

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

**Sixteenth Tri-Annual Report of the  
Federal Receiver's Turnaround Plan of Action  
For  
September 1 – December 31, 2010**

**January 15, 2011**

# **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.

# Table of Contents

	Page
<b>1. Executive Summary.....</b>	<b>1</b>
<b>2. The Receiver’s Reporting Requirements.....</b>	<b>4</b>
<b>3. Status and Progress Toward the Turnaround Plan Initiatives.....</b>	<b>5</b>
<b>GOAL 1 Ensure Timely Access to Health Care Services.....</b>	<b>5</b>
<i>Objective 1.1</i> Screening and Assessment Processes.....	5
<i>Objective 1.2</i> Access Staffing and Processes.....	5
<i>Objective 1.3</i> Scheduling and Patient-Inmate Tracking System.....	7
<i>Objective 1.4</i> Standardized Utilization Management System.....	8
<b>GOAL 2 Establish a Prison Medical Program Addressing the Full</b>	
<b>Continuum of Health Care Services.....</b>	<b>10</b>
<i>Objective 2.1</i> Primary Care.....	10
<i>Objective 2.2</i> Chronic Care.....	10
<i>Objective 2.3</i> Emergency Response.....	10
<i>Objective 2.4</i> Specialty Care and Hospitalization.....	10
<b>GOAL 3 Recruit, Train and Retain a Professional Quality Medical Care</b>	
<b>Workforce.....</b>	<b>15</b>
<i>Objective 3.1</i> Physicians and Nurses.....	15
<i>Objective 3.2</i> Clinical Leadership and Management Structure.....	17
<i>Objective 3.3</i> Professional Training Program.....	18
<b>GOAL 4 Implement a Quality Assurance and Continuous Improvement</b>	
<b>Program.....</b>	<b>20</b>
<i>Objective 4.1</i> Clinical Quality Measurement and Evaluation Program.....	20
<i>Objective 4.2</i> Quality Improvement Programs.....	21
<i>Objective 4.3</i> Medical Peer Review and Discipline Process.....	23
<i>Objective 4.4</i> Medical Oversight Unit.....	26

<i>Objective 4.5</i>	Health Care Appeals Process.....	28
<i>Objective 4.6</i>	Out-of-State, Community Correctional Facilities and Re-entry Oversight.....	28
<b>GOAL 5</b>	<b>Establish Medical Support / Allied Health Infrastructure.....</b>	<b>31</b>
<i>Objective 5.1</i>	Pharmacy.....	31
<i>Objective 5.2</i>	Medical Records.....	32
<i>Objective 5.3</i>	Imaging/Radiology and Laboratory Services.....	33
<i>Objective 5.4</i>	Clinical Information Systems.....	35
<i>Objective 5.5</i>	Telemedicine.....	36
<b>GOAL 6</b>	<b>Provide for Necessary Clinical, Administrative and Housing     Facilities.....</b>	<b>39</b>
<i>Objective 6.1</i>	Upgrade Administrative and Clinical Facilities.....	39
<i>Objective 6.2</i>	Expand Administrative, Clinical, and House Facilities.....	39
<i>Objective 6.3</i>	Finish Construction at San Quentin State Prison.....	40
<b>4.</b>	<b>Additional Successes Achieved by the Receiver.....</b>	<b>41</b>
A.	Correctional Medical System Personnel Comparison.....	41
<b>5.</b>	<b>Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented By Institutions Or Individuals.....</b>	<b>42</b>
<b>6.</b>	<b>An Accounting of Expenditures for the Reporting Period.....</b>	<b>43</b>
<b>7.</b>	<b>Other Matters Deemed Appropriate for Judicial Review.....</b>	<b>44</b>
A.	Coordination with Other Lawsuits.....	44
B.	Master Contract Waiver Reporting.....	44
C.	Consultant Staff Engaged by the Receiver.....	44
<b>8.</b>	<b>Conclusion.....</b>	<b>45</b>

# Section 1

## Executive Summary

In our first Tri-Annual report for 2011, the accomplishments for the period of September 1 through December 31, 2010 are highlighted. Progress continues toward implementing the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights of progress include the following:

- Prison Health Care Chief Executive Officer (CEO) – Since the CEO examination was launched on December 24, 2008, five hundred fifteen CEO applicants have been added to the certification list and twenty-four hires have been completed. All CEO positions were filled as of October 31, 2010. There are 9 pairings of institutions (eighteen institutions) that will be under the direction of one CEO at each of the paired institutions.
- Prison Health Care Nurse Executive - Since the Receiver's Nurse Executive examination commenced in September 2008, four hundred six Nurse Executive applicants have been added to the certification list and thirteen Nurse Executives have been hired. Due to the varying institutional medical missions and physical distance between Centinella and Calipatria State Prison, it was determined that they should not be paired. As a result, it was determined that 8 pairings (sixteen institutions) was appropriate for the purpose of hiring Institution Chief Nurse Executives. Therefore twenty-five Institution Chief Nurse Executives will be filled statewide.
- Prison Health Care Medical Executive - Since the Receiver's Medical Executive examination was launched in December 2008, one hundred sixty Medical Executive applicants have been added to the certification list. Twenty-two Medical Executives have been hired. Due to the varying institutional medical missions and physical distance between Sierra Conservation Center and Mule Creek State Prison and between Centinella and Calipatria State Prison, it was determined that 7 pairings of institutions (fourteen institutions) was appropriate for the purpose of hiring Institution Chief Medical Executives. Therefore, twenty-six Institution Chief Medical Executives will be filled statewide.
- Prison Clinical Executives - The Receiver's Clinical Executive examination was launched in November 2009 for 4 disciplines: Laboratory, Imaging, Dietary, and Pharmacy. The Dietary discipline was placed on hold until December 2010 and the Pharmacy discipline is filled. Since the last report, the Laboratory and Imaging disciplines are now vacant and interviews are in process to fill those disciplines.
- Health Care Provider Network - A contract was awarded to Health Net to build and maintain a consistent and cost-effective provider network. Part of that effort included interfaces between the Third Party Administrator (TPA) and Health Net for pricing and their data warehouse. These interfaces are complete, and the first data transfer is expected in January 2011. These interfaces will create enhanced access to utilization and expenditure information to assist the institutions in managing their health care programs.
- Medical Savings - The two-year post audit effort resulted in twenty-three million dollars in refunds as of December 2010. These refunds represent overpayments recovered by Viant for

the two-year post audit for the time period July 1, 2007 through June 30, 2009, as well as voluntary provider refunds. A bill (ABX1 10, Lowenthal) has been introduced (ABX1 10, Lowenthal) to allow audit recovery funds from previously overpaid health care invoices to be credited to the current-year budget.

- **Construction:** The first project approvals for facility upgrades are scheduled for the April 2011 Public Works Board (PWB) meeting. A groundbreaking ceremony was held on October 15, 2010 for the California Health Care Facility in Stockton. Contractors have submitted statements of qualifications in response to CDCR's competitive solicitation and selection of a contractor is scheduled to occur in April 2011.

While improvements continue in many important areas, the momentum of these efforts continues to be affected by the State's budget and fiscal crisis and severe overcrowding in the prisons. (For details please reference the 15<sup>th</sup> Tri-Annual Report.) The budget and fiscal crisis are likely to continue for the foreseeable future, and the Receivership is doing everything it can to reduce expenditures without cutting into core health care areas. However, productivity is 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.

During the 2009-2010 legislative session, California Prison Health Care Services (CPHCS) sponsored several successful bills that became effective on January 1, 2011. These legislative changes authorize the central fill pharmacy, require a utilization management program, require electronic management of provider claims, and establish a medical parole process. The medical parole bill creates a new category for permanently medically incapacitated inmates that allows corrections to save on guarding costs and to apply for federal reimbursement money for these patient-inmates' health care costs. Implementation of the medical parole program is moving forward and CPHCS keeps a list of candidates that is regularly updated to drive the process.

This year, CPHCS introduced a bill (ABX1 10, Lowenthal) to allow audit recovery funds from previously overpaid health care invoices to be credited to the current-year budget. Without this legislative change, money recovered from previous fiscal years would be credited back to those years and would be unavailable to help solve California's current budget crisis.

### Format of the Report

To assist the reader, this Report provides 3 forms of supporting data:

1. *Metrics:* Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions. Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the CPHCS website ([http://www.cprinc.org/receiver\\_mo.aspx](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, this format provides an activity status report 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 toward 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 sixteenth report filed by the Receivership, and the tenth 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 4 federal courts responsible for the major health care class actions pending against the CDCR, the Receiver now files the Tri-Annual Report in 4 different federal court class action cases: *Armstrong, Coleman, Perez, and Plata*. 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 fifteen and sixteen. ([http://www.cphcs.ca.gov/receiver\\_tri.aspx](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 is completed.

*Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons*

This action is completed.

New processes have been implemented and revisions to the Reception Center Policy and Procedures are being finalized. Once finalized and adopted, we will proceed with statewide implementation.

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

This action is completed.

On January 20, 2010, all Reception Center institutions began using the Medical Classification System on all new inmates.

*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.

At the time of this report twenty-five formal on site certification surveys were conducted of which twelve institutions passed. Thirteen institutions were not completely compliant with the Medical Classification System implementation. An additional 3 institutions have self-certified and are currently pending formal on site certification surveys. Implementation of the on site certification of the Medical Classification for the remaining institutions is pending a realignment of resources to perform this function.

**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 health care 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 is completed.

