

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

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

May 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 our first Tri-Annual reporting for 2010, we recognize and share the accomplishments achieved by prison healthcare stakeholders and advocates. While we continue to be 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:

- Prison Healthcare Chief Executive Officer (CEO) - Since the CEO examination was launched on December 24, 2008, 476 CEO applicants have been added to the certification list and 12 hires have been completed. The pool of CEO candidates is very competitive and interest remains high with 12 CEO positions to fill for oversight of 33 institutions.
- Utilization Management (UM) – We recently hired a Lead UM Nurse Consultant who has successfully recruited 5 UM Nurse Consultant Program Review (NCPR) nurses who have been trained to support field based regional UM and care coordination activities. They are all actively working in the 4 Regions, to align the Receiver's UM objectives and institutional outcomes.
- The Request for Proposal (RFP) to obtain a medical services network from a Preferred Provider Organization (PPO), as allowed under the new legislation (SB X4 13, 2009, which amended Penal Code section 5023.5), was released October 20, 2009. Proposals were received and are in evaluation. Due to the number and complexity of proposals received, the evaluation period has been extended into the next reporting period. The plan is to make an award by the first of July 2010.
- Medical invoice processing activity has continued to be streamlined for efficiency through the use of Third Party Administrators (TPA) and system enhancements. As of March 2010, the TPA is within the mandated 30-day processing timeframe. The Two-Year Post Audit identified billing discrepancies which has resulted in \$13.8 million in refunds as of early April 2010. These refunds apply to the timeframe between July, 1, 2007 and June 30, 2009 and will not apply to current year savings.
- Pharmacy – On April 15, 2010 the Office of the Inspector General (OIG) released their report entitled “Lost Opportunities for Savings within the California Prison Pharmacies.” While acknowledging that there is more to do to rein in the high cost of inmate medicines, the report was a snapshot of a changing situation in our pharmacies. Our Tri-Annual and Monthly reports continue to showcase the progress made in pharmacy and the cost savings/avoidance achieved through the implementation of formulary management, over-the-counter (OTC) policy changes, the return-to-stock program, and the rollout of the Central Fill Pharmacy Facility (scheduled to open in May) and program.
- Telemedicine: Phase 2 of the Telemedicine Services Project was completed, which included the Six Institution Initiative to Expand Telemedicine Encounters. The Initiative resulted in a 14 percent increase in telemedicine services at the target institutions, and provided

experience that will facilitate telemedicine expansion at the other California Department of Corrections and Rehabilitation (CDCR) institutions.

- Avenal - Construction at Avenal State Prison is complete. All clinics were fully operational as of February 5, 2010.
- San Quentin - The Central Health Services Building is complete. We began seeing inmates in December 2009. CTC licensure was achieved in January 2010.
- California Health Care Facility (CHCF) - In January 2010, the Department of Finance submitted the 30-day notification letter to the Joint Legislative Budget Committee (JLBC) for review. At the request of the JLBC this project was pulled from the February Public Works Board (PWB) agenda and has not been rescheduled. Legislation (AB 552) is pending that would clarify the use of AB 900 bond funding for this project.

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 continues to be 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 California Prison Health Care Services (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, for statewide applications/programs, and by institution, as appropriate for and in coordination with that operation.

The Enterprise Project Deployment worksheet and the Institution Project Deployment worksheet provide an illustration of the progress made towards each action item outlined in the RTPA and reported in 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. 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](#).

Information Technology Project Matrix

In addition to the RTPA Matrix, a separate chart has been created to specifically illustrate the major technology projects and the deployment of those projects. This document is included as [Appendix 2](#).

Section 2

The Receiver's Reporting Requirements

This is the fourteenth report filed by the Receivership, and the eighth 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 2010, implement new processes at each of the major reception center prisons

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.

This action has been completed.

On January 20, 2010, all Reception Center institutions began using the Medical Classification System on all newly arrived inmates. During this reporting period, Local Operating Procedures for each institution were approved by the Regional Leadership Teams and the Medical Classification Chrono was implemented. At the time of this report nine of eleven Reception Center institutions have self-certified they are compliant with the Medical Classification System Policy and Procedure. The Regional Leadership Teams are currently preparing for the formal site certification visits.

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

On March 8, 2010, all non-reception center institutions began implementation of the Medical Classification System. As the institutions report self-certification status, the Regional Leadership Teams will schedule formal site certification visits. Implementation certification of the Medical Classification for all institutions is expected before January 2011.

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)

The HCAUs continue to be effective in facilitating inmate access to care. All Access Quality Reports indicate that improvements in access to care are being maintained. The reported improvements indicate that healthcare access programs have the resources necessary to support healthcare operations at the current level of service. Because of these improvements, and barring any regression or inability to support the field, it is possible that operational control of the custody HCAU could be transferred back to CDCR and released from Receivership control by next fiscal year (target July 2011).

Corrections Services continues to work with CDCR to modify post orders, hours of work and days off to better facilitate access to care. Correction Services staff work with CDCR to mitigate the effect of mission changes and in the implementation of the short, intermediate and long term bed projects, to ensure that healthcare operations are not interrupted.

Operational Assessments

Corrections Services is in the process of reviewing the operations of institutions HCAU to determine the effectiveness of the positions allocated for this purpose as well as reduce any access to care barriers. Operational assessments for all 33 institutions are scheduled to be completed by July of 2011.

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

AQR data remained stable during this reporting period. February's AQR indicated that overall 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 1.9 percent of the total number of ducats.

There were no updates to the AQR during this reporting period; all data elements remained the same. Field Operations staff met with COMPSTAT to review modifications to the data collection tool. The updates to the data collection tool will result in a report that mirrors the AQR, and it is anticipated that institutions will begin inputting 09/10 AQR data into COMPSTAT within the next month.

Corrections Services Field Operations Unit continues meeting quarterly with the Division of Adult Institutions (DAI), 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 3](#) for the Executive Summary and Health Care AQRs for December 2009 – February 2010.

Vehicles

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 (High Desert State Prison/California Correctional Center) (Correctional Training Facility/Salinas Valley State Prison) 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.

Currently all vehicle responsibilities are being transitioned back to CDCR. This transition will be completed in the next fiscal year (2010/2011). There are currently 7 remaining vehicles for distribution to institutions (2 to Sierra Conservation Center, 1 to Central California Women's Facility, 2 to California Correctional Institution, 1 to California Institution for Women and 1 to Valley State Prison for Women). The distribution of remaining vehicles will be completed by the end of May, 2010.

Fair Labor Standards Act (FLSA) Validation

The FLSA Validation was scheduled to be completed by March, 31, 2010. In order to address technical processing delays, completion timeline has been extended to April 30, 2010. The FLSA validation process will assist in confirming expenses charged and custody resources needed as part of fully implementing the HCAU.

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.

Upon completion of the design requirements for the new Health Care Scheduling System (HCSS) which resulted in the system prototype and the General System Design Document, the project team conducted a series of workshops with clinical subject matter experts to document the future state process flows for scheduling using 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.

While the system is being developed, efforts to plan for deployment, change management, training and communication have continued. The deployment of the system will occur in phases, with the three women's institutions going first in October and November 2010. The roll-out will then proceed to men's institutions that currently do not use technology for scheduling and then on to the remaining institutions. The deployment date for the first men's institution is currently set for November 29, 2010. The sequence of the deployment is currently in planning. Roll-out of healthcare scheduling to all institutions is scheduled to be completed by mid-year of 2012.

Communication activities included several statewide calls and presentations to CPHCS leadership of the new system, including a demonstration of the prototype. Feedback on the system received to date has been overwhelmingly positive.

In March, the HCSS project team has grown to seven members. The team includes a lead project manager, an IT subject matter expert, a technical lead, a CPHCS business analyst and project managers for change management, deployment, and test & training. During the next few months, detailed planning activities for the new scheduling systems will continue on multiple fronts. These activities will include the detailed deployment planning, user provisioning and change management. At the same time, the team will be working on user acceptance testing and the development of training materials for the new system.

Objective 1.4. Establish a Standardized Utilization Management System

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

The scope of this project is to convert a 200 bed General Population dormitory into a 72 bed Outpatient Housing Unit (OHU). The construction adds exam rooms, nurses' 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.

This project was delayed due to Fire Marshall issues and the execution of the fire alarm and fire sprinkler contracts. Construction is scheduled to begin on May 6, 2010 and construction

completion is scheduled for July 30, 2010. Activation will start immediately thereafter with patient admissions beginning August 1, 2010.

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

The UM program promotes the appropriate use of limited health care resources within CPHCS. The headquarters staff of this program includes 5 physicians, 5 NCPRs, 6 analysts & support staff, and project management consultants. The purpose of this staffing structure is to support the work in the field.

Currently the program undertakes regular site visits, conducts clinical rounds, coordinates network issues between community hospitals and institutional staff, and maintains functions in institutional mentoring and monitoring.

The program also issues a library of regular reports on specialist referral activity and hospital utilization outcomes. These reports are designed to assist institutions and headquarters in the determination of healthcare cost drivers and the corrective actions to ameliorate them. The library of reports consists of the following:

- Bed management reports derived from the Census and Discharge Information System database; bed census data from the community hospitals; and collections of on-site bed counts of vacancies from institutional staff.
- Specialty referral statistics from the InterQual decision support system; institutional counts of specialty referral activity; and the collection of specialty referrals specifically related to potentially high cost and high risk diagnoses.
- Statewide and site specific reports that combine the program's outcome measures into actionable information.

During the reporting period a proposed assembly bill (AB 1817 – *Arambula*) has been sponsored by the Receiver's office to place the ongoing operation of the CPHCS UM department into statute. The bill would require the department to maintain a statewide UM program consistent with its current operational components. The goal of the legislation is to safeguard the delivery of cost-effective, quality care as the department transitions from the Receivership back into formal state administration. The bill was passed by the Health Care Committee on April 20th 2010.

In addition to the continuation of the UM program's current operational components the proposed bill also requires the establishment of management performance objectives, yearly program planning, and annual reporting to the legislature. Partially in response to these pending requirements, and partially as good management tool, the program has developed a yearly work plan to guide program administration. The work plan is currently in the process of being integrated into all program activities.

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 July 2009, complete the redesign of sick call processes, forms, and staffing models.

A draft of new Episodic Care Processes and forms was completed and submitted for policy review on December 31, 2009. As noted in Action 2.1.2, the policy, procedures and forms are being tested at Mule Creek State Prison.

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

During this reporting period, the test of new Episodic Care Processes and forms that began in Facility A at Mule Creek State Prison was expanded to Yards B and C. Draft Episodic Care policy, procedures and forms were developed and are currently undergoing testing at Mule Creek State Prison. Full implementation at all institutions is anticipated to be completed by September 2010.

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

Action 2.2.1. By April 2009, complete a comprehensive, one-year Chronic Care Initiative to assess and remediate systemic weaknesses in how chronic care is delivered.

This action has been completed.

