-wide is now at 89 percent. Compliance continues to be evaluated quarterly.

Recruitment efforts continue in an effort to fill pharmacy positions across the State. Work continues through the centralized hiring process to identify, interview and select qualified applicants. Also during this time period, pharmacy leadership have worked with finance and human resources staff to address significant differences between the deficient historical pharmacy staffing levels approved in prior appropriations cycles and the actual staffing levels required by current workloads and processes. While implementation of the Central Fill Pharmacy (CFP) will help in bridging this gap, discussion continues in order to ensure that mission critical services will be maintained in the interim and during the implementation of the CFP. Meetings with CPHCS leadership and finance staff are ongoing to address these issues.

Pharmacy inspections are conducted and documented monthly. The number of pharmacies with an inspection rating score of pass/problem (not failed) has increased from 21 percent in March 2007 to 64 percent in November 2009. This percentage is down from a high of 85 percent reported in July 2009. Pharmacy inspection scores are dropping largely due to late submissions of inspection reports by facilities. CPHCS is taking action to improve the timeliness of these submissions to avoid this drop in scores. Pharmacy inspection status data is displayed in Table 18.

Table 18

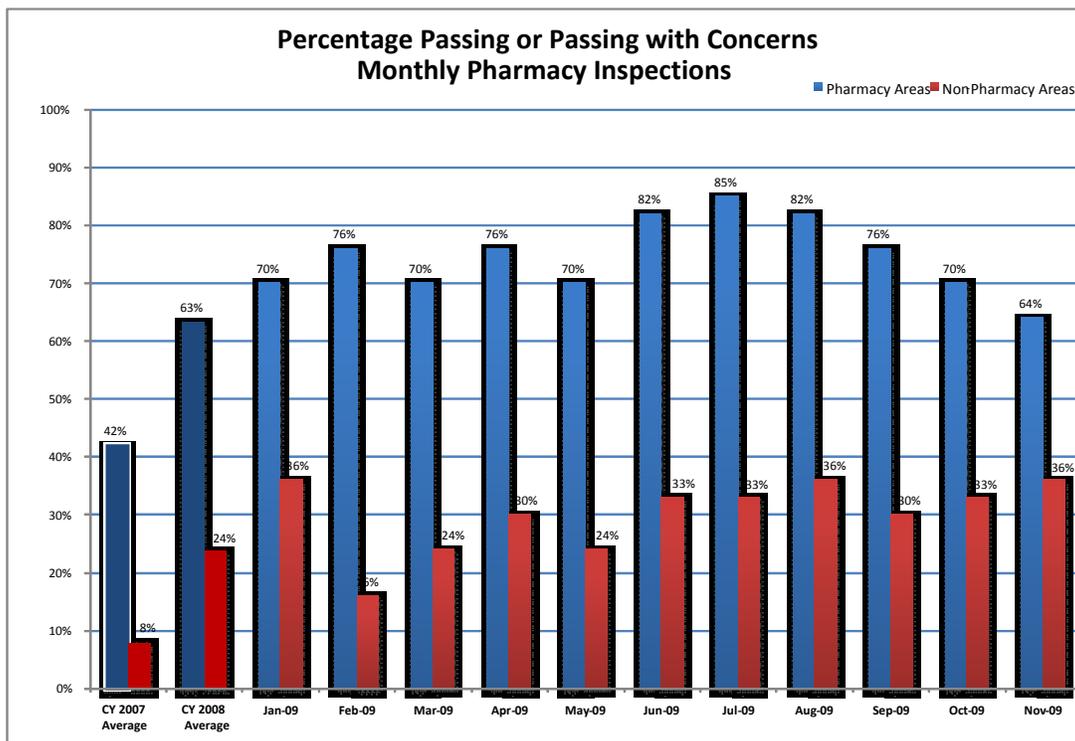


Table 18 Results Explanation Pharmacy areas are denoted in blue, and non-pharmacy locations (medication administration locations) are denoted in red: Independent Maxor Validation of Monthly Inspection Data began in February 2008.

Roll-out of the GuardianRx® System

The GuardianRx® pharmacy operating system has now been successfully implemented in 29 of the 33 CDCR institutions. Pre-conversion meetings and training at upcoming facilities continue. The remaining four facilities are Sierra Conservation Center, Richard J. Donovan Correctional Facility, California State Prison, Solano, and California Medical Facility. Each of these facilities has significant infrastructure issues which are being considered as final scheduling takes place by the GuardianRx® Steering Committee.