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

#### Health Care Access

The CPHCS continues to be effective in facilitating inmate access to care for scheduled appointments, which involves guarded escorts and from inmates health care appointments. All Access Quality Reports (AQRs) indicate that improvements in access to care are being maintained. The reported improvements indicate that health care access programs have the resources necessary to support health care 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 process could be transferred back to CDCR and released from Receivership control in the next 6 to twelve months.

#### Operational Assessments

The process of reviewing the CPHCS custody operations at institutions to determine the effectiveness of the positions allocated for access to care as well as reduce any identifiable barriers is initiated. During this reporting period, Operational Assessments have been conducted at Avenal State Prison (ASP), Salinas Valley State Prison, California State Prison, Los Angeles County, California Medical Facility (CMF), California State Prison, Solano (SOL), and Deuel Vocational Institution. A follow-up visit will be conducted at each institution to ensure Corrective Action Plan (CAP) items have been addressed prior to transition to CDCR. Operational Assessments for all thirty-three institutions are scheduled to be completed by July of 2011.

In addition, Webinar training is tentatively scheduled for January 2011 for all Health Care Access Units Associate Wardens and Captains. As part of the training, a copy of the assessment tool and all elements assessed as part of the Operational Assessment will be provided. This will assist those institutions that have not yet participated in the Operational Assessment and the follow-up assessments, which are anticipated to begin during the first quarter of 2011.

#### Monthly Health Care AQR - Data Collection Instrument

AQR data remained stable during this reporting period. October's AQR indicated that overall ninety-two percent of all patient-inmates that received ducat(s) for a health care appointment(s) were seen by a clinical provider. Specific to custody performance, the number of inmates *Not Seen Due to Custody* represented 0.6 percent of the total number of ducats.

There were no updates to the AQR during this reporting period; all data elements remained the same. It was anticipated that the automation of mental health data reporting for the AQR via the Mental Health Tracking System (MHTS) would begin during this reporting period. *However, analysis of MHTS data revealed a need for further training and reporting code modification.*

*MHTS and AQR data are being collected concurrently and then compared in an effort to mitigate these issues.*

Incorporation of the AQR into COMPSTAT (CDCR database) is delayed due to technical issues. CDCR and CPHCS are working collaboratively toward a resolution, anticipated by January 2011. Full implementation of the AQR into COMPSTAT is expected by July 2011 given no further delays.

Refer to [Appendix 3](#) for the Executive Summary and Health Care AQRs for July 2010 through October 2010.

### Vehicles

By the end of the fiscal year, it is anticipated that the health care vehicle resources and its responsibilities will commence for transition back to the CDCR. There are currently 5 medical transportation vans for distribution anticipated by February 2011 (One to Central California Women's Facility (CCWF), 1 to California Correctional Institution, 1 to California Institution for Women (CIW), 1 to Valley State Prison for Women (VSPW), and 1 to Pelican Bay State Prison (PBSP)). There is 1 additional medical transportation van for PBSP that will be modified and inspected for distribution by the end of this fiscal year.

### Fair Labor Standards Act (FLSA) Validation

The FLSA validation has been completed and CPHCS has informed CDCR of our recommendations for the appropriate use of FLSA pay codes in order to prevent coding errors from occurring in the future. CDCR and CPHCS have cooperatively developed preliminary recommendations on changes to current policy requirements and security needs specific to medical guarding staffing.

## **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 (SOMS) with a scheduling and inmate tracking system as one of its first deliverables.***

During this reporting period, the CPHCS Health Care Scheduling System (HCSS) Project Team has been testing the initial version of the SOMS/HCSS software. In addition, the HCSS Team has been working with technical staff of CPHCS and the CDCR Enterprise Information Systems (EIS) team to develop and test interfaces between SOMS/HCSS and the Mental Health Tracking System (MHTS) and Clinical Data Repository (CDR). This work has been proceeding according to schedule and should be completed by late February 2011. The interfaces will supply scheduling information to the MHTS reporting system and will make appointments information visible to CPHCS clinicians through the CDR portal.

The first modules of SOMS, Intake, Movements, and Counts, are scheduled to be deployed to the women's institutions in March 2011. The HCSS critical design revision is scheduled to be completed and tested by April 9, 2011. Shortly thereafter, on April 20, 2011, CPHCS will deploy Health Care Scheduling to the first women's institution, CIW. To reduce risk during this

initial implementation, the HCSS team will deploy to the health care disciplines sequentially, beginning with Dental and followed shortly thereafter by the Medical and Mental Health programs. Custody Scheduling will be deployed at the same time as Mental Health and will then be implemented at the same time as Health Care Scheduling at all future institutions. On site hands-on training delivered by resources dedicated to the HCSS project will occur just prior to each deployment.

Following implementation at CIW, Health Care and Custody Scheduling will be deployed in turn to VSPW in June 2011 and to CCWF in July 2011. The Project Team has visited all 3 of the women's institutions and has communicated preliminary plans and schedules to them. These visits allowed the team the opportunity to gather specific information on the procedures within the institutions and special considerations based upon the institutions' characteristics. The visits also provided an opportunity to meet staff in the institutions and demonstrate the prototype system. Feedback on the system received to date has been overwhelmingly positive. The roll-out will proceed to men's institutions that currently do not use technology for scheduling starting in the summer of 2011. The exact sequence of the deployment is currently in planning. When the deployment procedures become fully repeatable, we will roll-out Health Care Scheduling to 2 institutions per month using 2 deployment teams, with direction and oversight from a Headquarters project management team. Implementation at all institutions is scheduled to be completed by early 2013, though the addition of more deployment teams is being considered as a means of expediting the deployment.

In preparation for the deployment, the HCSS Project Team has begun to assemble a Clinical Deployment Support Team. The proposal is to identify a team of 12 CPHCS/CDCR employees who will be assigned to HCSS deployment for a period of up to 2 years and will assist with all the site preparation, training, and user support activities at each site. Because of severe resource constraints within the organization, the HCSS Team and its sponsors are also looking at alternative models that may have reduced impact on staff resources.

The HCSS Core Leadership Team has begun to meet more frequently and is actively addressing many of the issues and decision points encountered by the Project Team. Core Leadership Team meetings will begin on a monthly basis in January, as institution deployment plans become more certain.

#### **Objective 1.4. Establish a Standardized Utilization Management (UM) System**

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

This action is completed.

The CMF Outpatient Housing Unit (OHU) project scope was to convert General Population dormitory into a seventy-two bed OHU. Patient admissions began on August 16, 2010.

The savings for this project is approximately three million dollars as of November 2010. This estimate is based on an approximate reduction of one thousand aberrant days.

***Action 1.4.2. By October 2010, establish a centralized UM System.***

During the 2010 legislative season, CPHCS sponsored 4 bills as part of a bill package designed to lower the cost of prison health care in California. One of these bills, AB 1817 (Arambula) required the State to maintain a robust UM program to oversee and manage the provision of necessary medical services for State patient-inmates. This bill passed the Senate and the Assembly with unanimous support, but was declared unnecessary and vetoed by Governor Schwarzenegger. The same bill language was later adopted in the Corrections budget trailer bill (AB 1620) as part of the State budget agreement. The State of California is now required by law to maintain a UM program for prison health care services.

The UM Annual Workplan provides the framework for all UM program activities. Volume and cost based utilization reports, with the diagnostic and patient drivers of high cost, high volume and high risk specialty categories, are made available monthly to executive and institutional leadership to assist institutional leadership in achieving the Receiver's access, outcomes and cost avoidance goals.

UM activities focus on the top 2 drivers of utilization: firstly hospitalization, and secondly specialty referrals. Bed rounds in all high volume high census hospitals are conducted daily. Institutional Chief Medical Executives are expected to actively participate in treatment and management of their patients while in community hospitals and return of inmates to their institutions once medically stable.

Institutional bed and community hospital census are currently tracked through the Census and Discharge Data Information system (CADDIS), a system comprised of fifty-four individual Access databases synchronized daily in Headquarters to produce statewide day old reports. A new program is under development to enable CPHCS to have a simplified, stable and real time census reporting system.

Specialty referrals, the second highest cost driver, have sustained its goal of eighty-five referrals per thousand inmate population. Request for Services that could potentially result in high cost unnecessary services are monitored and reviewed.

UM has been in collaboration with the Prison Health Care Provider Network (PHCPN) and will play a key role in mentoring and monitoring the institutional transition to the new network beginning January 1, 2011. UM staff will assist with patient care transitions, provider and hospital orientation issues, and access and availability gaps, if any.

UM is also involved in the planning for deployment of the Medical Parole legislation. UM will assist in the identification of potentially eligible Medical Parole patients and appropriate placement for their medical condition, and case management of medically paroled inmates and is partnering with CDCR who will be implementing the Bill.

## **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.*

During this reporting period, the Episodic Care Policy and Procedure has continued to undergo review and revision based on multidisciplinary program feedback. The final Policy, Procedure and Forms package will be submitted for formal policy approval by the executive team with the goal of releasing in the next reporting period.

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

Upon approval of the Policy and Procedure, the implementation team will begin a phased rollout at 7 institutions by the end of Q1 2011. Full implementation at all institutions is anticipated to be completed by July 2011.

### **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 is 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 is 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 is completed.

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

This action is 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 is completed.

The UM program is continuing its oversight over the provision of care in community hospitals and for specialty services. While Table 1 is inclusive of all bed day utilization in community hospitals, Table 2 only includes those days that are not medically necessary or days that could have been avoided should there have been available institutional beds (administrative or aberrant bed days). Table 3 illustrates the volume of Specialty Referrals.