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.

The UM section is continuing its oversight over the provision of care for specialists and in community hospitals. The current performance measures for these activities are as follows:

Table 1: Hospital and Institutional Bed Management

Table 1: Community Hospital Bed Utilization Data							
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							
Aug-09	1196		9913	332.4	8.3	149474	795.8
Sep-09	1107	1129	9206	302.4	8.3	152870	722.7
Oct-09	1027	1060	8567	261.0	8.2	153906	668.0
Nov-09	1004	995	8253	275.1	8.2	153203	646.4
Dec-09	1065	1085	8256	266.3	7.8	154154	642.7
Jan-10	990	978	7430	239.7	7.5	153261	581.8
Feb-10	963	956	6973	249.0	7.2	152501	548.7
Mar-10	1126	1133	7676	247.6	8.0	151972	606.1

Table 2: Specialty Referrals

Table 2: Specialty Referral Volume						
Requests For Services (RFS)- Total Volume						
	North	South	Central	Fourth	Statewide	RFS/1000 patients/month
Monthly Baseline: 08/09					25000	
Apr-09	4525	6674	10023		21222	137.19
May-09	3479	5647	7482		16608	104.38
Jun-09	3578	4978	8124		16680	109.67
Jul-09	4905	4245	6600		15750	102.89
Aug-09	3875	3708	3999	2478	14060	92.46
Sep-09	3811	4018	4536	2333	14698	98.15
Oct-09	3995	4131	4415	2518	15059	97.85
Nov-09	3261	3549	3688	1941	12439	81.19
Dec-09	3446	3693	4218	2182	13539	87.83
Jan-10	3479	3317	3692	1978	12466	81.34
Feb-10	3508	3434	3986	2400	13328	87.40
Mar-10	3774	3635	4998	2354	14761	95.73

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

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

ProdÁgio Contract Processing System

The ProdÁgio Contract Processing System was upgraded in January 2010. This upgrade enhanced the processing features including auto-filing of contract documents, and an analyst time-tracking feature. These upgrades will help to ease the transition of direct medical services contracting to the Business Information System (BIS).

CDCR's BIS

CPHCS is currently working on an Implementation Plan to bring Medical Contracts on board the BIS system. There continues to be participation in work groups, weekly conference calls, training of Medical Contracts staff, and demonstrations organized by the CDCR BIS Team.

Streamlining Medical Contracting and Aligning Resources to Achieve Performance Goals

Medical Contracts Branch continues to develop and implement policies and procedures, standardized contracting templates, and training to support a statewide medical services contracting program. Stakeholder outreach and communication is also continually expanded and improved through regional teleconference meetings, a standardized broadcast system for contract notifications, dissemination of policies and procedures, and general announcements, classroom and web-based training, provider relations, and distribution of a weekly critical medical specialty contracts coverage summary. Implementing these and other streamlining improvements allow CPHCS to provide significantly greater patient-inmate access to care at a reduced cost.

The achievements, streamlining, and alignment of resources during this period resulted in the following:

- Executed 100 new statewide contracts for hospital and specialty physician services.
- Executed 36 competitively bid contracts through centralized coordination with CPHCS Workforce Planning, Medical Program Services, and individual institutions.
- Conducted six centralized outreach meetings with all institution medical staff, regional administrators, and internal stakeholders regarding current status of pending medical contracts, discussions of future medical service needs, clarification of practices, contracting practice updates, concerns, and/or clarification of information release. These meetings provide a forum for centralized communication practices providing Medical Contracts Branch opportunities to gain additional perspectives on streamlining and alignment of our centralized contracting practices.

The RFP to obtain a medical services network from a PPO, as allowed under the new legislation (SB X4 13, 2009, which amended Penal Code section 5023.5), was released October 20, 2009. Proposals were received and are under evaluation. Due to the number and complexity of proposals received, the evaluation period has been extended into the next reporting period.

Hospital Rate Negotiations

Since the last reporting period, the only hospital partner to discontinue service due to the capped rates outlined in SB X4 13 (2009), Community Regional Medical Center in Fresno, has agreed to enter into a contract at those rates. See [Appendix 4](#) for an updated Hospital Coverage Map.

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

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

Invoice Processing Days

As stated previously, in November 2008 the backlog of claims was approximately 60,000. Since that time staff has worked to implement the electronic claims processing system as well as to continue to process the claims that will not be processed by the TPA, including registry and laboratory. The backlog of claims has been cleared and as of March 2010 we are within the mandated 30-day processing timeframe for the first time since 2006.

Third Party Administrator

The full transition of claims submitted on industry standard forms (hospital, physician, and ambulance) to the TPA, Correct Care Integrated Health (CCIH) began on October 5, 2009 for dates of service September 1, 2009 forward. As of March 2010, the TPA is within the mandated 30-day processing timeframe.

The eligibility interface between the TPA and the Offender Based Information System is online which eliminated the majority of the manual eligibility verification. Additionally, the Provider Web Portal is online and allows providers to directly access their payments information.

The initial planning stage for the electronic interface between the providers and the TPA has begun. A rollout plan for implementation is being developed. We expect that approximately 80 percent of the providers will submit their claims electronically by Fall 2010.

Two-Year Post Audit

The two-year post audit effort has resulted in \$13.8 million in refunds as of early April 2010. These refunds apply to the timeframe between July, 1, 2007 and June 30, 2009 and will not apply to current year savings. Viant continues to identify potential overpayments and plan recovery efforts surrounding those overpayments. Viant will begin its go-forward audit on the claims processed through CCIH in May 2010.

Access to Data from the TPA

Due to the need for additional data elements which the TPA collects, the data interface workgroup decided to obtain those elements separately from the Contract Medical Database. This workgroup has adopted system requirements and has received an initial data set which is now in the process of validation testing. The data is expected to be fully validated and usable for reporting in May 2010.

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.

This action has been completed.

As of February 28, 2010, which is the most recent reporting period available, over 91 percent of the nursing positions have been filled statewide (this percentage is an average of six State nursing classifications).

More specifically, the goal of filling 90 percent or higher of the Registered Nurse (RN) positions has been achieved at 27 institutions (81.8 percent of all institutions), with 4 institutions (12.1 percent) having filled 100 percent of their positions. Six institutions (18.1 percent) have filled 80 to 89 percent of their RN positions.

The goal of filling 90 percent or higher of the Licensed Vocational Nurse (LVN) positions has been achieved at 20 institutions (60.6 percent), with 6 institutions (18.1 percent) having filled 100 percent of their LVN positions. Eleven institutions (33.3 percent) have filled 80 to 89 percent of their LVN positions.

Twenty-three institutions (69.6 percent) have achieved the goal of filling 90 percent of their Psych Tech positions, with 11 institutions (33.3 percent) having filled 100 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, wwwIndeed.com, www.VetJobs.com, www.caljobs.ca.gov, 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 and access to their database of jobseeker resumes. 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: California Correctional Institution, High Desert State Prison, and Pleasant Valley State Prison 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 February 2010 Human Resources Recruitment and Retention Report. A moderate vacancy rate (11 to 30 percent) exists at California Medical Facility, California Men's Colony, Chuckawalla Valley State Prison, Ironwood State Prison, and Sierra

Conservation Center. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for December 2009 and January and February 2010. These reports are included as [Appendix 5](#). 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.

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

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 February 28, 2010, nearly 88 percent of physician positions are filled (this percentage is an average of all three State physician classifications). More specifically, 90 percent of the Chief Medical Officer (CMO)/medical executive positions are filled; 89 percent of the CP&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; 16 of these institutions have filled at least 95 percent of their P&S positions. Five institutions (15.1 percent) have filled 80 – 89 percent of their P&S positions.

While the Central Valley region, as well as Chuckawalla Valley State Prison, continue to be “hard-to-fill,” the following institutions decreased their vacancy rate during this reporting period: Avenal State Prison, California Correctional Institution, Centinela State Prison, California Men’s Colony, California Medical Facility, Corcoran State Prison, Mule Creek State Prison, North Kern State Prison, Pelican Bay State Prison, California State Prison Solano, Salinas Valley State Prison, and Valley State Prison for Women. Of special note, Centinela State Prison; California State Prison, Corcoran; Pelican Bay State Prison; and Valley State Prison for Women have now filled 100 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, a RFP for physician and executive search services was released in March 2010. These services will be used to recruit a statewide executive leader, as well as assist with staffing at the “hard-to-fill” institutions and the medical executive positions.

A high vacancy rate (30 percent or higher) and turnover rate (20 percent or higher) exists at Correctional Training Facility and Chuckawalla Valley State Prison as displayed in the Physicians Filled Percentage and Turnover Rate map in the February 2010 Human Resources Recruitment and Retention Report. A high turnover rate (20 percent or higher) and moderate vacancy rate (11 to 30 percent vacant) exists at Avenal State Prison; California State Prison, Los Angeles County; High Desert State Prison; Pelican Bay State Prison; and Salinas Valley State

Prison. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for December 2009 and January and February 2010. These reports are included as [Appendix 5](#). 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.

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

Since the CEO examination was launched on December 24, 2008, 476 CEO applicants have been added to the certification list and 12 hires have been completed. 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.

Since the Receiver's Nurse Executive examination commenced in September 2008, 322 Nurse Executive applicants have been added to the certification list and nine Nurse Executives have been hired.

Since the Receiver's Medical Executive examination was launched in December 2008, 112 Medical Executive applicants have been added to the certification list. Nine Medical Executives have been hired.

A fifth Receiver's Career Executive Assignment, Receiver's Health Care Administrator that will be responsible for all medical administration subject areas that are not clinical in nature, was approved by the State Personnel Board on December 17, 2009. Prior to filling jobs covered by this classification, a salary study must be conducted and salaries approved by the Department of Personnel Administration.

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.

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

Status of New Employee Orientation and Training

Health Care New Employee Orientation (HCNEO) was delegated to each institution to comply with the January 2010 implementation date. This was done through formal training for trainers

webinars covering the approved lesson plans. Each institution has the approved lesson plans and student workbooks to enable them to train all Medical, Mental Health, Dental, Pharmacy, other allied health, and support staff. Currently 19 out of 33 institutions have offered HCNEO in some format (14 of them plan to offer HCNEO again within the next two months). The Education and Training Unit is working closely with the nursing instructors and IST offices to identify needs and provide any necessary assistance. Further collaboration between CPHCS and CDCR is necessary to complete the implementation process. Headquarters staff continues to receive training on a monthly basis in the greater Sacramento area. Training for out-of-state patient-inmate providers continues to be offered via a computer-based training program. HCNEO course evaluations indicate this orientation is well received. The next tri-annual report will provide an update on the resolution of the issues and problems identified in the implementation process.

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. The target date for revising the program is June 2011.

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.

The action has been completed. Progress during this reporting period is as follows:

The Continuing Medical Education (CME) courses (listed below) were conducted for a total of 44 sessions at various institutions throughout the department. These sessions were provided to 217 MDs and 115 non-MDs for a total of 1,112 hours of instruction.