The Receiver has completed initial efforts to improve pharmacy policies and practices at each institution by the initial target date of June 2009, having completed a comprehensive initial review and revision of all pharmacy policies and procedures. Efforts to enhance training and improve compliance with these policies and procedures continue. However, the timeline for rollout of the GuardianRx® system has been extended, as described above, and will not be fully implemented statewide until at least March 2010.

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

Work continues towards the establishment of a CFP Facility for the CDCR. The pre-centralization ambulatory model is being defined and implemented as processes are standardized and validated as part of the GuardianRx® implementation work plan. Following the final approval of the lease terms with the property owner by Department of General Services in early August, demolition, permitting and renovation work on the facility was started. Coordination with DGS architects and space planners, the CPHCS Project Manager, the construction team and the automation vendor occurs on a daily basis as this vital project enters the active construction phase. The building contractor is proceeding on schedule with the renovations and build-out of the facility. Meetings with Cornerstone Automation Systems (the vendor selected to provide the automation equipment for the facility) continue to ensure equipment specifications are met and installation schedules are coordinated. Cornerstone Automation Systems has recently advised scheduling obstacles with a potential delay of 60 days. CPHCS staff is actively working with the vendor to resolve for on time delivery.

Additionally, work related to the staffing and operation of the facility has also continued. Meetings have been held to plan the process of moving positions for the CFP and reevaluate time lines and system wide pharmacy staffing. Work is being done to define the pharmacy staffing model going forward and the interim staffing model until the CFP is fully operational. Based on current schedules, the CFP Facility is now estimated to be operational by May 2010. Once opened, it is expected to take approximately 14-18 months to transition all prisons completely over to central fill.

The Monthly Summary Reports for the months of September, October, and November are attached as [Appendix 6](#).

Objective 5.2. Establish Standardized Health Records Practice

Implementation of the Health Information Management (HIM)/Health Records remediation road map continues to move forward to achieve improved patient health records management based

on evidence-based practices and increased cost-efficiency. Progress continues and is detailed below.

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

The Receiver has been developing a plan for an enterprise-wide UHR Conversion initiative where all UHR's and loose filing at the institutions will be scanned into a "paper-like" scanned UHR (s-UHR). This same effort will also scan all of the Paroled UHR's at the Health Records Center (HRC). This effort is taking advantage of the Strategic Offender Management System (SOMS) Custody File (C-File) scanning effort for CDCR after they have completed scanning the C-Files at each institution. The first institutions and HRC will have their UHR's scanned in July 2010 and the last institution will be completed approximately 12 months later.

The process of establishing an s-UHR will also establish a "day-forward" scanning operation at each facility that will process all loose filing. These efforts are an important step for CPHCS to advance to an electronic UHR or EMR by moving UHR users away from a paper UHR. This effort will also improve the standardization and use of healthcare forms as well as the many business processes that utilize or provide input to the UHR.

These efforts will improve the availability of the UHR at the point of care and will significantly advance the quality of new UHR content. These efforts combined with additional advancements of the CPHCS CDR and other Allied Health Services domains (e.g., Lab, Radiology, and Pharmacy) will support an effective Electronic Medical Record (EMR). The EMR provides an effective management system for ensuring standardized health records use and practice at all institutions.

At HRC there is currently a loose filing backlog of 50,000 inches. This backlog will be eliminated by a scanning process that will start by early February 2010. These scanned loose files will then be distributed to active UHR's at institutions and will no longer be missing from clinical visibility.

Active recruitment is underway for two Health Information Management (HIM) CEA positions for a Chief of Health Information Management and an Assistant Chief/Privacy Officer. These critical managers will provide CPHCS leadership guidance over stabilization, remediation and ongoing enterprise-wide HIM operations.

The Dental effort toward a more efficient organization of the Dental portion of the unit health record has been proceeding. A purchase order for 51,314 multi-tab inserts and x-ray envelopes for the dental section has been completed. Prison Industry Authority (PIA) will manufacture the items and is in the process of procuring the materials to do such. Based upon the PIA factory schedule, the Receiver estimates that the items will be distributed to the institutions in March 2010.

Objective 5.3. Establish Effective Imaging/Radiology and Laboratory Services

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

Medical Records

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

Imaging/Radiology Services

This Action has been completed.