**Table 1**

<b>Community Hospital Bed Utilization Data</b>							
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
Aug-09	1,102	1,001	9,913	332	9.00	152,072	782.2
Sep-09	1,107	1,129	9,206	302	8.32	152,870	722.7
Oct-09	1,027	1,060	8,567	261	8.18	153,906	668.0
Nov-09	1,004	995	8,253	275	8.22	153,203	646.4
Dec-09	1,065	1,085	8,256	266	7.75	154,154	642.7
Jan-10	990	978	7,430	240	7.51	153,261	581.8
Feb-10	963	956	6,973	249	7.24	152,501	548.7
Mar-10	1,126	1,133	7,676	248	6.82	151,972	606.1
Apr-10	1,124	1,113	7,505	250	6.68	151,759	593.4
May-10	1,044	1,058	7,534	243	7.22	151,396	597.2
Jun-10	1,155	1,142	7,772	259	6.73	151,376	616.1
Jul-10	1,081	1,123	7,571	243	7.0	150,365	604.2
Aug-10	1,159	1,143	7,532	243	6.5	150,365	601.1
Sep-10	1,080	1,056	7,065	235	6.5	149,784	566.0
Oct-10	1,013	1,035	7,061	227	7.0	147,920	572.8
Nov-10	916	924	6,170	206	6.74	148,003	500.3

Note: Total number of discharges exceeds total number of admissions due to the methodology used in counting admissions and discharges for the month. Some patients are overflows from the prior month and discharged during the reporting month.

**Table 2**

<b>Community Hospital Administrative Bed Data*</b>		
	Amount Paid	Number of Administrative Days
Sep-09	\$ 588,971	571
Oct-09	\$ 403,551	449
Nov-09	\$ 507,060	495
Dec-09	\$ 705,068	734
Jan-10	\$ 515,613	511
Feb-10	\$ 546,165	602
Mar-10	\$ 556,887	582
Apr-10	\$ 600,670	610
May-10	\$ 350,898	355
Jun-10	\$ 337,351	389
Jul-10	\$ 823,541	832

Aug-10	\$ 390,053	434
Grand Total	\$ 6,325,828	6,564

\*This table is based on all claims paid by the Third Party Administrator as of Dec 10, 2010 and may not reflect all activity. This table is based on paid claims, not billed amounts.

**Table 3**

<b>Specialty Referral Volume</b>						
<b>Requests For Services (RFS)- Total Volume</b>						
	North	South	Central	Fourth	Statewide	RFS/1000 patients/month
Monthly Baseline: 08/09					25,000	
Apr-09	4,525	6,674	10,023		21,222	137.19
May-09	3,479	5,647	7,482		16,608	104.38
Jun-09	3,578	4,978	8,124		16,680	109.67
Jul-09	4,905	4,245	6,600		15,750	102.89
Aug-09	3,875	3,708	3,999	2,478	14,060	92.46
Sep-09	3,811	4,018	4,536	2,333	14,698	98.15
Oct-09	3,995	4,131	4,415	2,518	15,059	97.85
Nov-09	3,261	3,549	3,688	1,941	12,439	81.19
Dec-09	3,446	3,693	4,218	2,182	13,539	87.83
Jan-10	3,479	3,317	3,692	1,978	12,466	81.34
Feb-10	3,508	3,434	3,986	2,400	13,328	87.40
Mar-10	3,774	3,635	4,998	2,354	14,761	95.73
Apr-10	3,185	3,427	4,248	2,196	13,056	86.18
May-10	3,005	2,949	3,386	1,952	11,292	74.59
Jun-10	3,202	3,231	3,874	2,159	12,466	82.35
Jul-10	2,712	2,912	5,045	*	10,669	70.95
Aug-10	3,456	3,073	5,833	*	12,362	82.21
Sept-10	3,166	3,089	5,939	*	12,194	81.41
Oct-10	3,065	2,864	5,413	*	11,342	76.31
Nov-10	3,065	2,864	5,413	*	10,129	68.44

\*After June 2010, reporting for the Fourth Region has been combined with the Central Region.

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

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

**ProdÁgio Contract Processing System**

The ProdÁgio system continues to support a centrally stored depository of contracts that are accessible to all authorized users. This reporting period CPHCS focused its efforts of direct medical services contracting toward migration into the Business Information System (BIS).

### CDCR's BIS

CPHCS has completed its business requirements, gathering and analysis efforts toward its goal of migration of the medical contracts to BIS. The next steps include identifying options to meet functional requirements as well as restraints which may prohibit migration due to impacts to business processes.

### Streamlining Medical Contracting and Aligning Resources to Achieve Performance Goals

CPHCS continues to work with providers to execute service contracts at the statutory rate to ensure a consistent and equitable rate for reimbursement for services rendered.

These continued efforts have resulted in the following for this reporting period:

- Execution of one hundred thirty-three new statewide contracts for hospital and specialty physician services
- Execution of sixty-three competitively bid contracts through centralized coordination with CPHCS Workforce Planning, Medical Program Services, and individual institutions
- Training of headquarters and institution contract analysts on the usage of the ProdÁgio System, proper usage of registry contract competitive bidding matrices, and provider directory access and usage for the new provider network

Legislation (SB X4 13, 2009, which amended Penal Code section 5023.5) allowed CPHCS to contract for a statewide provider network company. A Request for Proposal (RFP) was released October 20, 2009, and the contract was approved on June 28, 2010. CPHCS and Health Net Federal Services, LLC (Health Net) have partnered to develop and maintain a statewide network of health care providers for all thirty-three institutions. This partnership, PHCPN, will provide patient-inmates with greater access to specialty medical services, including radiological and laboratory services, in the institutions and the community at sustainable rates. CPHCS and Health Net developed a plan for implementation of the provider network through comprehensive Utilization Analysis of patient-inmate medical service needs, institution medical staff input, and access availability in the provider communities near the CDCR institutions. The plan has resulted in Health Net being on target to meet the requirements for Phase 1 (sixty-six percent of the network in place) by January 1, 2011. We will continue to maintain current CPHCS contracted providers to ensure patient-inmate continuity of care and access to continuing episodes of treatment until the completion of Phase 2 by June 30, 2011, when one hundred percent of the network will be in place.

The implementation committee continues to work with all thirty-three institutions and CPHCS headquarter stakeholders to identify any gaps or changes in network needs and integration with technology projects. PHCPN training was given and completed in December 2010.

### Hospital Rate Negotiations

Now and in the future, this will be reported under the above *Streamlining Medical Contracting and Aligning Resources to Achieve Performance Goals* as part of the PHCPN updates.

***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

CPHCS continues to meet the thirty day processing timeframe outlined in the RTPA.

Third Party Administrator (TPA)

As previously reported, claims processing is within the mandated 30-day processing timeframe as indicated in the RTPA. Costs continue to be contained by reductions in duplicate payments, overcharges, late payment penalties and interest and overtime.

The electronic claims interface became active as of July 2010. The TPA is now receiving invoices electronically. This allows providers to submit claims electronically rather than sending claims in the mail. Approximately twenty percent of invoices are currently being submitted electronically, with participation increasing monthly.

Two-Year Post Audit

The two-year post audit effort has resulted in twenty-three million dollars in refunds as of December 2010. These refunds represent overpayments recovered by Viant for the two-year post audit for the time period July 1, 2007 through June 30, 2009, as well as voluntary provider refunds. This year, CPHCS introduced a bill (ABX1 10, Lowenthal) to allow audit recovery funds from previously overpaid health care invoices to be credited to the current-year budget. Without this legislative change, money recovered from previous fiscal years would be credited back to those years.

Access to Data from the TPA

The Contract Medical Database/TPA workgroup continues to receive data sets for validation testing. The data is usable for reporting utilization and expenditure information. Ongoing testing will continue to increase the integrity of the data elements and functionality of the reports.

Health Care Provider Network Pricing and Data Warehouse Interfaces

As reported, a contract was awarded to Health Net to build and maintain a consistent and cost-effective provider network. Part of that effort included interfaces between the TPA and Health Net for pricing and their data warehouse. These interfaces are complete, and the first data transfer is expected in January 2011. These interfaces will create enhanced access to utilization and expenditure information to assist the institutions in managing their health care programs.

## 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 ninety percent of nursing positions.*

This action is completed.

As of November 2010, nearly ninety-two percent of the nursing positions have been filled statewide, remaining virtually unchanged since the last report at 91.96 percent. This percentage is an average of 6 State nursing classifications.

More specifically, the goal of filling ninety percent or higher of the Registered Nurse (RN) positions has been achieved at twenty-eight institutions (84.9 percent of all institutions). Twelve institutions (36.4 percent) have filled one hundred percent of their RN positions during this reporting period.

The goal of filling ninety percent or higher of the Licensed Vocational Nurse (LVN) positions has been achieved at fifteen institutions (45.5 percent). Twelve institutions (36.4 percent) have filled eighty to eighty-nine percent of their LVN positions.