- 2009 Program Guide Training (Mental Health)
- Advance Directives
- CPHCS Pain Management Guidelines

The following CME courses are in various stages of development, approval or implementation.

- Low Back Pain / Acute Joint Pain
- Do No Resuscitate / POLST
- Diabetes
- HIV Medicine for the Primary Care Provider
- CPHCS HIV Update 2009-2010
- Introduction to the MHSDS for Medical Staff
- Insomnia

As a continuous effort to improve patient-inmate 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, staff from CPHCS produced the first statewide patient outcomes report focused on diabetes, which was widely disseminated in March 2010. In order to produce the first Diabetes Outcomes Report, staff from the Quality Improvement Section, Information Technology, and Allied Health partnered with clinical leaders from the institution and region to integrate and validate pharmacy, laboratory, and inmate locator data. This first Report, which provided baseline data on three of the five diabetes-related quality and outcome measures that were specified in the Quality Management (QM) Plan 2010, will be produced on a quarterly basis to determine progress towards performance objectives. (The QM Work Plan, Diabetes Outcomes Report is attached as [Appendix 6](#)).

In April 2010, CPHCS staff also produced a similar type of clinical report that included data associated with quality of care for asthma patients. (The Monitoring and Improving Asthma Care Report is attached as [Appendix 7](#)). In 2008, CPHCS piloted an approach to asthma care at six institutions emphasizing team-based care, evidence-based practice, patient self-management and clinical information to evaluate and improve care, and in 2009, this approach was implemented statewide. The Report which contained results on two asthma performance measures was disseminated along with treatment algorithms and patient self-management materials (i.e. Asthma Care Guide), and recommended practices from institutions that have performed well on the asthma performance measures.

Preliminary data show that the majority of institutions have met established performance objectives. Those institutions not yet at goal have been instructed to take appropriate action to bring their performance in alignment with the performance objectives, using tools such as the Asthma Care Guide. Three outlier institutions received detailed information at the prescriber level to conduct targeted staff development and program improvement activities. Next quarter, a follow-up report will be produced to assess progress on the two performance measures.

To document and measure health care delivery, use of a “balanced scorecard” showing each institution’s disease burden, utilization, staffing, access-to-case measures, clinical quality indicators and financial performance is a demonstrated and valuable performance measurement tool. For the past several months, we have issued the monthly Medical Program Management Report (MPMR), which includes utilization, costs, staffing, and access to care data. (The MPMR, with supplement, is attached as [Appendix 8](#)). Many of the performance measures in the MPMR align with the OIG medical inspection indicators and are a useful tool that assists institutions in monitoring compliance with OIG indicators, *Plata* mandates, and other aspects of local program management.

In this reporting period, we exceeded six months of MPMR reporting, allowing for trending of performance data in an Institution Profile and statewide summary. In addition to the MPMR, staff designed and disseminated more reliable data collection methodologies for six critical access measures.

With the addition of the diabetes and asthma patient outcome and quality of care data, we now collect most of the data elements called for in the RTPA, reflected in our “balanced scorecard.” In the next reporting period, staff will continue to expand outcomes and quality of care reporting to include additional performance measures described in the 2010 QM Plan, consistent with nationally accepted indicators and court mandated requirements.

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 has been completed.

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 January 1, 2010, through March 31, 2010, the Credentials Committee reviewed 35 individual provider cases. Of the 35 cases reviewed, 18 were approved, six denied, seven reviews resulted in either a Credential Alert or a Credential Bar, one case was closed, and three are pending a final determination. During this period there were also 33 issues discussed as an “Open Item Discussion.” The issues ranged from file reviews to policy and procedure.

Credential Applications

Within this reporting period, the Credentialing and Privileging Unit staff processed 497 credential applications. Of these, 393 were approved, 12 denied, 52 were closed due to being incomplete, and 40 files are pending completion.

Two-Year Reappointment Compliance

During the reporting period of January 1, 2010, through March 31, 2010, 168 civil service providers were notified to complete their two-year reappointment. Of the 168 notified, 76 have been completed while 92 remain pending completion. Of the 92 pending reappointments, 11 are currently being processed by the Unit staff, leaving the remaining balance of 81 pending due to provider compliance (Compliance is when provider has completed the re-credentialing process which verifies he/she possess a renewed & current license to practice.)

To date, 412 reappointments are pending completion with 36 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 has provided 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 January 1, 2010, through March 31, 2010. During this reporting period 84 Notice of Licensure Expirations were processed and renewed. To date, all monitored provider's license are current through March 31, 2010. 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.

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.

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

Quality Advisors and Champions

As part of their management responsibilities, regional executives and their staff have assumed a more prominent role as quality advisors to the field. Regional and headquarter executives were involved with establishing the performance objectives listed in the annual Quality Work Plan; communicating expectations to the field regarding performance and quality improvement activities; monitoring each institution's progress in meeting performance objectives; and providing focused technical assistance to select institutions.

In addition, physician and nurse managers at each institution serve as clinical champions of change. These clinical leaders and the institution CEO are the main liaisons with the region's leadership during implementation of statewide quality improvement initiatives, and they are responsible for conveying initiative expectations; educating staff about the initiatives; overseeing local efforts to meet program objectives; and providing critical feedback to headquarters necessary for refining new statewide programs.

Quality Management Committee

In March, the headquarters QM Committee adopted a 2010 QM Plan with a focus on strengthening the statewide QM organizational structures and enhancing quality improvement capacity at institutions. The 2010 QM Plan outlines performance objectives, which will enhance overall value of healthcare services, and that will be measured and reported in the coming year in the areas of access, utilization, costs, quality and patient outcomes. The QM Plan also describes

major initiatives and strategies that will be used to accomplish the performance objectives for the year, and cites how those initiatives align with the RTPA.

One of the major initiatives in the 2010 QM Plan is to coordinate the activities of the committees that prioritize, develop, implement, and evaluate clinical programs and manage change. During this reporting period, a formal communication process was established among committees and subcommittees to ensure coordination of strategic activities, especially as relates to the QM Plan, and programmatic performance improvement.

Quality Improvement Programs

In April 2010, CPHCS began implementation of another major QM Plan initiative, the Clinical Outcomes Initiative, which includes a series of coordinated activities designed to (1) improve patient outcomes, (2) reinforce team-based primary care and (3) build quality improvement capacity in the field. For many reasons, including relative health risk to CPHCS patients and costs associated with care, CPHCS has selected patients with cardiovascular risk and diabetes as the targeted population for 2010. The 2010 QM Plan lists five performance improvement objectives for this patient population, which are consistent with national standards of care.

In addition to Improving Diabetes Outcomes, the QM Plan includes performance objectives and initiatives to improve (1) access to clinical services; (2) cost and utilization especially as it relates to pharmaceuticals, specialty services and community hospitalizations; and (3) quality of care particularly focused on prevalent chronic diseases and preventive services.

Accreditation

CPHCS has been exploring options for national healthcare accreditation, in accordance with another stated strategy in the QM Work Plan. There are a number of benefits to securing national healthcare accreditation, among them program sustainability over time, alignment with recognized industry standards for quality of care and patient safety, participation in a national correctional healthcare forum, and mitigation of legal risk. During this reporting period, CPHCS researched options for accreditation, resources required to support an accreditation effort, and alignment with mental health and dental accreditation efforts under Division of Correctional Health Care Services (DCHCS).

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.

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 Governing Body has met four times during this reporting period to take final action on recommendations from the Professional Practice Executive Committee (PPEC) regarding practitioners.

The PPEC and Peer Review Subcommittee (PRSC) met 11 times during this reporting period and have reviewed a total of 77 civil service referrals. The PRSC closed four referrals following review or the successful results of training and/or monitoring plans. There were 22 monitoring or training plans initiated by PRSC or PPEC for those providers whose standard of practice warranted closer review. The Governing Body approved 12 case closures of providers whose clinical practice was deemed to meet an appropriate standard of care following a peer review investigation and restored the privileges of four providers.

In this reporting period, the PPEC did not summarily suspend the privileges of any providers and no providers that were under investigation were separated from State service. The Governing Body did not issue any Notices of Final Proposed Action under the new policy that would have resulted in the revocation of privileges and employment. Graphical displays of PPEC and Governing Body outcomes for the period January 2010 through March 2010 are presented in Tables 3 and 4.

Table 3.

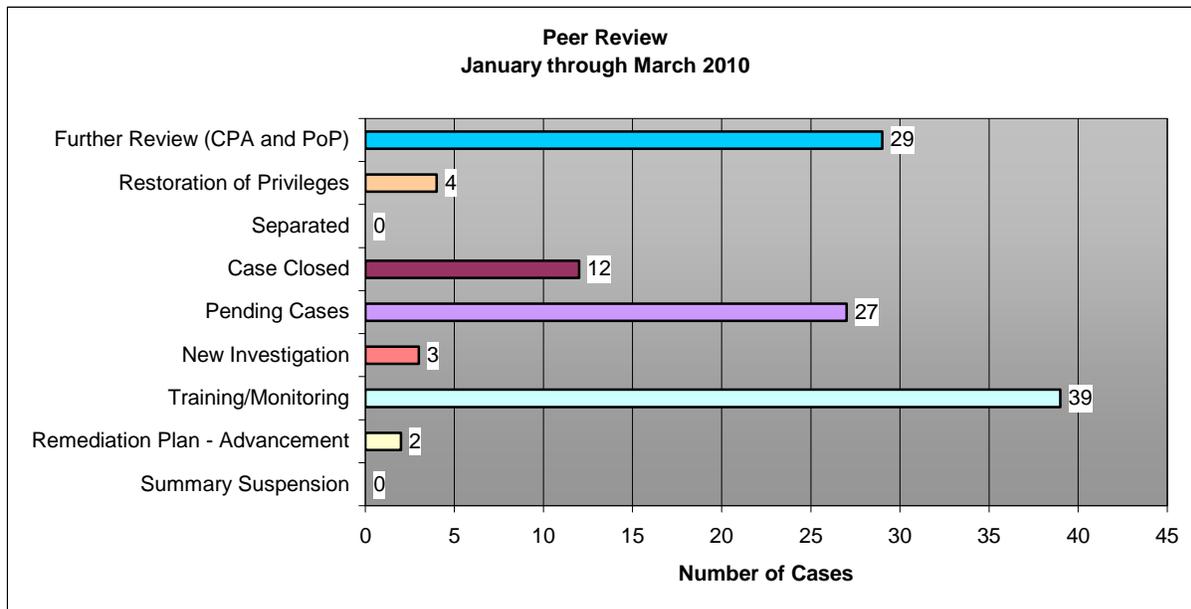
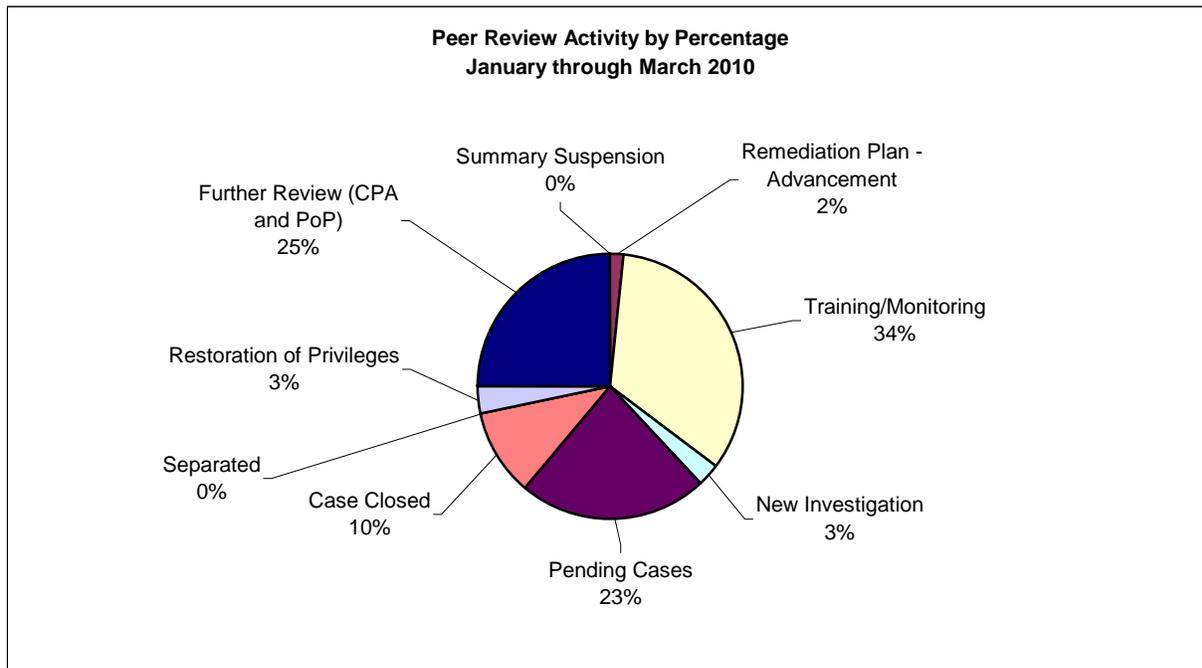