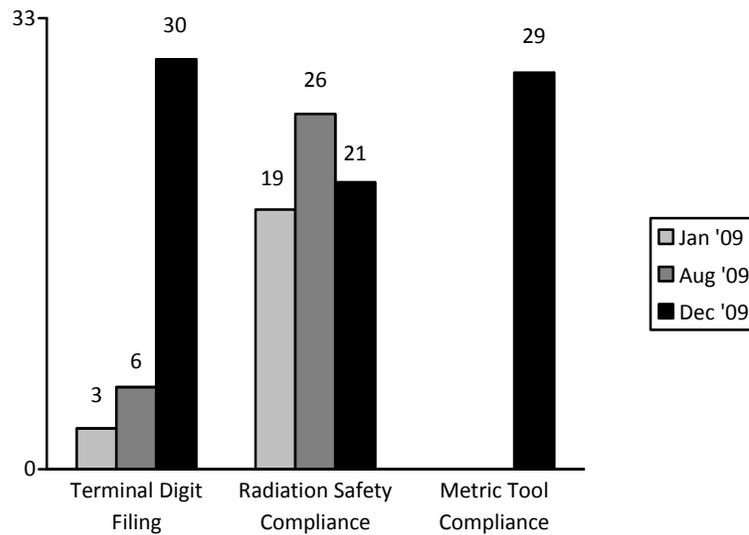
During this reporting period, Ascendian Healthcare Consulting (formerly McKenzie Stephenson, Inc.) completed site visits to all 33 adult institutions, with the goal of improving several areas of imaging departmental functions. Standardized and accurate processes are valuable in preventing delays in diagnosing patient-inmate conditions, reducing costly repeat diagnostic studies, and improving overall safety.

One area of focus included compliance with report and film handling, proper film filing methods, and tracking mechanisms required to safely transport medical data throughout the State. We have made significant improvements in terminal digit filing for film storage, with the number of sites in compliance rising from 6 to 30 as indicated in Table 19.

Another area of focus was to implement metrics tools designed to provide a baseline for operational volumes, workload, equipment maintenance and uptime, referrals, and other important data related to improving patient care and access. This metrics management process began in September 2009 and has been widely adopted. As shown in Table 19, 29 institutions currently report operational, clinical, and safety metrics on an ongoing basis.

A third area of focus has been compliance with radiation safety guidelines. As in Table 19, there appears to be a negative trend in radiation safety compliance since August. This is a result of a new and stricter compliance measurement and monitoring regime, which includes new metrics associated with Physicist reports and Radiation Supervisor positions. We are working with all non-compliant sites to ensure that the proper paperwork is submitted and supervision is provided as required.

Table 19: Imaging/Radiology Metrics - Compliance by Institution

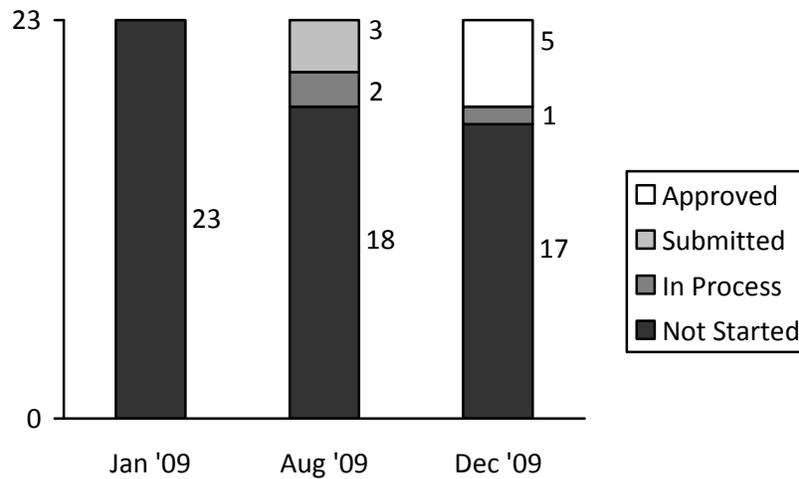


Personnel issues at the adult institutions also are being addressed to ensure staffing ratios fit institutional characteristics and meet the demand of examinations ordered. To assist with setting a staffing baseline and to avoid conflicts with ongoing efforts to redesign the statewide imaging staffing model, a hiring freeze within Radiology was implemented. This hiring freeze was coordinated with CPHCS Human Resources and Regional Personnel Directors. A revised staffing model is under review, with approval and implementation expected for early 2010.

Ascendian Healthcare Consulting expects to complete Mammography Quality Standards Act (MQSA) certification at Valley State Prison for Women prior to the end of 2009. Issues related to equipment reliability and documentation initially delayed the completion of this process, however the paperwork has since been filed. In addition, all three female institutions are prepared to comply with recent state legislation that reinforces existing policies regarding the posting of violations of MQSA guidelines.