The following hiring-related initiatives took place during the reporting period: focused recruitment continues statewide for LVNs and Psych Techs; a State Registered Nurse (SRN) II mailer was sent to seventy-nine thousand RNs with a California license for ten years or more who live within a commutable distance of a prison; and online job postings. Nursing vacancies are posted on multiple websites including: [www.ChangingPrisonHealthCare.org](http://www.ChangingPrisonHealthCare.org), [www.Indeed.com](http://www.Indeed.com), [www.VetJobs.com](http://www.VetJobs.com), [www.caljobs.ca.gov](http://www.caljobs.ca.gov), school career websites, and several more. Each job posting often represents multiple vacancies at an institution. Staff monitors vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

Listed below are the nursing vacancy and turnover rates at various institutions:

#### Low Vacancy (<10%)/ Low Turnover (<10%)

California Correctional Center	Calipatria State Prison
California Correctional Institute	Centinela State Prison
California Institution for Men	Deuel Vocational Institution
California Institution for Women	Folsom State Prison
California Medical Facility	Mule Creek State Prison
California Men's Colony	North Kern Valley State Prison
California State Prison, Corcoran	Richard J. Donovan Correctional Facility
California State Prison, Los Angeles County	San Quentin State Prison

Moderate Vacancy (11% - 30%) / Low Turnover (<10%)

California Rehabilitation Center	Kern Valley State Prison
California State Prison, Sacramento	Salinas Valley State Prison
Chuckawalla Valley State Prison	Valley State Prison for Women
Correctional Training Facility	

Moderate Vacancy (11% - 30%) / Moderate Turnover (11% - 19%)

California State Prison, Solano	Pleasant Valley State Prison
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For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September, October, and November 2010. These reports are included as [Appendix 4](#). Included at the beginning of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: Physicians Filled Percentage and Turnover Rate, Physicians Filled Percentage, Physician Turnover Rate, Nursing Filled Percentage and Turnover Rate, Nursing Filled Percentage, and Nursing Turnover Rate.

***Action 3.1.2. By January 2010, fill ninety percent 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 November 2010, nearly eighty-eight percent of physician positions are filled (this percentage is an average of all 3 State physician classifications). More specifically, sixty-seven percent of the Chief Medical Officer (CMO)/Receiver’s Medical Executive positions are filled, a decrease from ninety percent since the last report. However, this decrease in percent filled is attributable to an increase in authorized Receiver’s Medical Executive positions. The CMO positions will be abolished through attrition since the role of the Chief Medical Executive is no longer filled with the CMO classification, but rather, the Receiver’s Medical Executive classification. Chief Physician and Surgeon (CP&S) positions were eighty-six percent filled; and ninety-two percent of the Physician and Surgeon (P&S) positions are filled.

Twenty-one institutions (63.6 percent) have achieved the goal of filling ninety percent of their P&S positions; twenty of these institutions (60.6 percent) have filled one hundred percent of their P&S positions. Eight institutions (24.2 percent) have filled eighty to eighty-nine percent of their P&S positions.

While the Central Valley region continues to be “hard-to-fill,” the following institutions decreased their vacancy rate during this reporting period: Chuckawalla Valley State Prison, Pleasant Valley State Prison, Salinas Valley State Prison, Calipatria State Prison, California Institute for Men, California Institute for Women, California Rehabilitation Center, Correctional Training Facility, Deuel Vocational Institution, Kern Valley State Prison, North Kern State Prison, Substance Abuse Treatment Facility, California State Prison Solano, California State

Prison San Quentin, and Salinas Valley State Prison. Of special note, Chuckawalla Valley State Prison has now filled one hundred percent of their P&S positions. Cejka Search, a vendor for physician and executive search services, continues to conduct physician searches for Pleasant Valley State Prison and the Substance Abuse Treatment Facility.

Job postings continue to be placed online at the Department's recruitment website, other online job boards, and staff continues to recruit at medical conferences.

Listed below are the physician vacancy and turnover rates at various institutions:

Low Vacancy (<10%) / Low Turnover (<10%)

California Correctional Institution	Folsom State Prison
California Medical Facility	Ironwood State Prison
California Institution for Men	Kern Valley State Prison
California Institution for Women	Mule Creek State Prison
California Rehabilitation Center	Richard J. Donovan Correctional Facility
California State Prison, Solano	Salinas Valley State Prison
Calipatria State Prison	Sierra Conservation Center
Centinela State Prison	Valley State Prison for Women
Deuel Vocational Institution	Wasco State Prison

Moderate Vacancy (11% - 30%) / High Turnover (>20%)

California Correctional Center	Chuckawalla Valley State Prison
Central California Women's Facility	

High Vacancy (>30%) / High Turnover (>20%)

Pelican Bay State Prison	Pleasant Valley State Prison
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For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September, October, and November 2010. These reports are included as [Appendix 4](#). Included at the beginning of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: Physicians Filled Percentage and Turnover Rate, Physicians Filled Percentage, Physician Turnover Rate, Nursing Filled Percentage and Turnover Rate, Nursing Filled Percentage, and 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, five hundred fifteen CEO applicants have been added to the certification list and twenty-four hires have been completed.

All CEO positions were filled as of October 31, 2010. There are 9 pairings of institutions (eighteen institutions) that will be under the direction of 1 CEO at each of the paired institutions. Since the Receiver's Nurse Executive examination commenced in September 2008, four hundred six Nurse Executive applicants have been added to the certification list and thirteen Nurse Executives have been hired. Due to the varying institutional medical missions and physical distance between Centinella and Calipatria State Prison, it was determined that they should not be paired. As a result, it was determined that 8 pairings (sixteen institutions) was appropriate for the purpose of hiring Institution Chief Nurse Executives. Therefore twenty-five Institution Chief Nurse Executives will be filled statewide.

Since the Receiver's Medical Executive examination was launched in December 2008, one hundred sixty Medical Executive applicants have been added to the certification list. Twenty-two Medical Executives have been hired. Due to the varying institutional medical missions and physical distance between Sierra Conservation Center and Mule Creek State Prison and the distance between Centinella and Calipatria State Prison, it was determined that 7 pairings of institutions (fourteen institutions) was appropriate for the purpose of hiring Institution Chief Medical Executives. Therefore, twenty-six Institution Chief Medical Executives will be filled statewide.

The Receiver's Clinical Executive examination was launched in November 2009 for 4 disciplines: Laboratory, Imaging, Dietary, and Pharmacy. The Dietary discipline was placed on hold until December 2010 and the Pharmacy discipline has been filled. Since the last report, the Laboratory and Imaging disciplines are now vacant and interviews are in process to fill those disciplines.

### **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**

In January 2010, all thirty-three institution In-Service Training (IST) offices were delegated the responsibility of providing Health Care New Employee Orientation (HCNEO) to Medical, Mental Health, Dental, and other allied health and support staff. HCNEO curriculum was derived from IST NEO content; extracting all relevant topics necessary to orient health care employees to safely work in a correctional environment and ensuring continuity statewide.

The last report noted that twenty-seven institutions implemented the 3-day HCNEO; the number has since dropped to thirteen. Factors contributing to this decline include: staff changes in both the nursing education and IST offices, and a delay in implementing day-four curriculum for clinical staff. HCNEO at headquarters in Sacramento continues.

We will continue to communicate and partner with IST Managers, Nurse Instructors, Chief Executive Officers, and Wardens to find resolution to the obstacles preventing full implementation of HCNEO.

### 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 in collaboration with other programs so that fewer resources are needed 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 is completed. The following is a summary of activity during this reporting period:

In March 2009, CPHCS achieved accreditation from the Institute of Medical Quality/California Medical Association as a Continuing Medical Education Provider. The Continuing Medical Education Program consists of an interdisciplinary committee, and administrative support staff. The administrative staff and Committee members are currently preparing for a reaccreditation survey, set to occur in February 2011.

The Continuing Medical Education program accomplished the following:

- Continuing Medical Education activities were conducted for a total of six hundred forty-five hours of instruction, and were provided to five hundred ninety licensed health care staff of which four hundred eight were physicians.
- Developed and conducted training programs for four Continuing Medical Education activities:
  - Physician Orders for Life Sustaining Treatment
  - End-Stage Liver Disease
  - Effective CME Lesson Planning
  - Low Back Pain
- Ten Continuing Medical Education activities are in various stages of development, review, approval and/or implementation:
  - Hepatitis C Virus
  - Personality Disorders
  - HIV Medicine for the Primary Care Provider
  - Introduction to the MHSDS for Medical Staff
  - Insomnia
  - Cardiovascular Risk Factors Part II: Hypertension/ Hyperlipidemia
  - Cardiovascular Risk Factors Part III: Metabolic Syndrome / Atypical Antipsychotics
  - Chest Pain
  - Behavioral Pain Management
  - Clark Training for Mental Health

As a continuous effort to improve patient-inmate health care, the CPHCS Continuing Medical Education Committee continues to work with other programs to assess the educational needs of clinicians.

## **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.*

In October 2010, CPHCS issued the first Health Care Services Dashboard, accessible to all correctional health care staff through the intranet. The Health Care Services Dashboard presents strategic performance information for all clinical program areas displayed in 4 major views, including individual institution scorecards. Designed to allow users access to greater degrees of detail for particular measures according to interest and relevance, the Dashboard encompasses more than seventy measures in 7 domains, covering all of the areas cited in the RTPA.

Each year, CPHCS adopts a Quality Management (QM) Plan, which includes a series of strategic performance objectives related to clinical conditions or program areas that are determined to be priorities. The Health Care Services Dashboard contains information necessary to monitor progress toward achieving the performance objectives, as well as other data that can be used to identify opportunities for improvement. As the quality improvement priorities evolve, the Health Care Services Dashboard will be modified to align with the QM Plan. Please see the Health Care Services Dashboard, [Appendix 5](#).