Table 4.



Tables 3 and 4 Results Explanation:

The data represented pertains to licensed independent practitioners including, physicians and surgeons, psychiatrists, psychologists, dentists, nurse practitioners, physician assistants and licensed clinical social workers. “Separated” status refers to employees that separate from State service after a peer review investigation is initiated by PPEC.

“Case closed” is defined as licensed independent practitioners 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.

“Remediation Plan-Advancement” is defined as a legally binding agreement between PCHCS and the provider, staying Governing Body actions pending the provider’s participation in training, monitoring, and phasing in of privileges to full restoration.

CPHCS is now in the final phase of completing the transition of the appeal hearing process for physicians from the Office of Administrative Hearings to the SPB as specified in the Federal court ordered policies. This transition will be completed by June 30, 2010.

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.

Efforts are continuing to simplify the MOP processes and include: directing responsibility for death reviews and MOP Roll-Out determinations to the Regional Medical Executive (RME) and Nurse Executive (RNE), and coordination and delegation of death review activities to be handled by the RME and RNE with the institutions. The decision for a MOP Roll-Out has been delegated to the RMEs and/or the RCNEs and institution CMOs based on their review of the daily death reports.

If a Roll-Out is required, the RMEs will now be responsible for notifying the Clinical Operations Support Branch Deputy Director or the MOP Manager II. The MOP administrative support will notify the CDCR Office of Internal Affairs (OIA) and Employee Advocacy and Prosecuting Team to assemble a MOP Roll-Out Team.

The MOP continues to review the most egregious of sentinel events. During this reporting period, the MOP was activated for 23 cases. The Medical/Central Intake Panel opened four cases for investigation, rejected nine cases for investigation, and nine cases are pending further review. With respect to the disposition of cases reviewed by the Panel, 10 “Direct Actions” were referred back to the hiring authority, 10 subjects were referred to Nursing Practice Review and 13 subjects were referred to the PPEC.

Graphs of MOP outcomes for January – April 2010 are in Tables 5 and 6.

Table 5.

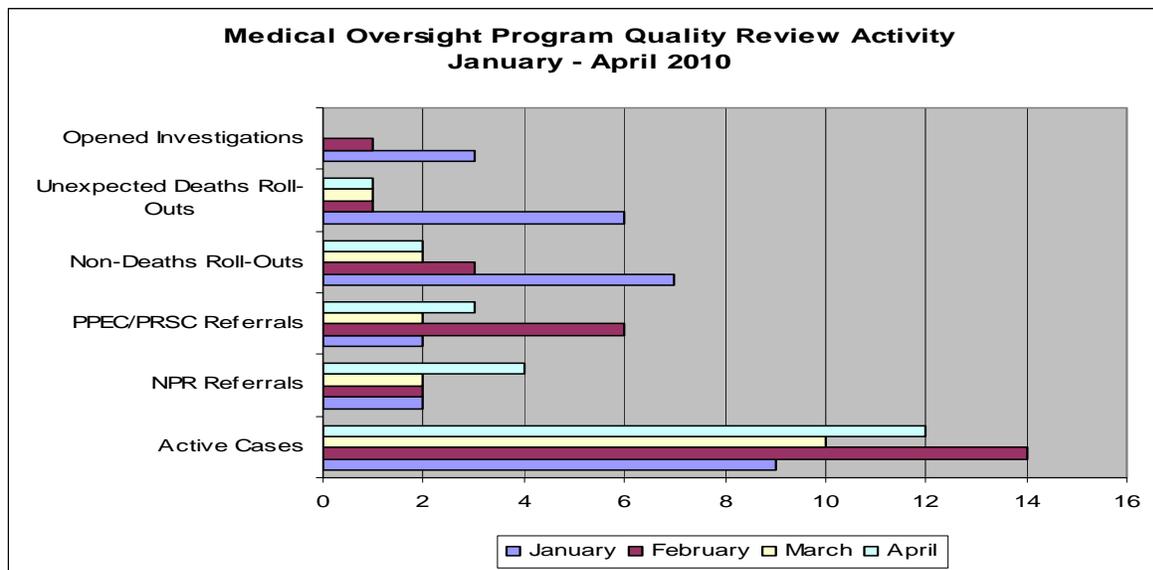


Table 5 Results Explanation:

“Opened Investigations” are formal investigations conducted by MOP.
 “Unexpected Deaths Roll-Outs” 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-Deaths Roll-Outs” 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 Referrals” are 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 6.

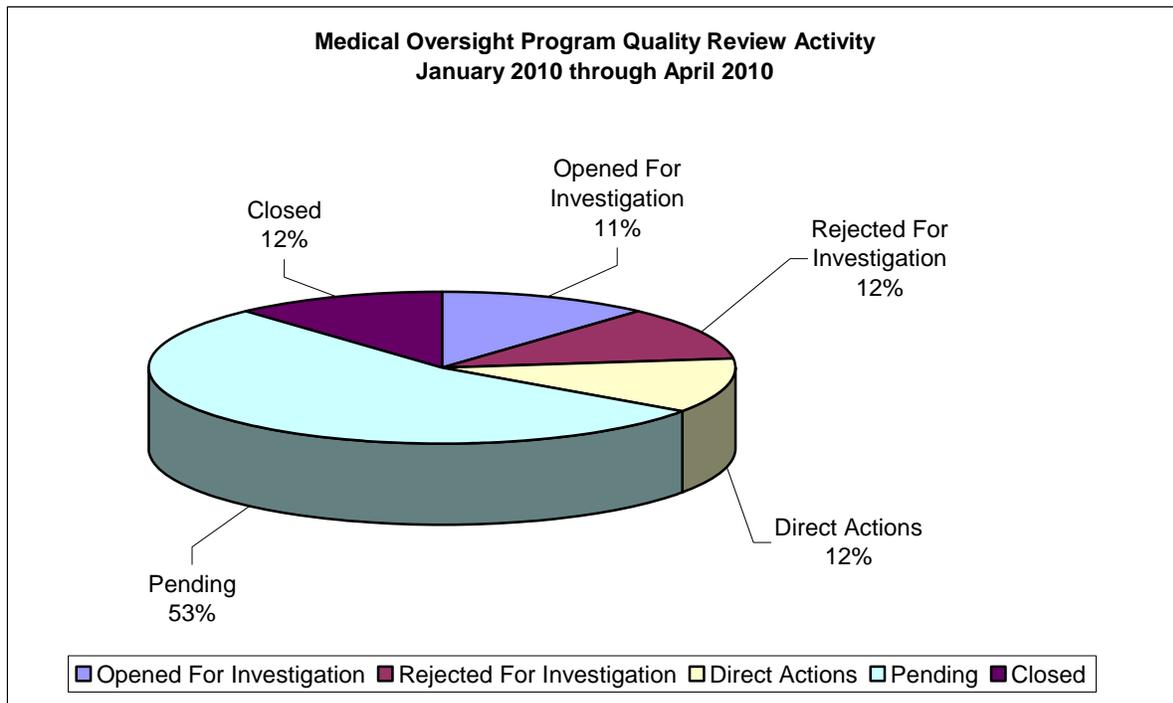


Table 6 Results Explanation:

“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.

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.

Objective 4.6. Establish Out-of-State, Community Correctional Facilities (CCF) 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 the last reporting period, it was anticipated that CPHCS' Field Support Division (FSD) and Corrections Corporation of America (CCA) staff would finalize all pending policies; however, only CCA Policy 13-62, Notification of Next of Kin/Others was approved for implementation by CCA. Although additional discussions and meetings have occurred related to the remaining pending policies they have not been finalized to date. The delay in finalizing the pending policies comes as a result of the increased workload associated with FSD staff conducting 12 on-site compliance reviews during this reporting period. FSD staff will continue to work with CPHCS's clinical leadership and CCA staff to resolve all outstanding issues so that the pending policies can be finalized and implemented as quickly as possible.

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:**

While CPHCS clinical staff began completing Clinical Performance Appraisals (CPAs) of all CCA Primary Care Providers (PCPs) providing care to California patient-inmates in August 2008, FSD staff did not begin tracking that information until May 2009. Since that time, CPHCS has completed 26 CPAs, of which 21 were annual or initial reviews and 5 were follow-up reviews. Five of the 21 annual/initial CPAs were conducted on PCPs who have subsequently resigned from CCA or no longer see California patient-inmates.

CCA has completed Peer Reviews (which is CCA's version of CPAs) on all PCPs who provide medical care to California patient-inmates in CCA contracted facilities. CCA performs Peer Reviews annually on all PCPs, unless a PCP falls below a standard rating, which results in more frequent follow-up monitoring. CCA has submitted a total of 16 completed Peer Reviews to the FSD. FSD staff will continue to monitor this process on a monthly basis.