Our team continues to work through the 23 different types of contracts held for support of Radiology and Imaging Services. As indicated in Table 20, we have been making progress on the remediation of these contracts. Due to concerns related to contract accuracy and accountability, the scope of the work conducted by this team now includes management and oversight of vendor invoicing and payment.

Table 20: Progress of Radiology/Imaging Contract Remediation



Work on the Mobile MRI program has ceased due to project budget and scope changes. CPHCS has established a preference for contracted services as a long-term solution to providing on-site MRI services, whereas the previous strategy was to implement state-owned and operated MRI services. We currently are reviewing the infrastructure at all institutions to determine what improvements are required to meet the minimum requirements for mobile MRI and CT service. The first five sites selected (California State Prison, Corcoran, California Substance Abuse Treatment Facility, North Kern State Prison, Kern Valley State Prison and Wasco State Prison) all require upgrades to provide level concrete pads or proper electrical hookups. While we had initially planned to expedite this project, CPHCS learned that the project is subject to Section 6 state funding requirements and approval process. To fulfill this process, the timeline has been adjusted and is expected to be completed by end of fiscal year 09/10.

We continue to coordinate with other CDCR and CPHCS project teams that are implementing technologies overlapping with imaging services (e.g., transcription, scheduling, CDR). Our goal is to ensure that these overlapping processes accommodate the work and data flow required for interoperability with Radiology and Imaging Services. However, recent changes in budget and resource allocation have delayed the Radiology Information System (RIS) implementation, which is designed to capture relevant patient data and allow for interoperability across the enterprise. Revised expectations on RIS implementation schedule, cost, and patient care impact currently are under development.

Laboratory Services

The Receiver has completed a work plan to stabilize/reform the Reference Lab Contracts and to provide a statewide reference lab service. Approximately half of CPHCS lab tests are performed through the CPHCS Reference Lab contracts. This statewide service will significantly improve the quality, timeliness, and effectiveness of reportable lab results that inform clinical decisions at

each of our institutions. The next two reporting periods will be focused on implementing this work plan.

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

Objective 5.4. Establish Clinical Information Systems

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

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

As of December 2009, the CDR has transitioned into the Maintenance & Operations Phase, with rollout of the CDR to Valley State Prison for Women; California Correctional Facility for Woman and Los Angeles County institutions. In the months leading up to December, historical data was loaded from custody, pharmacy and laboratory partners and live data feeds from these partners was initiated. Staff at the pilot institutions was trained on the CDR and on-site and remote assistance was provided to support the roll out.

The pilot phase of the project will run through January 2010. During this period the system will be evaluated for stability and performance. Remediation work will be performed in areas that require such services. Rollout to additional institutions will begin in February 2010.

Objective 5.5. Expand and Improve Telemedicine Capabilities

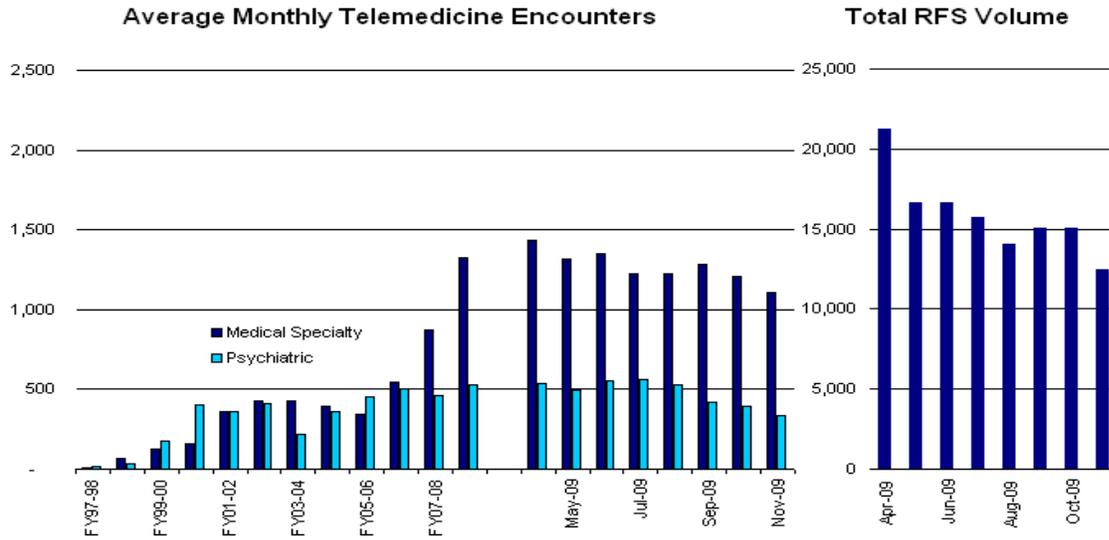
Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure.