Through the Health Care Services Dashboard and performance management reports, CPHCS provides statewide and institution-level data that managers can use to identify and prioritize improvement opportunities, recognize patient safety concerns, and monitor progress toward compliance and quality improvement objectives. However, additional clinical information is required for primary care teams, at the point of care, to make the changes with individual patients' care that results in system-wide improvements. During this reporting period, CPHCS continued to provide both performance reports, which monitors institution and statewide progress toward performance objectives and customized patient lists, which flag patients who have not received timely services based on guidelines or who have abnormal results for primary care teams to take action.

During this reporting period, CPHCS produced a performance report on the rate of colon cancer and breast cancer screening for patients at fifty years of age or older. Cancer was the leading cause of death for California prison inmates in 2009; screening is recommended by the United States Preventive Services Task Force for certain types of cancer because early detection significantly improves patient outcomes. Please see [Appendix 6](#). CPHCS also compiled and posted a list of patients over fifty years of age and their cancer screening status for each institution, prompting institutions to improve their processes to track and screen patients.

CPHCS also issued the third in a series of diabetic outcomes reports in December 2010. CPHCS monitors performance on 5 quality and outcome measures related to cardiovascular risk and diabetes. (The 3<sup>rd</sup> Quarterly Diabetes Outcomes Report is attached as [Appendix 7](#)). The third

report reflected progress on all performance objectives. Accompanying this report was an updated list of diabetic patients for each institution.

During this reporting period, CPHCS worked with mental health, dental, and allied health staff to support program evaluation activities in those areas. During the next reporting period, CPHCS will issue baseline performance reports on a number of areas that impact patient outcomes, and the quality and costs of health care services including crisis prevention, treatment of patients with specific mental illnesses, anticoagulation therapy, and hepatitis C, as well as progress reports for ongoing improvement initiatives, including pain care, diabetes, and cancer screening.

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

This action is completed.

**Objective 4.2. Establish a Quality Improvement Program**

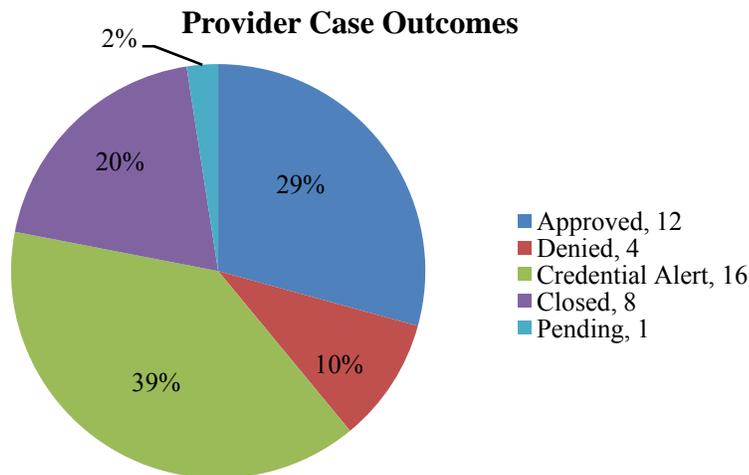
Part of the Quality Improvement Program is the implementation of a Credentialing and Privileging Program. The Program contains both a formal committee and a support unit to process all initial and reappointment medical staff applications, while ensuring all providers have appropriate and current credentials. Below is a summary of activity during this reporting period:

**Credentials Committee**

The committee is responsible for ensuring that only providers who meet the quality of care, professional conduct, credentialing requirements, and practice standards are granted credential approval and core privileges to provide health care services to patient-inmates.

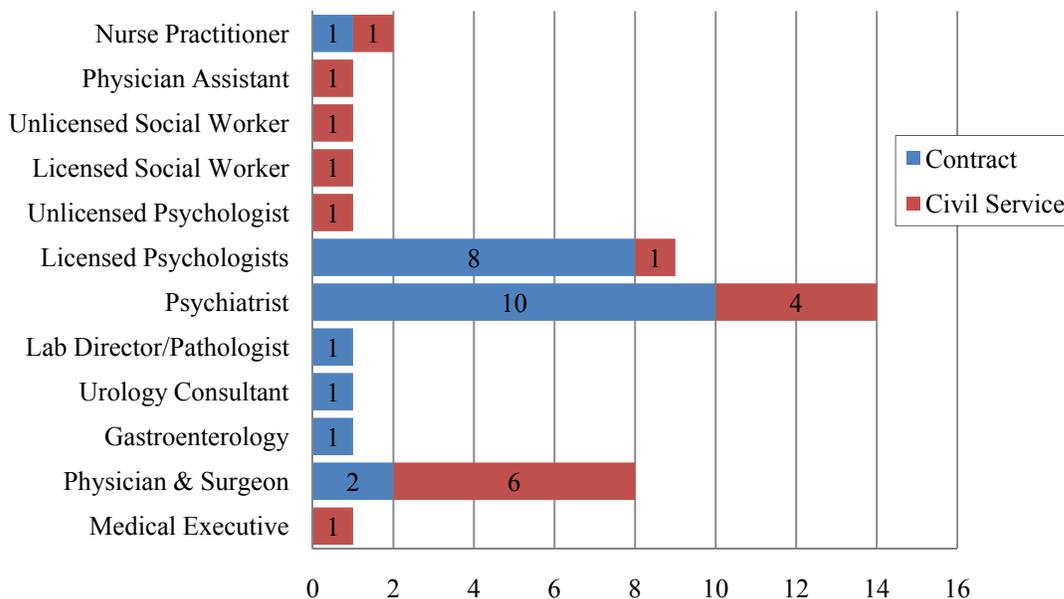
During this review period, the Credentials Committee reviewed forty-one provider cases as detailed in Tables 4 and 5 below.

**Table 4**



**Table 5**

**Provider Cases Reviewed by Credentials Committee  
September through December 2010**



Tracking of License and Board Certification Expirations

To ensure provider compliance with state and department requirements, the Credentialing and Privileging Unit monitors the activity of physician board certification and licensure. The tracking of expiring license and board certifications is an ongoing process with notifications being sent on a monthly basis to ensure that the practitioners have active and current credentials. During this reporting period eighty-nine Notice of Licensure Expirations were processed, and twenty-five Physician and Surgeons board certifications are pending renewal.

***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:

During this reporting period, CPHCS focused on building quality improvement capacity and capabilities at the institution level. On December 1, 2011, fourteen Chief Executive Officers (CEOs) convened in a special workgroup to identify factors that are critical to the success of the statewide quality management program, and determine strategies to establish local quality improvement infrastructure and an organizational culture that promotes continuous learning and

positive change. The CEOs from this workgroup recommended several strategies to strengthen quality management and performance improvement efforts including prioritizing a subset of these strategies as most important for implementation in 2011.

In early 2011, the Quality Management Committee (QMC) at headquarters, which includes leaders from major statewide health care areas and some executives from the field, will meet to review the draft Quality Management Plan 2011 and organizational Dashboard as well as several program performance reports, and to discuss the recommended strategies submitted by the Chief Executive Officers' workgroup noted above. Throughout 2011, the QMC will regularly meet to consider recommendations from workgroups focusing on system-wide performance evaluation and improvement, review progress made toward performance objectives, discuss best practices and lessons learned, and to recommend interventions to enhance organizational and institution specific performance.

***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 is 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 is 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 is completed.

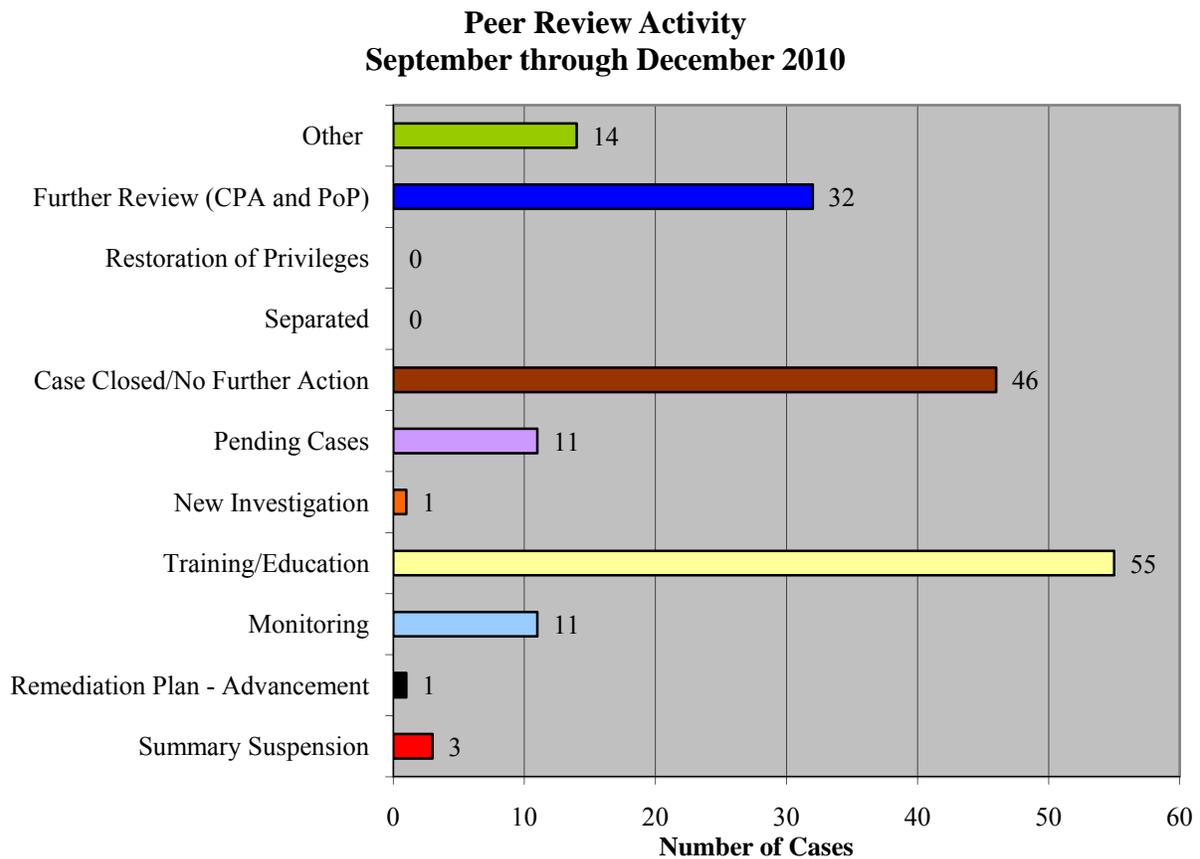
In a health care organization, the Governing Body is the highest policy making body for the provision of health care. Consistent with community standards and health care organizations, the Governing Body is responsible for the administration, direction, monitoring, and quality of health care services provided to patient-inmates within CPHCS and Division of Correctional Health Care Services (DCHCS) adult institutions. The Governing Body has met 4 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 twenty times during the period of September through December 2010. The committees reviewed one hundred thirty-nine referrals regarding clinical practice concerns resulting in one hundred seventy-four actions. The PPEC and PRSC closed forty-six referrals following review of the provider successfully completing training plans or resigning. There were eleven monitoring plans initiated by PPEC for those providers whose standard of practice warranted closer review. The Governing Body approved 9