2. **Weekly Physicians Collaborative Update on CCF Patient-Inmates:**

During this reporting period, an average of 33 medical cases per week was discussed on the weekly Physician's Collaborative Conference Call. These discussions have resulted in an

average of approximately 5 patient-inmates per month being returned to California for medical reasons.

3. CPHCS Review of Credentialing Information of CCA Primary Care Provider (PCP)

Candidates:

Because of CCA and FSD staff's involvement in on-site facility compliance reviews conducted during this reporting period, CCA's policy related to credentialing was not finalized. FSD staff and CPHCS clinical leadership will continue to work with CCA to finalize this policy.

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

During this reporting period FSD nursing staff conducted a monthly average of 154 post audits for patient-inmates transferred to out-of-state facilities. Although an average of 5 patient-inmates were inappropriately identified for out-of-state placement, the FSD CMO's review found that based on the patient-inmate's current medical status they were eligible to remain out-of-state. As the newly implemented Medical Classification Process is phased in, FSD staff will no longer be required to conduct post audits of patient-inmate transfers out-of-state. Until such time, we will continue to provide an update on this issue.

5. Establishment of Monitoring Reports:

During this reporting period, compliance reports continue to be generated on a monthly or quarterly basis and are being used by analytical and nursing staff in preparation for the on-site facility compliance reviews being conducted at the out-of-state facilities. Discrepancies related to the information contained in the reports and timeframe compliance issues continue to be discussed with CCA facility staff when necessary. FSD staff will continue to work on developing monthly executive reports that will be distributed to CPHCS and CCA management.

6. Clinical Staffing Levels at CCA Facilities:

During this reporting period, CPHCS's clinical leadership has approved the CCA PCP staffing levels; however, the staffing levels identified for nursing are still pending. Staffing level information has been identified and submitted to CPHCS nursing leadership for their review, modification, and/or approval and it is anticipated that this issue will be resolved during the next reporting period.

7. Compliance Audits Beginning January 2010:

During this reporting period, FSD staff conducted on-site compliance audits at each of the out-of-state facilities. While the intent was to conduct two audits at each of the facilities by June 30, 2010, a decision has been made to cancel the second audits scheduled to occur during April through June 2010. A review of findings from the audits conducted found that CCA has implemented all approved policies at the all five out-of-state facilities, which resulted in fewer deficiencies than originally expected. Also, cancellation of the second audit will allow FSD staff to finalize all compliance review reports and to make modifications to the audit instruments developed for this process. It is anticipated that all compliance review

reports will be finalized and submitted to CPHCS management during the next reporting period.

8. Community Correctional Facilities

Following CDCR's decision to close three CCFs, and CPHCS's on-site compliance review of four of the ten open CFFs during the previous reporting period, seven on-site compliance reviews at the remaining six CCFs and at the Female Community Correctional Center (FRCCC) were conducted during this reporting period. However, in March 2010, CDCR closed an additional CCF, reducing the number of facilities to nine CCFs and the FRCCC.

Preliminary discussions related to the findings at these facilities have occurred between FSD staff and CPHCS clinical and nursing leadership. It is anticipated that all compliance review reports will be finalized and submitted to CPHCS management during the next reporting period.

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* has made significant progress and reached key milestones relating to the deployment of the GuardianRx pharmacy system and the establishment of a Central Fill Pharmacy facility. 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 Committee continued its monthly meetings to review utilization trends, actively manage the formulary, 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.

Formulary decisions during this reporting period included approval of a therapeutic interchange for ketorolac (Acular) 0.5 percent ophthalmic solution as an addition to the formulary. The P&T Committee reviewed and approved multiple changes to the formulary in order to match the formulary to the newly approved pain management guidelines. An addition of Tdap (tetanus, diphtheria and pertussis combined vaccination) to the formulary was also approved.

The committee also finalized formulary changes consistent with the approved OTC items initiative by removing selected, non-medically necessary OTC products from the formulary. These OTC items contribute to an increased workload for healthcare staff, such as nurses who administer and deliver medications and pharmacists who dispense these items. A carefully constructed implementation package was prepared and distributed to assist in this change which became effective in February.

Clinical pharmacy support has been provided for ongoing UM efforts including the Medication Efficiency and Quality Improvement initiative. This clinical leadership effort has targeted several goals related to pharmacy utilization including a reduction in the use of non-formulary medications. Initial results have been positive, with data from February indicating a 23 percent reduction in the percentage of non-formulary prescriptions from the July 2009 levels.

As displayed in Table 7, Pharmacy has documented a cost avoidance of \$4,963,929 in calendar year 2010 through March from the use of targeted contracting strategies linked to P&T Committee decisions.

Table 7.

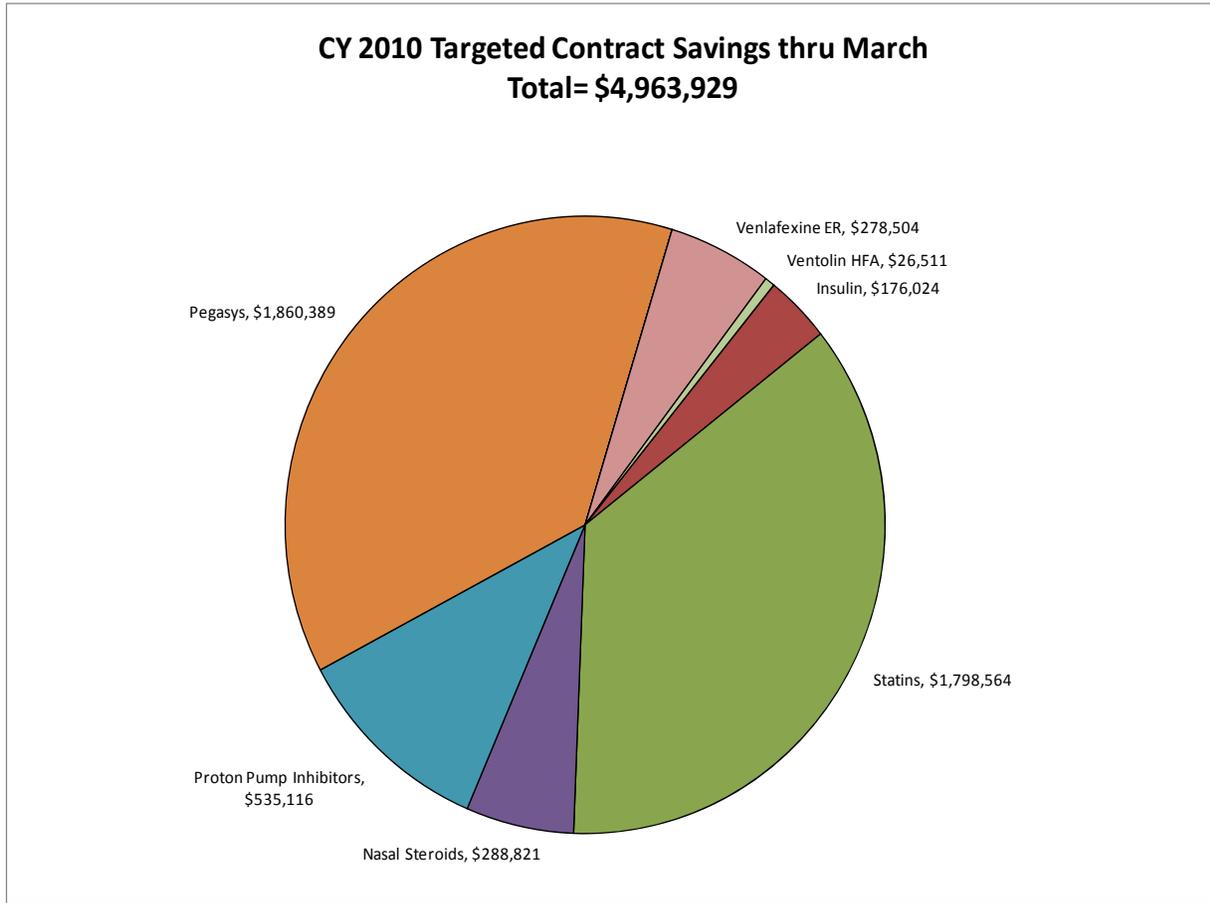


Table 7 Results Explanation: *These categories represent specific P&T Committee initiatives targeting particular drugs or drug classes. Savings calculated by comparing purchases using the actual targeted contract rate to the pre-targeted contract rate.*

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 8 and 9. In just the first three months of CY 2010, over \$18.4 million in expenditures were avoided when compared to prior historical trends.

Table 8.

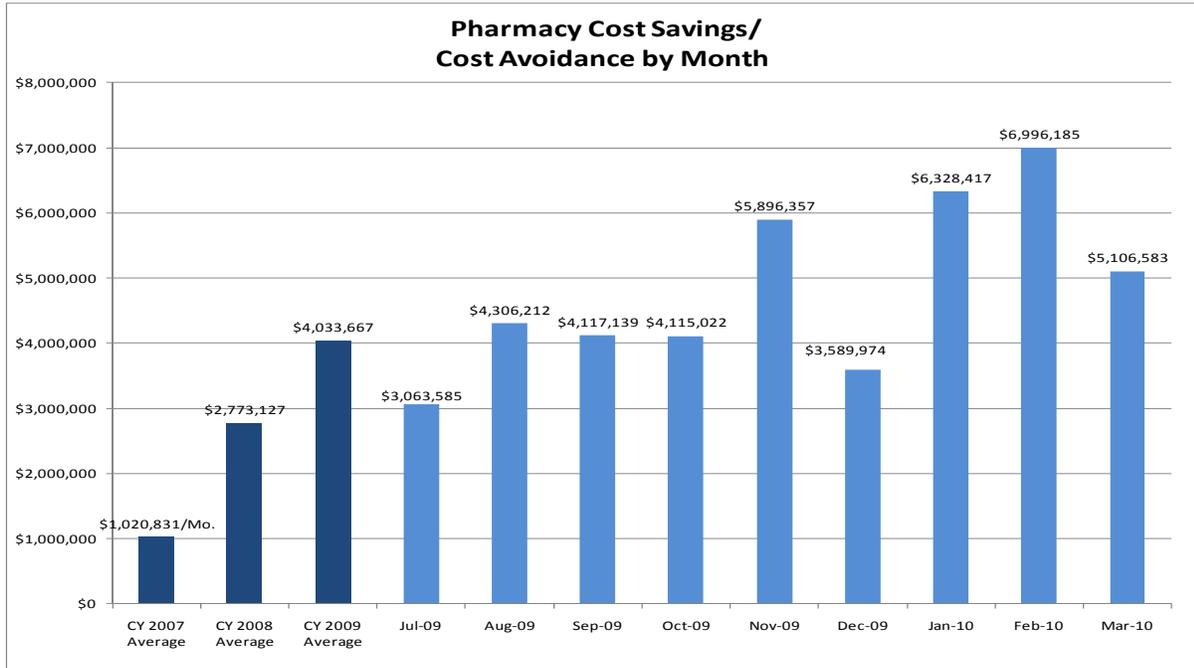


Table 8 Results Explanation: Cost savings/cost avoidance calculated based on comparing actual wholesaler purchases to prior historical trend line (also based on wholesaler purchases). Data pulled monthly from Wholesaler Purchase data. Maxor began managing pharmacy purchasing in April-May 2007.