This Action has been completed.

Telemedicine staffing and governance continues to improve. During this reporting period, CPHCS hired 2 new staff members to conduct the scheduling of specialty services, and are recruiting for a Health Program Manager. We also held the initial meeting of the Telemedicine Services Core Leadership Team.

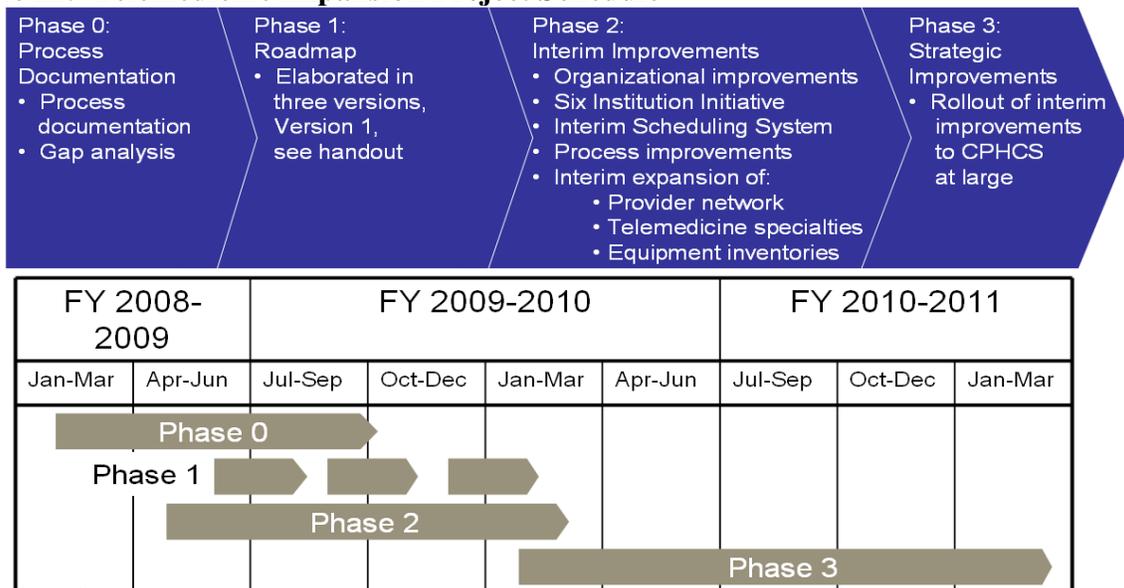
Progress in expanding telemedicine system-wide is shown in Table 21. While total RFS volume is declining because of the recently implemented utilization management program, telemedicine encounters are continuing at a steady pace.

Table 21: Telemedicine and RFS Trends



Phases One and Two of the six-institution initiative to expand telemedicine services are underway (Table 22). This initiative is being conducted at North Kern State Prison, Kern Valley State Prison, Richard J. Donovan Correctional Facility, Centinela State Prison, California State Prison at Corcoran and Substance Abuse Treatment Facility. At the six institutions, we are expanding telemedicine equipment, addressing access to care obstacles, expanding the provider network, increasing the number of telemedicine specialties, and taking other steps to increase telemedicine usage. We also are collecting statistics to measure our progress in increasing telemedicine encounters while at the same time reducing off-site specialty services encounters. This data will be shared in future reports.

Table 22: Telemedicine Expansion Project Schedule



The CPHCS team is working closely with our Information Technology experts to identify the most cost-effective approach to developing and expanding the technology infrastructure that supports the delivery of telemedicine services. We recently met with several vendors to review current technologies and equipment as it relates to telemedicine services, including *store and forward* technology.

During this reporting period, CPHCS has implemented various process and staffing improvements. These improvements include reassigning the RN staff from scheduling and administrative functions to clinically focused tasks of the Telemedicine Program. We also are in the process of automating our telemedicine scheduling process.

The “Provider On-Boarding” process was fully implemented in this reporting period to expand patient access to telemedicine specialty providers, with an additional provider organization “on-boarded” to provide statewide services. The addition of the new providers has increased the number of specialty services offered from sixteen to twenty. These additional services are Plastic/Reconstructive, Nephrology, Oncology and Urology. We are also working to transition the UCSF on-site services to telemedicine.