case closures of providers whose clinical practice was deemed to meet an appropriate standard of care following a peer review investigation.

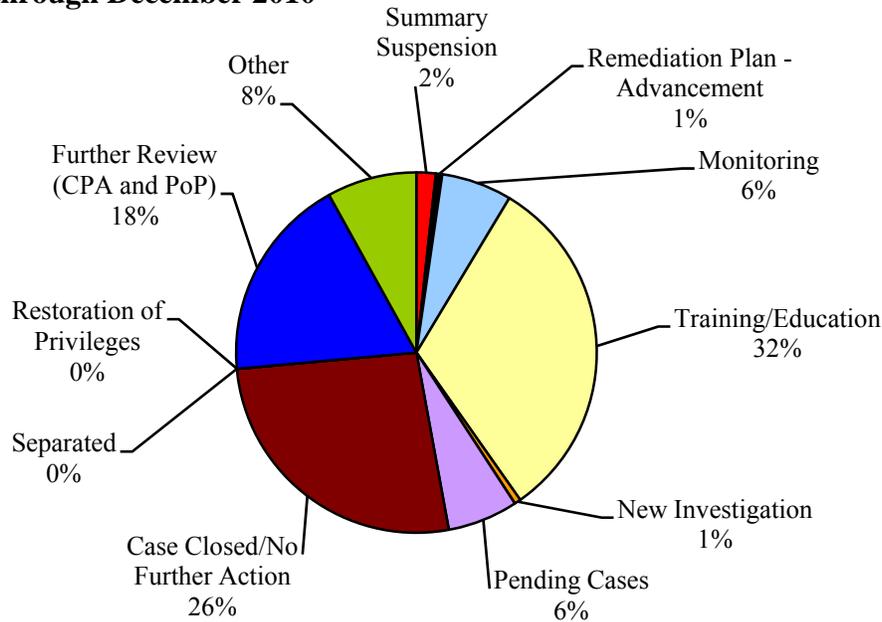
In this reporting period, the PPEC summarily suspended the privileges of 2 practitioners and no providers were separated from State service while under investigation. The Governing Body did not issue any Notices of Final Proposed Action under the Federal court ordered physician policies that would have resulted in the revocation of privileges and termination of employment. Graphical displays of PPEC and PRSC outcomes for the period September 2010 through December 2010 are presented in Tables 6 and 7.

**Table 6**



**Table 7**

**Peer Review Activity by Percentage  
September through December 2010**



**Table 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/Education/Monitoring” is the manner in which provider’s are supported in the development of clinical competency through training/education/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 CPHCS and the provider, staying Governing Body actions pending the provider’s participation in training, monitoring, and phasing in of privileges to full restoration.*

While the PPEC’s primary charge is providing for patient safety, PPEC is also charged with supporting the practice improvement of practitioners. With an improving physician, mid-level, mental health and dental workforce, the PPEC continues to focus efforts on remediation and practice improvement while providing for patient safety. The trend continues to show the number of referrals and summary actions decreasing while case closures, training, and remedial activities are increasing.

In a continued effort to ensure physicians are afforded their due process rights in a timely manner, CPHCS continues to take affirmative steps to implement the professional practice disciplinary process. During this reporting period, there were no appeals filed requesting a hearing before a Judicial Review Committee in a matter concerning a physician. Effective July 1, 2010, the State Personnel Board conducts the Medical Quality Appeal hearings, as specified in the Federal court ordered physician policies. The Office of Administrative Hearings continues to have responsibility for privileging hearings for mid-level practitioners, psychiatrists, psychologists and licensed clinical social workers.

**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 is completed.

The CPHCS Medical Oversight Program (MOP) continues to review sentinel events. Clinical Executive Leadership has a lead role in determining whether an unexpected death and/or event, based on the MOP “Sentinel Event” Criteria, meet the requirements of MOP Activation. Once it is determined, the MOP administrative support will notify CDCR’s Office of Internal Affairs (OIA) and Employee Advocacy and Prosecuting Team (EAPT) to assemble a MOP Activation Team. The team performs a “case-triage” review of all UHR records, reports, and availability of applicable data. This review enables the team to determine whether to conduct a site-visit, open the case for investigation, or reject the case for no cause; thereby, ensuring a consistent, transparent, and impartial approach in all sentinel event reviews.

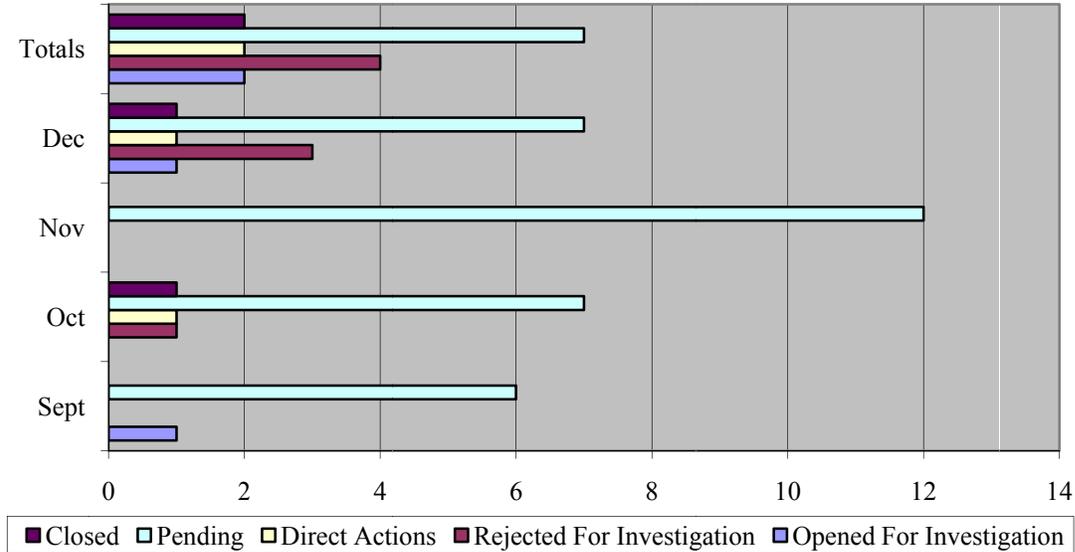
The MOP Team provided an overview of the program to the Statewide Chief Medical Executive, Assistant Statewide Medical Executive, Deputy Medical Executives, Chief Nurse Executives and the Chief of Clinical Operations Support Branch on December 3, 2010 regarding the MOP and presented statistics. Additionally, MOP stakeholders successfully conducted an in-depth MOP Orientation Training on December 7, 2010, for newly assigned clinicians, special agents, and vertical advocates.

During this reporting period, the MOP was activated for fifteen cases. The Medical/Central Intake Panel opened 2 cases for investigation, 4 cases were rejected for investigations; 7 cases are pending further MOP review. With respect to the disposition of cases reviewed by the Panel, 2 cases were referred back to the hiring authority for “Direct Actions,” and 3 physicians were referred to peer review; there were no nurses referred to peer review. Currently MOP has seventeen active ongoing investigations and 2 investigations were closed during this period.

Graphs of MOP outcomes for September through December 2010 are as follows in Tables 8 and 9.