Table 9.



Table 9 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.

This action has been completed.

Pharmacy Policies and Practices

During this reporting period, the P&T Committee continued to actively review and revise pharmacy policies and procedures as needed. The committee approved a new pharmacy P&P, Ch. 43, Medication Profile and Drug Regimen Review. This policy requires a pharmacist to review medication profile and drug regimen of patients in licensed intermediate care and licensed skilled nursing facility beds as clinically necessary to ensure appropriate drug therapy is provided in compliance with regulatory and practice standards. In addition, the committee approved a revised pharmacy P&P, Ch. 9, Prescription Requirements, which extends the allowable prescription duration to twelve months and approved revisions to pharmacy P&P Ch.34, Heat Risk Medications, updating the listing of medications subject to heat related restrictions. The revisions were reflected in the Heat Plan for 2010.

Additionally, pharmacy leadership has continued to focus on implementation of policy and procedures at the facility level to ensure compliance. To strengthen accountability for such compliance and to begin preparations for transitioning pharmacy oversight and management back to the state, CPHCS Pharmacy leadership assignments were authorized. Monthly meetings with the facility Pharmacists-in-Charge have been conducted to emphasize compliance with pharmacy policy, including return to stock efforts and inventory management.

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 76 percent in February 2010. Pharmacy leadership continues to objectively validate the improvements for any facility moving from non-passing to passing status in their monthly inspection reports by conducting independent onsite validations. Pharmacy inspection status data is displayed in Table 10.

Table 10.

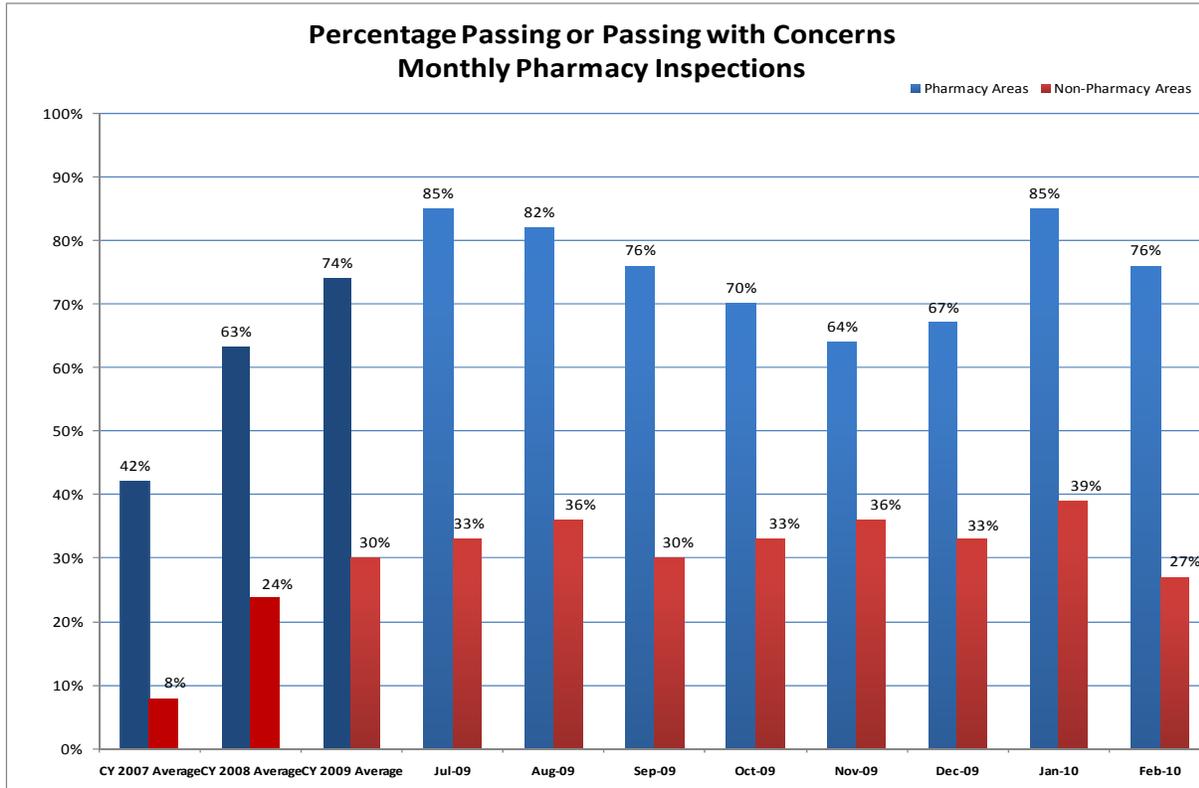


Table 10 Results Explanation Pharmacy areas are denoted in blue, and non-pharmacy locations (medication administration locations) are denoted in red: Independent Maxor Validation of Monthly Inspection Data began in Feb 2008.

Roll-out of the GuardianRx® System

The conversion of all 33 facilities to the GuardianRx® pharmacy operating system has been completed. The advantages of the GuardianRx system are already evident in terms of improved patient safety, continuity of care, and increased access to medication related information for managing the pharmacy program. Safety improvements include up-to-date drug interaction detection, drug allergy tracking, duplicate drug tracking and incorrect dosage detection. Continuity of care is enhanced because the software is enterprise-based, meaning the inmate’s medication profile is accessible throughout the system. Workload management is enhanced by the ability to view and process prescriptions from one institution at another in the event of service disruptions. Perhaps most beneficial of all, healthcare leadership has access to current, accurate and detailed medication utilization information that is essential to implementing cost-effective pharmaceutical therapies.

The Receiver completed initial efforts to improve pharmacy policies and practices at each institution by the initial target date of June 2009, having completed a comprehensive review and revision of all pharmacy policies and procedures. Policies are reviewed on an ongoing basis by the P&T Committee to keep them current. Efforts to enhance training and improve compliance with these policies and procedures continue.

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

The establishment of a central fill pharmacy has been completed and implementation of the central fill distribution model will begin over the next 18 months.

The Central Fill Pharmacy Facility has been established. The facility began installing equipment and training staff in early April of 2010 and has now received almost all of the equipment. In May, the facility is conducting comprehensive testing of the equipment, finalizing staff training and operating procedures and preparing inventory to begin converting facilities to Central Fill. The first facility to be converted will be California State Prison, Sacramento, who will begin to receive prescriptions from the Central Fill Pharmacy Facility in June as the first pilot site to test the implementation methodology and processes. A second pilot site, Mule Creek State Prison, will be added in July. Following the review and validation of methodology with the first two facilities, the ongoing implementation process will begin in August following a schedule that calls for converting two facilities each month. Initial meetings with the facility CEOs and Pharmacists-in-Charge for the first eight implementation sites have been held to begin preparation activities for the implementation process.

The Pharmacy Services Performance Reports for the months of December, January and February are attached as [Appendix 9](#). In addition, the Annual Report for 2009 prepared by Maxor, the Receiver's pharmacy management consultant, is attached for reference as [Appendix 10](#).

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.

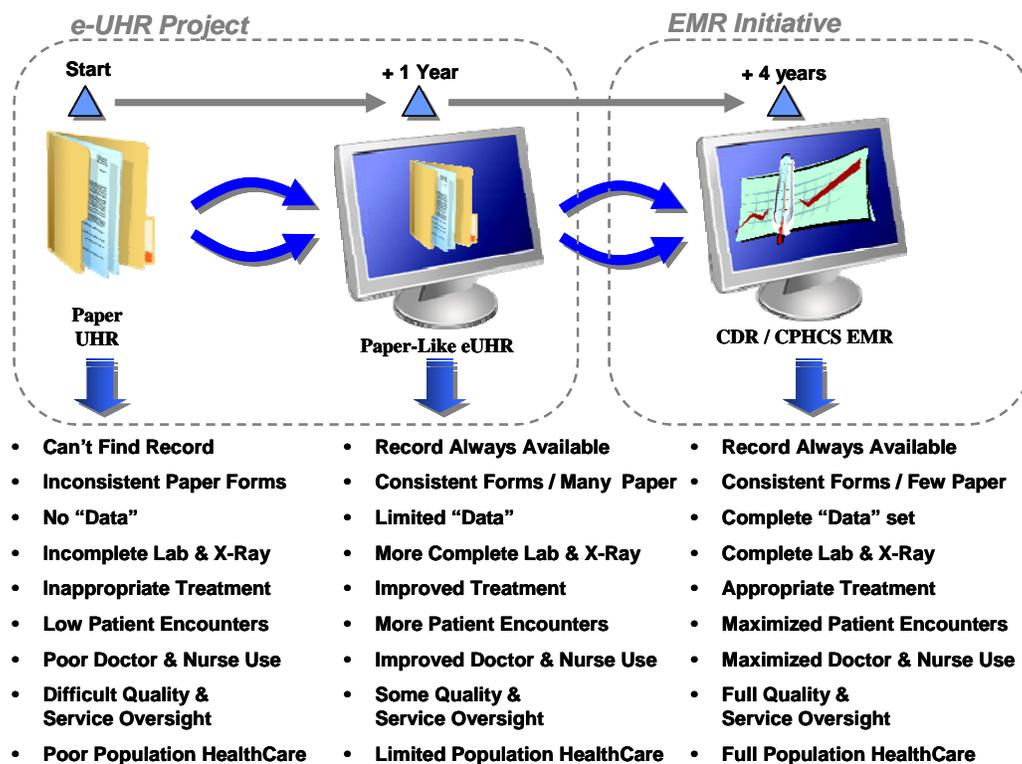
Action 5.2.1. By November 2009, create a roadmap for achieving an effective management system that ensures standardized health records practice in all institutions.

This action has been completed.

The Receiver has continued with plans for an enterprise-wide Unit Health Record (UHR) Conversion initiative where all UHRs and loose filing will be scanned into a "paper-like" scanned electronic UHR (eUHR). The Receiver has advanced through the Planning, project initiation, technology procurement and is currently in the Requirements & Network Infrastructure Stage, which will be followed by Design, and Technology Deployment stages.

Since the last reporting period, the Receiver has engaged representatives from Mental Health, Dental, Medical, and Allied Health disciplines to complete a "Proof of Concept" milestone. This milestone event demonstrated that documents could be converted to an electronic form that met the CPHCS acceptance standard of "at least as good as the original document." These and other key stakeholders from institutions, headquarters, and regional offices are being engaged in each stage of the initiative.