Ongoing review of statewide scheduling backlogs and patient needs will continue to be a factor in provider recruitment efforts, which will help us meet demand for specialty care statewide. The CPHCS team is engaged in discussions with prospective medical groups and providers throughout the state that can provide telemedicine services. To support this expansion, we have updated the contract language to include telemedicine provisions in all medical general services agreements. The Telemedicine Program also is working with our Credentialing and Privileging unit to establish credentialing protocol for telemedicine providers.

During the next reporting period, we expect to successfully complete the six-institution initiative, complete the automation and re-engineering of our scheduling function, further expand our provider network and launch initiatives to increase telemedicine at other institutions. CPHCS anticipates the successful completion of the six-institution initiative and a phased rollout of increased telemedicine services statewide.

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

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

Progress on this objective continues to be impacted due to lack of funding. Assessments, planning, design and construction progress was limited due to the funding impacts. The timeframes originally established in the action items are no longer feasible and will continue to be negatively impacted until such time as AB 900 funding becomes available.

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

In concert with the most recent Abt study data and the proposed medical classification system proposed by CPHCS's medical planning group, Vanir is providing input to this team from the data collected during site visits at all 33 institutions. This input includes confirmation of existing conditions, such as confirming bed counts and locations at each yard, and identifying the best potential locations for needed new beds identified by the medical planning group as having an acute care mission.

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

Upgrade Construction at Avenal State Prison:

Construction at Avenal State Prison is in its final stages. Work under construction includes three yard clinics to provide medical and mental health treatment space, an Administrative-Segregation clinic and a healthcare administration building to provide support for healthcare access and administration, on schedule for completion by January 2010. Institution staff began moving into the new buildings sequentially, starting in December 2009.

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

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

The "Receiver's Report on Options for Long-Term Care Bed Construction," filed with the court on February 6, 2009, details the four-year history of the Receivership's efforts to work with CDCR and the State to secure funding for construction of facilities which are a necessary step toward bringing prison healthcare up to constitutional standards. A complete copy of that report is available on the website http://cprinc.org/docs/court/doc2065_20090206_Options.pdf.

The construction options identified in that report were intended to be one component of a long range plan to bring medical care up to constitutional standards. The other components are dependent upon improvements in prison and health care, and program improvements that have not been fully realized in part because of CDCR's severe.

In brief summary, the initial planning efforts, begun in 2006, culminated in 2008 with an agreement with the Administration to seek new funding in the amount of \$6 billion to construct seven new facilities around the state which would have added approximately 10,000 beds for inmates requiring basic care for long-term, chronic medical problems, serious mental health concerns, and medical conditions requiring special housing and ready access to care. The plan was intended to satisfy healthcare bed needs projected out to 2018. Under the Receiver's plan, these facilities would have been built and operated by the Receivership to ensure timely completion of construction and operation of the facilities consistent with constitutional standards. The Administration also agreed to \$1 billion in funding to improve facilities at existing prisons to support medical and mental health treatment (this figure was raised during 2008 to \$2 billion when the Administration requested that the Receivership take on facilities improvements for the dental program). The Receiver believes that this \$8 billion capital investment, if combined with other operational and staffing improvements and a reduction in the prison population, would likely be sufficient to end the four primary class actions involving prison health care in the near future.

Beginning in July of 2008, the Administration withdrew its support for this investment. After a brief period of litigation between state officials and the Receivership (which is still pending before the Ninth Circuit), and with the collapse of the national economy and California's budget, the Receiver began working collaboratively with Secretary Matt Cate and other CDCR staff to attempt to scale back construction plans to a level more consistent with available resources. These discussions ultimately resulted in CDCR submitting a long-term bed plan to the *Coleman* court which provides approximately \$2.34 billion in funding for healthcare-related construction to be financed from the sale of bonds previously authorized by AB 900. Instead of 7 facilities and 10,000 new beds to be operated by the Receivership, the new plan envisions only 1 new facility of approximately 1,600 beds for inmates with medical and mental health problems, the use of three juvenile justice facilities which would be converted to hold approximately 3,200 inmates with medical and mental health conditions, and allocation of \$700 million for improvements to existing facilities. Although the current plan is likely to fall short of actual needs in some material respects, the Receiver believes it is the most that can be accomplished at this time given the state's serious financial problems and the amount of funding available under AB 900.

As of this date, although there is a plan to build, the state still has not provided access to any funding to implement this plan, it remains uncertain whether funding will ever be made available for these purposes, and it is unclear whether the State will significantly reduce its prison population.