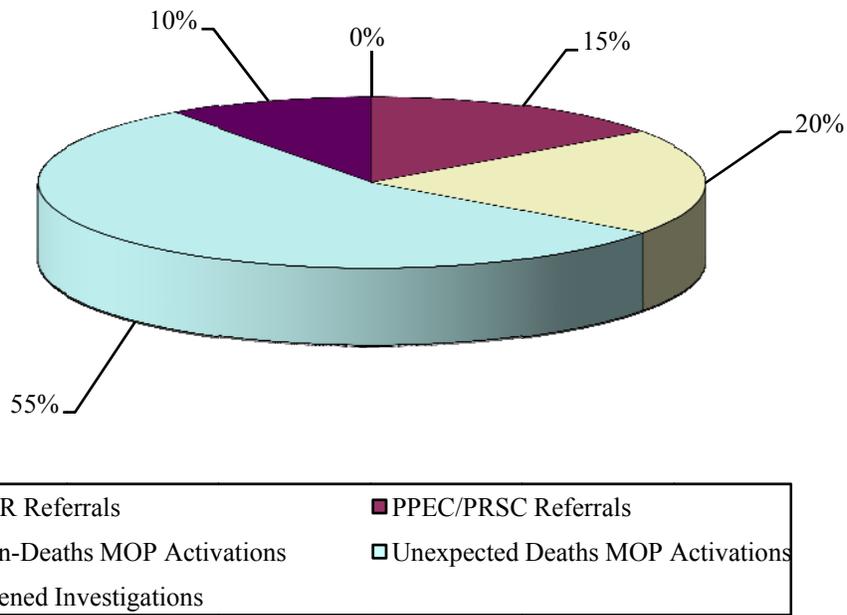
**Table 8**

**Medical Oversight Program Quality Review Activity  
September 2010 through December 2010**



**Table 9**

**Medical Oversight Program Quality Review Activity  
September 2010 through December 2010**



**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 health care patient-inmate appeals, correspondence and habeas corpus petitions.*

This action is 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 is 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 is completed.

During this reporting period, CPHCS, Private Prison Compliance and Monitoring Unit forwarded final drafts of Corrections Corporation of America (CCA) Policies 13-46 (Hunger Strike), 13-56 (Credentialing, Privileging and Licensure), 13-6 (Chronic Care), and 13-52 (Continued Quality Improvement to CCA) to review and include recommended modifications prior to submitting final policies to CPHCS for approval. We anticipate CPHCS approval and CCA implementation of these policies before the next reporting period. CCA Policy 13-47, Infection Control is still undergoing coordinated revisions between the CPHCS Public Health Unit and CCA Clinical Management.

**Current Activities**

The following provides an overview of the current activities Private Prison Compliance and Monitoring Unit staff is involved in to ensuring CCA's compliance with the Remedial Plan developed in July 2008 and Community Correctional Facilities compliance with the Inmate Medical Services Program Policies and Procedures.

1. **CPHCS Clinical Performance Appraisals (CPAs) of CCA Primary Care Providers:**

CPHCS has completed 5 Clinical Performance Appraisals as captured through Private Prison Compliance and Monitoring Unit's monthly monitoring process. Of the 5 CPAs completed, 2 were initial reviews, 1 was an annual review and 2 were follow-up reviews.

CCA has submitted 3 completed Peer Reviews to the Private Prison Compliance and Monitoring Unit for the same reporting period. All 3 Peer Reviews were initial reviews. Private Prison Compliance and Monitoring Unit will continue to monitor this process on a monthly basis.

2. Weekly Physicians Collaborative Update on California Out-of-State Correctional Facility Inmate-patients:

An average of twenty-five medical cases per week was discussed on the weekly Physician's Collaborative Conference Call. These discussions have resulted in an average of 4 inmate-patients per month being returned to California for medical reasons.

3. CPHCS' Review of Credentialing Information of CCA Primary Care Provider Candidates:

The Private Prison Compliance and Monitoring Unit staff and CPHCS clinical leadership continues to work with CCA to finalize the credentialing and privileging policy. It is anticipated that the final draft policy will be submitted to CPHCS's Credentialing Unit for their review and approval within the next reporting period.

Six credentialing packets were received from CCA and reviewed by the CPHCS Credentialing Committee. Of the 6 packets reviewed, 4 were approved to provide medical care to California inmate-patients housed in out-of-state institutions and 2 were not approved for hire.

4. Unit Health Record (UHR) Post Audits of Inmate-patients Transferred Out-of-State:

Nursing staff has completed an average of four hundred fifty UHR post audits per month for inmate-patients transferred to out-of-state facilities to ensure appropriate eligibility screening of transfers. As a result of the UHR post audits, nursing staff found 5 inmate-patients inappropriately identified for out-of-state placement. Further review by the Medical Director, Community and Out-of-State Facilities; found that based on the inmate-patient's current medical status all are eligible to remain out-of state.

The Medical Classification System has been rolled out in all thirty-three CDCR institutions statewide effective March 2010. During this reporting period, Private Prison Compliance and Monitoring Unit nursing staff identified a significant decrease in the number of institutions continuing to utilize the dual screening process for California Out-of-State Correctional Facility placement. As previously stated, it is anticipated that the dual screening process will continue until approximately March 2011. Also during this reporting period, we identified a need to conduct post audits of the newly implemented Medical Classification System as it impacts out-of-state placement. Based on review, follow-up training and discussions have occurred with the impacted institutions to ensure compliance with the Medical Classification System requirements. Consequently, reporting on this activity will continue.

5. Establishment of Monitoring Reports:

Compliance reports continue to be generated monthly and quarterly while being used by analytical and nursing staff preparing for private prison compliance reviews. Process-related issues are still being addressed with Information Technology staff. We anticipate these issues being resolved within the next reporting period.

6. California Out-of-State Correctional Facilities Compliance Audits for Fiscal Year 2010/11:  
The Private Prison Compliance and Monitoring Unit completed 2 on site out-of-state facility audits (North Fork Correctional Facility and Tallahatchie Correctional Facility). It is anticipated that the final audit reports will be submitted to CPHCS executive staff for review and approval for distribution during the next reporting period.

CAPs from the previous audits were received and reviewed; however, the CAPs were returned to Corrections Corporation of America for modification and the completion date extended. There has been ongoing communication between Private Prison Compliance and Monitoring Unit and the Out-of-State Facilities, and they are working diligently to meet the requirements identified in the CAP. This will require continuous monitoring by Private Prison Compliance and Monitoring Unit staff. The CAPS will be reviewed monthly until such time all deficiencies have been adequately corrected and documented. We anticipate this will be completed by the next reporting period.

7. Community Correctional Facilities Audits Beginning July 2010:  
During this reporting period the Private Prison Compliance and Monitoring Unit completed 6 on site facility audits at Claremont Community Correctional Facility, Lassen Community Correctional Facility, Leo Chesney Community Correctional Facility, Central Valley Modified Community Correctional Facility, Female Rehabilitative Community Correctional Center, and Taft Community Correctional Facility. It is anticipated that the final audit reports will be submitted to CPHCS executive staff for review and approval. Once approved, the reports will be distributed during the next reporting period.

CAPs from the previous audits were also reviewed during this reporting period. Several systemic issues have been identified and Private Prison Compliance and Monitoring Unit staff is working closely with CDCR, Community Correctional Facility Administration to develop strategies to correct these deficiencies. To that extent, Private Prison Compliance and Monitoring Unit staff developed monitoring logs and a user guide to help the Community Correctional Facilities begin to come into compliance with the Inmate Medical Services Program Policies and Procedures; however, it should be noted that the majority of the Community Correctional Facilities written policies and procedures will need to be revised to reflect CPHCS requirements. The Private Prison Compliance and Monitoring Unit staff will continue monitoring the progress of the CAPs and incorporate updated findings from the facility audits that have already occurred and are scheduled to occur during the next reporting period.

8. Potential California Out-of-State Correctional Facilities Expansion of an Additional Five Thousand Beds:  
The CDCR has approved expansion of the California Out-of-State Correctional Facilities program by an additional five thousand beds. Prairie Correctional Facility, Appleton, MN and North Lake Correctional Facility, Baldwin, MI. have been chosen as additional program sites. As additional information is received from CDCR, updates regarding the status of this activity will be provided.

## **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 continued to make progress. In addition, Pharmacy Services continued the rollout of the Central 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 (P&T) has continued its monthly meetings to review utilization trends, actively manage the formulary, and review and approve pharmacy policies and procedures. During these meetings, the committee members reviewed monthly reports including the pharmacy dashboard, monthly metrics summary, and medication error reports. A newly revised medication error reporting tool developed by Nursing Services was reviewed and approved by P&T and it is currently awaiting final approval by CPHCS leadership before statewide implementation. Level 4 medication errors that have been submitted over the last year were analyzed to assist in targeting quality improvement efforts.

The P&T Committee removed the thio-glitazone-class of oral anti-diabetic medications from the formulary because of the recent FDA MedWatch precautions on the safety of these agents.

#### ***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 is completed.

The P&T Committee continued to actively review and revise pharmacy policies and procedures as needed, thus completing the annual review of all pharmacy policies.

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

This action is completed.

Implementation of the central distribution model will continue through 2011.

The Central Pharmacy began installing equipment and training staff in early April 2010. Four institutions are now being served by the central pharmacy, and are as follows: California State Prison Sacramento, Mule Creek State Prison, Folsom State Prison, and Sierra Conservation Camp. Following the review and validation of methodology with the first 2 facilities, a detailed analysis was performed to assess and remedy any system issues. From this assessment, it was discovered that there are several system improvements needed to support the full implementation of the central pharmacy project.

The assessment also points to the following challenges created from the project:

- Increased paper chase for nurses in order to deal with the paper-based medication administration records;
- Increased storage demands within all institution medication rooms;
- Increased the potential for waste in part due to the dynamic movement of patient-inmates throughout the system;
- Variation and non-adherence of pharmacy policies and formulary decisions at the institutional level.