The Receiver has actively engaged all institutions, including a basic walk-through of expected impacts, changes, and benefits of the eUHR initiative as well as how this initiative integrates with the CPHCS Emergency Medical Response (EMR) initiative. The figure below illustrates the relationship between the e-UHR Project and the EMR initiative, including the differences in timing and the incremental benefits of each.



As part of the Requirements and Network Infrastructure stage, the Receiver completed six site visits with the SOMS contractor (Hewlett-Packard) to illustrate the operational variability in UHR use across the CPHCS enterprise. Sites visited included, Kern Valley State Prison, North Kern State Prison, California Medical Facility, California Institution for Women, San Quentin State Prison, and Pelican Bay State Prison. These site visits allowed for the initiation of business process walk-throughs and associated requirements/design sessions with key stakeholder representatives from all disciplines affected by UHRs.

Although scanning the existing UHRs at this time will take advantage of and leverage the SOMS scanning efforts for the custody files (or C-files), CPHCS will realize many other benefits for our patient-inmates and the clinicians and other staff that support them. These eUHR benefits include:

1. Provides simultaneous UHR access by any authorized user.
2. Eliminates the work associated with "volumizing" the UHR and with searches and retrievals of old volumes.

3. Allows immediate access and eliminates the workload of pulling and transporting paper records throughout the institution and between institutions.
4. Eliminates the current burden of paper storage and management at each institution and at our central Health Records Center (HRC).
5. Allows us to efficiently process all loose filing into the eUHR within 24 hours of its creation, including monthly peaks in Medication Administration Report filings.
6. Allows HIM staff to perform quality audits on UHRs both locally and statewide.
7. Allows for electronic enforcement of privacy and security requirements to assure that we are safeguarding protected health information in accordance with regulations. This enforcement can be at the form or tab level and by user as well as aligned with consent allowances.
8. Allows us to more efficiently satisfy Requests for Information and administrative uses of UHRs for QM, third level appeals, and a variety of other enterprise business needs.
9. Provides a platform to bring our non-standard forms into an enterprise standard so that health information forms are supportive of enterprise clinical practice standards.
10. Deploys critical point-of-care computing technology to be leveraged by other electronic tool initiatives (e.g., EMR, HCSS).

Elimination of the HRC's historical loose filing backlog of 50,000 inches (created at HRC inception) is actively underway. This work is part of the eUHR scanning conversion scope.

CPHCS has recruited the Chief of Health Information Management and a Privacy Officer. These critical managers are providing CPHCS leadership guidance over stabilization, remediation, and ongoing enterprise-wide HIM operations.

Dental continues to proceed toward a more efficient paper based UHR. Recently Dental has refined the record structure of the paper UHR. Some institutions began receiving and using new folder inserts that facilitate this refinement in late February 2010. Distribution continued throughout March, and it is anticipated that the remaining institutions will receive their inserts by the end of April. The eUHR initiative will establish electronic Dental dividers that are reflective of the reformed paper UHR structure.

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.

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

Medical Records

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

Imaging/Radiology Services

During this reporting period, work has continued in an effort to implement standardized and accurate processes to ensure the elimination of patient backlogs, improve patient-inmate conditions, create a safer work environment, and reduce operational costs to the state.

In the first quarter of 2010 we have nearly completed the implementation of standardized film filing across all 33 institutions which improve efficiency, accuracy and access to patient records. All 33 institutions have adopted both Master Jacket and Terminal Digit filing standards as illustrated in Table 11, with most institutions nearing 100 percent conversion of active film files to this standardized process as indicated in Table 12 below.

Table 11.

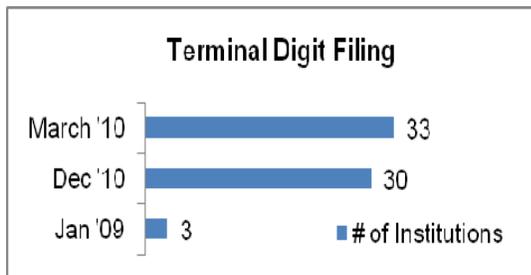
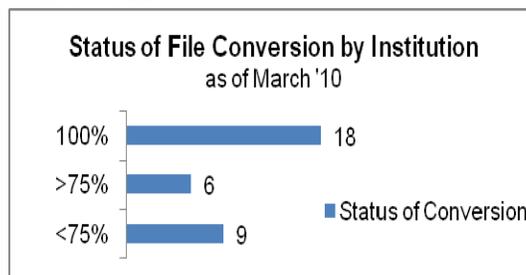


Table 12.



Due to ongoing issues associated with regulatory compliance within the Radiology/Imaging departments at a number of institutions staff have developed and distributed a guiding document specifically addressing state and federal regulations with which every institution must comply. This was implemented to ensure all sites are compliant with state and federal safety regulations related to Physicist inspections, annual calibration of equipment, X-ray tube registration and decommissioning of unused equipment.

Much work has been done in collaboration with the decision to open the Stark facility near California Institution for Men as a reception center. In order to repurpose the facility the imaging team has worked closely with both site and state-level staff to ensure there is adequate space for radiology film files. It has been determined that in the interim radiology services for patient-inmates housed at Stark will have X-rays performed at California Institution for Men.

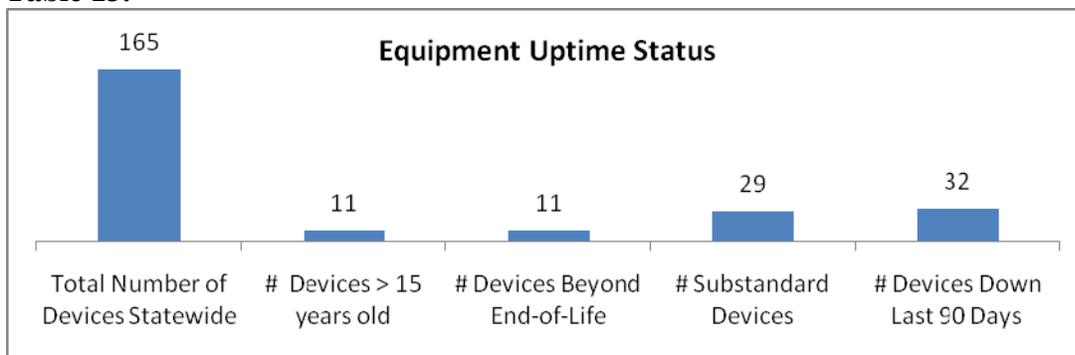
Personnel issues at the adult institutions also are being addressed to ensure staffing ratios fit institutional characteristics and meet the demand of examinations ordered. To assist with setting a staffing baseline and to avoid conflicts with ongoing efforts to redesign the statewide imaging staffing 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.

The imaging team has completed Mammography Quality Standards Act certification at Valley State Prison for Women in January 2010. This brings all three (3) adult female institutions in compliance with mammography standards. All three institutions provide Mammography

screening for female patient-inmates according the American College of Radiology and the American Cancer Society recommendations.

During this period an audit was conducted of the services provided by contracted vendors in the area of equipment maintenance and support. The results of this comprehensive review revealed opportunities to significantly reduce costs as well as revise the contract to ensure better service and fully qualified contractors. This will lead to better functioning equipment which ensures access to care and reduces backlogs. The importance of these contracts will continue to escalate due to growing issues with old and outdated equipment as indicated by Table 13 below. This metric was available for the first time in March 2010. We will continue to monitor equipment status for trending purposes which will assist with the prioritization of equipment replacement.

Table 13.



Work on constructing Mobile service pads for CT/MRI vendors at 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) is underway at four of the five sites. One institution, North Kern State Prison, may require Public Works approval due to the inclusion of a new transformer for additional power. This will delay the start of the construction and may not complete by end of FY 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, UHR, and Clinical Data Repository (CDR)). Our goal is to ensure that these overlapping processes accommodate the work and data flow required for interoperability with Radiology and Imaging Services.

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.

This action has been completed.

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 March 2010 the CDR has completed training & roll out to Folsom State Prison, Sacramento State Prison, and Wasco State Prison. In the months leading up to March, historical data was loaded from custody, pharmacy and laboratory partners. Staff at these institutions were trained on the CDR and on-site and remote assistance was provided to support the roll out. The CDR project team conducted performance and stabilization assessments, which led to increasing system memory, resulting in upgraded system performance.

The project will continue to train and roll out the CDR to additional institutions, with roll out to North Kern State Prison, San Quentin State Prison and Avenal State Prison planned over the next quarter. During this period the system will continue to be monitored for stability and performance, to ensure appropriate performance as additional institutions are brought on to the CDR.

Objective 5.5. Expand and Improve Telemedicine Capabilities

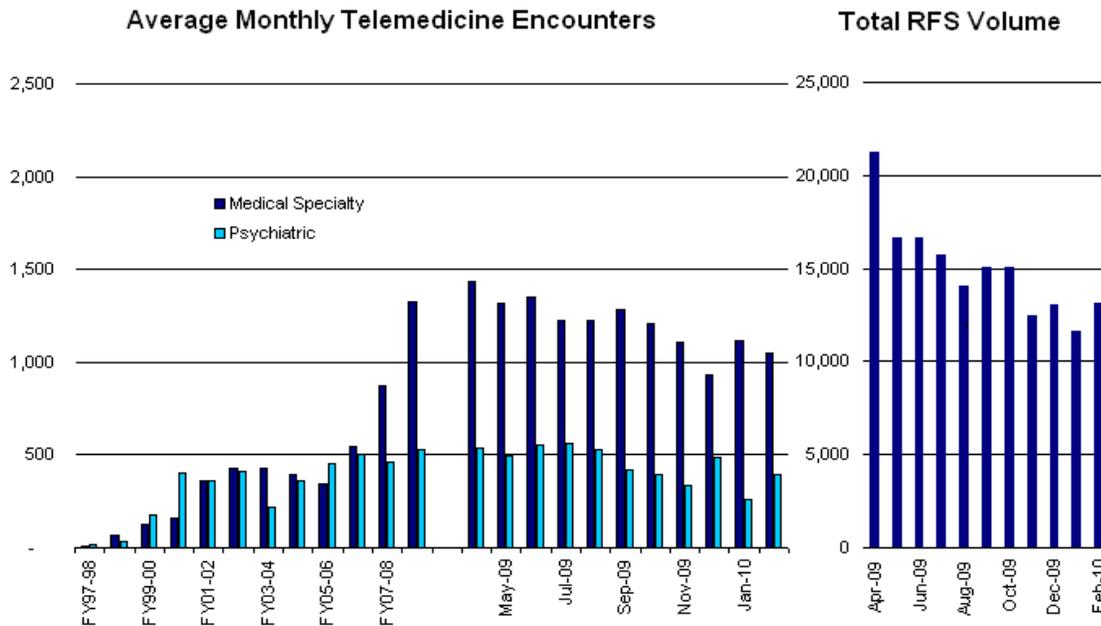
Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure.

This action has been completed. The Telemedicine program continues with efforts to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure.