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

During this reporting period, planning activities for the CCC have continued along with planning models and assumptions for the converted DJJ facilities. The CCC facility prototype, operational plans, facility plans, staffing model, and integrated healthcare program model are being revised and completed to a draft level that will allow for the facility to be constructed within an accelerated time-frame.

In November 2009, CPHCS construction staff transitioned to CDCR Facility Planning, Construction and Management Division to combine the construction efforts on all AB 900 projects.

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

This action has been delayed until such time as AB 900 funding becomes available.

Stockton Site Environmental Impact Report (EIR) Status - On October 12, 2009, the Receiver certified the final EIR and also signed the Resolution of Approval, approving the proposed project and the Secretary of the CDCR concurred. The Notice of Determination was filed on October 19, 2009.

A petition for writ of mandate challenging the EIR entitled *Greater Stockton Chamber of Commerce, County of San Joaquin and City of Stockton v. J Clark Kelso, in his capacity as Receiver and the Department of Corrections and Rehabilitation* was filed on November 17, 2009 in San Joaquin Superior Court, Case Number 39-2009-00230310 CU-WM-STK. An amended petition was filed on November 19, 2009. Both the Receiver and the CDCR were served on November 24, 2009. The case was removed to the jurisdiction of the United States Federal Court for the Eastern District of California on November 25, 2009. Notices of Related Case were filed on December 3, 2009 and the court ordered the matter related to the *Coleman v. Schwarzenegger* Case No.2:90-cv-520 LKK on December 4, 2009, with a status conference set for February 16, 2010. The attorneys for both the Receiver and CDCR are reviewing the amended petition and are preparing the record and necessary responses. The attorneys for both the Receiver and CDCR filed answers to the amended petition and are preparing the administrative record for certification by January 25, 2010. Petitioners filed a Motion to Remand the case back to state court, which is set for hearing before Honorable Judge Karlton on January 25, 2010.

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

A phased construction schedule has been developed that provides for an accelerated schedule to open these beds by April of 2013.

Objective 6.3. Complete Construction at San Quentin State Prison

Action 6.3.1. By December 2008, complete all construction except for the Central Health Services Facility.

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

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

The Central Health Services Building achieved substantial completion on November 19, 2009, almost three months ahead of the required contract completion date of February 8, 2010. Staff began occupancy of the building and the clinics and started treatment of inmates in December 2009. We are targeting a complete move of all mental health and medical patients by end of January 2010.

Section 4

Additional Successes Achieved by the Receiver

A. Joint Governing Body for Integrated Care

In a health care organization the Governing Body is the highest policy making body for the provision of health care. Consistent with community standards and health care organizations, the CPHCS and DCHCS Governing Body are responsible for the administration, direction, monitoring, and quality of health care services provided to inmate-patients within the adult institutions. These Governing Body Committees take final action on recommendations from the Professional Practice Executive Committee regarding all practitioners within CDCR.

During this reporting period the two separate and distinct Governing Bodies,

1) Medical - responsible for the practice of physicians, nurse practitioner's and physician assistants and 2) Mental Health and Dental - responsible for the practice of psychiatrists, psychologists, licensed clinical social workers, and dentists, were merged in to one Governing Body. This is a critical step in a deliberative process to reintegrate the health care services within CDCR.

To facilitate a seamless transition of enterprise wide health care policies and processes, the newly reconstituted Governing Body will focus on interdisciplinary practices issues and resolutions. The new Governing Body began convening in October and will draft formal Bylaws within the upcoming months.

B. Health Care Master Bed Plan – 2009 Chronic and Long-term Care in California Prisons: Needs Assessment Projections

Guided by the Vision and Mission of the Receiver's Turnaround Plan of Action, CPHCS is committed to ensuring a sustainable medical care system that increases the effectiveness of medical care while implementing system efficiencies for cost containment and savings. In support of that effort, the Receiver directed an assessment of the long-term care prison medical beds to ensure that the capacity was sufficient to support a constitutionally adequate level of medical care for inmates. Abt Associates revised their *2007 Chronic and Long-term Care in California Prisons: Needs Assessment* projections and improved the study outcome by adjusting the data collection tool. Pursuant to concerns raised about the 2007 study by independent reviewers, the assessment tool was modified and updated under the direct leadership and participation of CHPCS clinical staff. Complete analysis of the *Abt 2009 Chronic and Long-term Care* study is undergoing final review and will be shared in the 1st quarter of 2010.

To ensure resolute handling of this critical project, the Receiver directed a Medical Master Bed Planning Executive Leadership Group be created to oversee the medical bed master planning effort utilizing data from the study. In addition, a Health-Care Bed Master Planning Workgroup (Workgroup) was formed. The groups are comprised of representatives of all stakeholders,

including Court representatives for Plata, Coleman, Armstrong, and Perez, as well as leaders representing CPHCS, the CDCR Mental Health and Dental Programs, Facilities, the Division of Adult Institutions, and the Department of Mental Health.

With the benchmarking data from the study, the Receiver's goal is to create an Integrated Health Care Master Bed plan that will provide a continuum of care and serve a variety of care levels (including medical, mental health, and dental), that will meet or exceed the bed and treatment needs for integrated health care services, and that fulfills custody requirements for safety and security of CDCR facilities. The plan will incorporate the results of the following: population specific health care studies; data/findings from medical and mental health classification systems; the Mental Health Long Term Bed Plan filed with the Coleman Court; and the Dental Services Plan.

The Workgroup is nearing completion of its analysis and will provide recommendations for an Integrated Health Care Master Plan. They will present the recommendations in late January to the Leadership Group and Court monitors. It is anticipated that these recommendations will include adjustments to the current Bed Plan which are necessary to meet the projected long term health care needs of California's inmate-patients while ensuring the best use of planned construction resources.

Section 5

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

While the Receivership continues to make progress in many key areas to achieve the goal of providing a constitutional level of healthcare within California's adult correctional system, the State's fiscal crisis and resulting employee furlough program has had an impact administratively and at the Institutions, as it has on many state government operations. While this impact is difficult to define and measure, this Tri-Annual Report identified programmatic areas in which timelines have been adjusted. Many staff intensive administrative functions, such as inmate appeals processing and invoice processing, have failed to meet their goals. While blame for these failures can not be placed solely on furloughs or the lack of funding for new positions, there is little doubt that budget cuts and furloughs are contributing factors to some of these setbacks.

The budget forecast coupled with California's low financial rating will present challenges for all in 2010 and the years that follow. However, the Receiver continues to utilize all available resources to ensure that the goals and objectives within the Turnaround Plan of Action are achieved and will continue strive in these efforts to fulfill the Vision and Mission.

Section 6

An Accounting of Expenditures for the Reporting Period

A. Expenses

The total net operating and capital expenses of the Office of the Receiver for four months ended December 31, 2009 were \$3,033,872 and \$6,873,314 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 7](#).

B. Revenues

During the four month period ending December 31, 2009, the receiver requested transfers totaling \$1,100,000 from the state to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the office of the Receiver for the reporting period 2009-2010 Fiscal Year.

All funds were received in a timely manner.

Section 7

Other Matters Deemed Appropriate for Judicial Review

- **Coordination with Other Lawsuits**

During the reporting period, regular meetings between the Receiver and the monitors of the *Coleman, Perez, and Armstrong* (“Coordination Group”) class actions have continued. Coordination Group meetings were held on September 22, 2009, November 17, 2009, and December 9, 2009. Progress has continued during this reporting period.

- **Master Contract Waiver Reporting**

On June 4, 2007, the court approved the Receiver’s Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders issued since that date. The approved projects areas, the substitute bidding procedures and the Receiver’s corresponding reporting obligations are summarized in the Receiver’s Seventh Quarterly Report and are fully articulated in the court’s orders, and therefore, the Receiver will not reiterate those details here.

During the last reporting period, the Receiver has used the substitute contracting process for various solicitations relating to services to assist the Office of the Receiver in the development and delivery of constitutional care within CDCR and its prisons. However, those solicitations have not yet resulted in fully executed and approved contracts. Therefore, those contracts will be reported in subsequent Reports to the Court.

Section 8

Conclusion

We are approaching the halfway point in implementing the Turnaround Plan of Action. As this report reveals, there are many accomplishments which have contributed to improving the quality of care and reducing avoidable morbidity and mortality. At the same time, however, it is worth remembering that we have embarked on this extraordinarily challenging organizational improvement initiative in the midst of what is the worst budget and organizational conditions in California government in half a century.

Overcrowding continues essentially unabated, resources to improve and expand facilities have not been made available, employees have been subjected to furloughs and other employment pressures which undoubtedly interfere with their productivity, and the State's cash condition is unstable.

While we have clearly been presented with all of these challenges, as a State and the Receivership, we continue to work collaboratively with CDCR, the Department of Finance, the Department of Personnel Administration and the Governor's Office to achieve as much alignment as possible. The pace of our further progress will depend to a great extent upon our ability to build on the collaborative trust that we have developed over the last year and to gain the support from the State that we need to complete our task.