During this reporting period, CPHCS hired a new Health Program Manager. Phase 2 of the Telemedicine Services Project was completed, which included the Six Institution Initiative to Expand Telemedicine Encounters. The Initiative resulted in a 14 percent increase in telemedicine services at the target institutions, and provided experience that will facilitate telemedicine expansion at the other CDCR institutions.

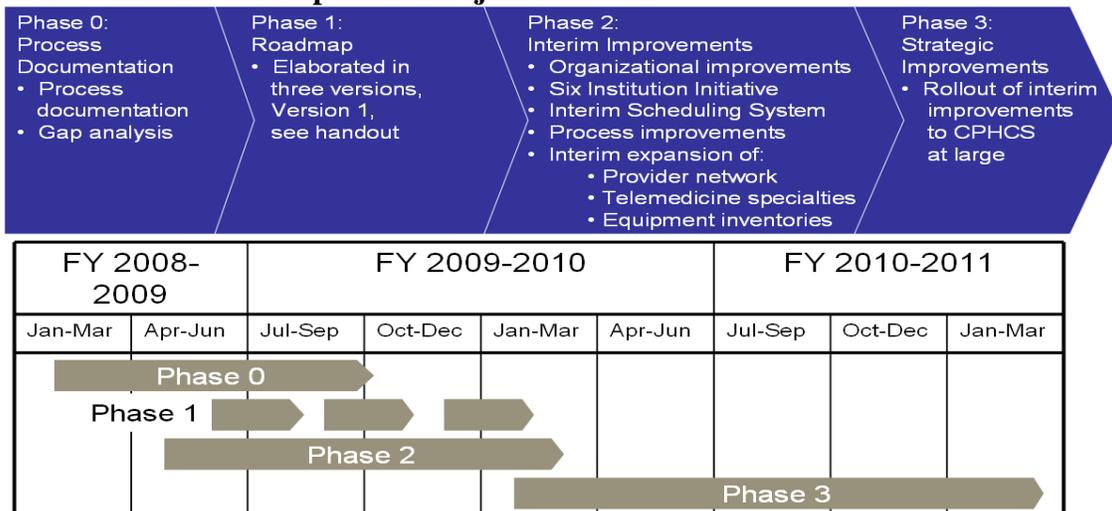
Progress in expanding telemedicine system-wide is shown in Table 14. While total Request for Services (RFS) volume is declining because of the UM program, the proportion resulting in telemedicine encounters is continuing at a steady pace.

Table 14: Telemedicine and RFS Trends



Phases 3 of the Telemedicine Services Project is being launched pursuant to the timeline in Table 15. Phase 3 will include a general expansion of telemedicine for specialty services and a pilot of telemedicine for primary care services. Additionally Phase 3 will implement a change in clinical protocol, making telemedicine the default escalation from primary care whenever clinically appropriate.

Table 15: Telemedicine Expansion Project Schedule



During the next period the CPHCS team will work closely with Information Technology staff to replace ISDN data communications for telemedicine with IP.

During the previous reporting period, CPHCS 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. The reassigned staff are learning and maturing in their new roles. Additionally, we are continuing the process of automating our telemedicine scheduling process.

The provider expansion for specialty services continues. Over the last period, three new specialty services (ENT/otolaryngology, maxillofacial, oncology/hematology) have been added to the list of telemedicine specialties available. Seven new providers and one new provider hub have been added to our network of telemedicine providers.

We have informed the University of California, San Francisco (UCSF)/CMCN that plans are being developed to transition HIV services to on-site CDCR physicians and Telemedicine in a phased in process that should start in July 2010 and be completed mid Fall. It is anticipated that UCSF support for these services will not be clinically necessary beyond mid Fall, as CDCR assumes responsibility for HIV patient care, and a collaborative effort that includes UCSF and CPHCS senior clinical leadership has been developed to oversee the transition.

The CPHCS team continues to engage in discussions with prospective medical groups and providers throughout the state that can provide telemedicine services.

During the next reporting period, we expect to successfully launch our system wide telemedicine expansion initiative for specialty services, to launch our pilot for telemedicine primary care services, to advance the automation and re-engineering of our scheduling function, and further expand our provider network. CPHCS anticipates the successful completion of the telemedicine specialty expansion initiative and a successful primary care pilot.

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 complete. Work completed 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. Institution staff began moving into the new buildings sequentially, starting in December 2009 and the first patient-inmates were seen on January 26, 2010. All clinics were fully operational as of February 5, 2010.

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 healthcare, and program improvements that have not been fully realized in part because of CDCR's severe budget shortfall.

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 believed that this \$8 billion capital investment, if combined with other operational and staffing improvements and a reduction in the prison population, would likely have been sufficient to end the four primary class actions involving prison healthcare.

Beginning in July of 2008, the Administration withdrew its support for this investment. After a period of litigation between state officials and the Receivership, 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 1,700 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.

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. Legislation to free up available funding is currently pending before the Senate.

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

During this reporting period, planning activities for the CHCF have continued along with planning models and assumptions for the converted Division of Juvenile Justice facilities. The CHCF 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.

On January 15, 2010, Department of Finance submitted the 30-day notification letter to the JLBC for review. At the request of the JLBC this project was pulled from the February PWB agenda and has not been rescheduled.

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. The Petitioners' Motion to Remand the case back to state court was denied on April 2, 2010.

The parties reached a tentative settlement agreement in late April and believe they have reached agreement in principle on the material settlement deal terms, subject to obtaining governmental approvals. They are in the process of preparing an integrated global settlement agreement memorializing those agreed terms which they anticipate will be finalized and executed by the authorized representatives of all parties within the next three to four weeks, allowing the case to be dismissed in its entirety.

Given this status, and the parties' desire to facilitate the settlement process and to avoid unnecessary expense litigating the case, the parties requested and the Court granted on April 27, 2010, a continuance of all litigation deadlines for thirty (30) days.

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.

This action has been completed. 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.

This action has been completed as of 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.

Section 4

Additional Successes Achieved by the Receiver

A. Clinical Quality Management and Evaluation Program

Improving Diabetes Outcomes

During this reporting period, staff from CPHCS produced the first statewide patient outcomes report focused on diabetes, which was widely disseminated in March 2010. In order to produce the first Diabetes Outcomes Report, staff from the Quality Improvement Section, Information Technology, and Allied Health partnered with clinical leaders from the institution and region to integrate and validate pharmacy, laboratory, and inmate locator data. This first Report, which provided baseline data on three of the five diabetes-related quality and outcome measures that were specified in the 2010 QM Plan, will be produced on a quarterly basis to determine progress towards performance objectives. (The QM Work Plan, Diabetes Outcomes Report is attached as [Appendix 6](#)).

The measures incorporated in the Diabetes Outcomes Report align with recommendations from RAND and standardized National Commission Quality Assurance HEDIS indicators used nationally by healthcare organizations to assess performance. By improving diabetes-related outcomes, the risks associated with diabetes and cardiovascular disease – major contributors of morbidity, mortality and costs – are mitigated. Severe diabetes complications like myocardial infarction and kidney failure contribute to significant expenditures annually in specialty care and community hospitalizations.

According to RAND findings from a study of correctional healthcare systems in the United States and Canada, California joins a small number of prison healthcare systems whose quality improvement programs have evolved to include patient outcome information.

During April 2010, centralized pharmacy, laboratory, and inmate locator data will be used to produce exception reports for the diabetic patient population at each institution. Exception reports are lists of diabetic patients who have not received services per clinical guidelines or have abnormal laboratory values. When these reports are provided to primary care teams each month, teams will be prompted to make immediate changes to treatment strategies for patients listed in the report, ultimately improving individual patient outcomes and overall outcomes in the diabetic patient population (see Objective 4.2).

Medical Program Management Report

The RTPA calls for a balanced scorecard that includes “each institution’s disease burden, utilization, staffing, access to care measures, clinical quality indicators, and financial performance.”

Over the past six months, staff from several areas of the organization have worked to aggregate existing data from multiple data sources used for operational purposes into a strategic or executive level report, which summarizes data into consolidated measures that are benchmarked, and consistent with the RTPA scorecard categories. This strategic level information appears in the monthly *Medical Program Management Report*. The MPMR is a representative version of an organizational scorecard that reports performance on strategic level indicators.

Although there is still much work to do in terms of formatting the report and expanding the measures to be more comprehensive, we have come a long way in a few months establishing a useful tool for management decision-making and monitoring progress.

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 April 30, 2010 were \$2,765,937 and \$2,684,493 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 11](#).

B. Revenues

During the four month period ending April 30, 2010, the receiver requested transfers totaling \$875,000 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

A. 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 February 10, 2010, and March 30, 2010. Progress has continued during this reporting period.

B. 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 project 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.

As ordered by the Court, included as [Appendix 12](#) is a summary of the contract the Receiver awarded during this reporting period, including (1) a brief description of the contract, (2) which project the contract pertains to, and (3) the method the Receiver utilized to award the contract (*i.e.*, expedited formal bid, urgent informal bid, sole source).

C. Consultant Staff Engaged by the Receiver

In accordance with Section III, Paragraph B, of the Court’s Order Appointing Receiver, dated February 14, 2006, the Receiver has engaged the following consultants:

During the prior reporting period, in November 2009, the Office of the Receiver engaged the following consultant to provide legal services, litigation support, and community outreach in furtherance of the construction program for the CHCF - Stockton: The Ochoa & Moore Law Firm.

During this reporting period, the Office of the Receiver engaged the following staff to provide consulting and intergovernmental relations services related to the creation of a new state correctional healthcare authority: Chris Kahn.

Section 8

Conclusion

This report reflects continuing success in recruiting and maintaining a highly qualified clinical staff. There is also continuing success in overcoming most obstacles to access to care. In sum, we are doing a better job in managing the “people” aspect of the prison health care system.

For the next several years, we will be concentrating a huge amount of our implementation energies upon the “information” piece of health care. The information piece includes electronic scheduling, the mental health tracking system, conversion of paper health records into digital health records, creation of a live electronic health record, more reliable and timely information flows for radiology and laboratory results, and increased utilization of telemedicine technologies to expand cost-effective access to care.

For CDCR, these information systems represent a quantum-leap into the information age. During the last two years, we have been building the technology infrastructure for these information systems, including acquisition of a modern fiber-based network to each institution, building out local area wireless and wired networks, installing 1,000’s of switches and up to 10,000 network drops at institutions, and installing thousands of desktops and laptops in the field. These numbers are large because CDCR is jumping forward from 1970s technologies to 21st century technologies.

We will also be focusing attention upon completing the “facilities” aspect of our turnaround plan. We have had very positive meetings with legislators this Spring to describe the construction plan that is jointly sponsored by the Administration and the Receivership, and we are within days or weeks of final approval by the Legislature. Construction and population reduction remain of critical importance to our efforts since the continuing overcrowding that exists within CDCR’s adult institutions stands as a significant obstacle to the delivery of care.