The CPHCS Pharmacy leadership is implementing the improvements needed and implementing bar coding for medication administration authentication. The project is planned to be active by July 2011.

### **Objective 5.2. Establish Standardized Health Records Practice**

Implementation of the Health Information Management (HIM)/Health Records remediation road map continues to move forward in order to achieve improved patient health records management based on evidence-based practices and increased cost efficiency. Progress continues and is detailed in the following sections.

*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 is completed.

CPHCS continues to move forward with plans for a statewide electronic Unit Health Record (eUHR). The project has advanced through the design and development phases and has moved into technology infrastructure configuration, testing, and deployment readiness and implementation tasks in preparation for the initial rollout to the women's institutions in early 2011.

The HIM team has completed review of various design specifications to validate overall concepts of the design against approved requirements. In addition, Hewlett Packard (HP) has completed the development of the eUHR solution, and has begun testing. HP continues to work on infrastructure development tasks to ensure the test, pre-production, and production technology infrastructure environments are in place to support the eUHR solution.

Efforts are underway to begin preparing for User Acceptance Test (UAT), which will consist of thirty-eight testers representing institution and headquarters staff from various disciplines. UAT provides a critical checkpoint in the project by allowing users the opportunity to validate that the solution meets approved business requirements and test that the solution works properly before implementation. This testing process is scheduled to begin at the end of December 2010 and last for 4 weeks.

In addition, various activities regarding the eUHR implementation and deployment are in progress. Health Records Readiness Team (HRRT) has completed onsite assessments along with reports of findings regarding the "readiness" of the health records departments in the 3 women's

institutions. The team meets with representatives from these institutions weekly to monitor activities to ensure files are prepared for conversion. HP's Advanced Planning team has completed their ninety-day checklist visits at the women's institutions. The CPHCS training team is finalizing materials for various user training sessions to be conducted in late December 2010 through January 2011.

The CPHCS infrastructure team has completed construction activities at all institutions except SOL to ensure network capabilities. SOL is expected to be completed by mid-January 2011. Deployment of equipment to support the eUHR rollout is currently underway. All but 4 institutions are over fifty percent completed with equipment set-up and installation, and 2 of the 3 women's institutions are ready for the initial rollout.

CPHCS has decided to de-couple from the SOMS Electronic Records Management System (ERMS) implementation schedule due to implementation issues and delays being experienced by the SOMS project. In addition, CPHCS has begun efforts to plan for an accelerated deployment schedule for the implementation of the eUHR to the men's institutions.

The Receiver continues to work toward the EMR initiative. The HIM team is working to create an overall strategy for implementation of the information capture within the EMR solution. Separate project efforts are the CDR, which is focused on collecting information from various outside data sources, and Clinical Documentation which is focused on automating data entry of health care data. The CDR project is currently on hold in order to research data integrity issues found with laboratory and pharmacy data. The Clinical Documentation project has several sub projects underway to work with stakeholder groups on their business processes and automated entry form design.

Efforts to eliminate the Health Records Center's (HRC) historical loose filing backlog of fifty thousand inches, which was created at HRC inception, are near completion. At this point, 99.9 percent of the project is complete including all scanning, indexing and quality control by HRC staff. The remaining files are in the process of being uploaded into the database.

### **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 Imaging Services**

CPHCS is currently interviewing for the replacement of Clinical Executive of Medical Imaging Services. Ascendian Healthcare Consulting remains engaged with providing subject matter expertise with the Imaging remediation project to ensure progress continues toward meeting the Receiver's goals in FY 10/11.

During this reporting period, CPHCS continued its effort to implement standardized and accurate operational workflow processes to ensure the elimination of backlogs and improve conditions for patient-inmates, create a safer work environment, and reduce operational costs to the State.

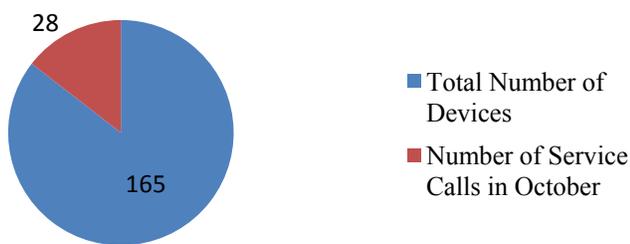
Standardizing of film filing and tracking at all thirty-three institutions is near completion. Six institutions remain and are actively working to complete the conversion process. Delays with these institutions are due to insufficient staffing to accommodate the short-term increase in workload. Efforts are currently underway to provide temporary re-assigned staff to assist with completing these efforts.

Film filing at the institutions has expanded to include centralized management of parolee film files. This solution will help in reducing non-locatable film jackets when patient-inmates recidivate. Utilizing HRC and tracking systems, institutions will send parolee film jackets to be stored and tracked centrally, which will result in better records management, and greater staffing and administrative efficiency.

Equipment performance, including x-ray, mammography, and fluoroscopy devices, continues to be a problem at multiple institutions due to outdated equipment and poor maintenance. As indicated in the Table 10 below, twenty-eight devices have recently required repair service, which impacts departmental functionality and ultimately access to care. In the last 4 months, CPHCS and Ascendian Healthcare Consulting have worked to resolve this problem with 2 parallel efforts. First, equipment maintenance contracts are being revised, and a new procurement with updated language will be released to ensure that qualified vendors are awarded contracts and minimum performance requirements are met. Second, replacement equipment is being procured and installed at the necessary institutions. CMF equipment is halfway through the procurement process, and CTF, WSP, and SCC are in the beginning stages.

**Table 10**

**Equipment Reliability for October**



Efforts to review and revise Professional Service contracts are now being re-examined due to the new Health Net contract. Staff is working to identify potential risks and issues, and then develop an implementation plan that meets the requirements of the Imaging Program.

Mobile pad construction is funded for FY 10/11. The goals are aggressive, but it is expected that the project will be completed on time with updated CT and MRI mobile pads that meet the minimum specification requirements at all thirty-three institutions.

A dental imaging system is in the process of being procured, and the project is scheduled to begin in 3 months. This system will provide statewide inter-operability for all dental images.

Finally, efforts have begun to craft the requirements for RIS/PACS. These systems will provide a community standard for capturing, displaying, archiving and distributing patient-inmate information including demographics and images for physicians at the point of care. The fully deployed system will dramatically reduce report turn-around times and provide better quality information and images for physicians, which will result in better patient-inmate care.

#### Laboratory Services

CPHCS is currently recruiting for a Chief of Laboratory Services. Once this position has been filled, CPHCS will have the state leadership needed to continue working on the ongoing Laboratory policies, improvements, and programs.

CPHCS has also contracted with Health Net to provide a single statewide reference laboratory for all off-site laboratory tests and results. By moving to a single reference laboratory, CPHCS will be able to standardize lab menus and tests, have access to online laboratory order entry and test results, and track lab results of patients who move from one institution to another. Implementation and transition to the new statewide reference laboratory will begin in January 2011.

#### **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 is completed.

As of September 2010 the CDR project team completed training and rollout to Pleasant Valley State Prison, Kern Valley State Prison, and Calipatria State Prison. In the months leading up to September, historical data was loaded from custody, pharmacy and laboratory partners for the above institutions. Staff, at these institutions, was trained on the CDR and on site and remote assistance was provided to support the rollout. This brings the total number of institutions that CDR has been deployed to twelve. In October 2010, access to the CDR portal was paused, to allow for integration with the eUHR (scanned unit health record) project. During the pause, a data validation and governance effort was also initiated. The integrated CDR and eUHR portal will be made available to institutions when the first eUHR site rolls out in early 2011.

During the period ending September 31, 2010, the CDR project team continued work on several commercial-off-the-shelf (COTS) EMR modules. Progress has been made in the Dental clinical documents area which will provide the ability for Dentists to electronically capture health care encounter information, within the CDR. In this period, detailed requirements were collected from

Dental subject matter experts, solution design was completed in the development environment and initial development was initiated.

Work also continues on the COTS EMR module, Patient and Disease Management. This module will provide the ability for a clinician to electronically enter patient encounter and problem information at the point of care and implement defined clinical pathways (workflow) related to chronic disease management (asthma, diabetes, etc.).

Over the next quarter CPHCS will continue to work on integration between the CDR and eUHR systems, and complete the data validation and governance effort, with a goal of releasing a combined CDR and eUHR in spring 2011.

### **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 is 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 continued with Phase 3 of the Telemedicine Services Project, which applies the lessons from previous project phases to advance the ongoing expansion of Telemedicine Services to CDCR statewide. In order to realize continued success, the following work tasks are currently underway:

**Telemedicine Interim Scheduler** - This solution replaces the previous paper-based scheduling system. On July 16, 2010, CPHCS upgraded the Interim Telemedicine Scheduler to its first major version, release 1.0. Over the coming months, we look forward to system enhancements that will allow for increased scheduling efficiencies. The implementation of the RightFax client is completed. RightFax eliminates the need for paper fax. The plan is to see Telemedicine requirements in the broader HCSS. However, the availability of this application is dependent upon the HCSS timeline.

**Network Connectivity** – CPHCS continues to perform site assessments and network upgrades to take advantage of Internet protocol (IP)-based networking systems, thereby replacing the outdated and expensive ISDN lines currently in use. Nine out of thirty-three institutions are upgraded to IP with an average of 3 converted per month. Fifteen out of thirty-three will be converted by January 2011. Five out of 6 HUBs are IP capable/ready. It is expected that this project will continue through 2011, depending on the rollout of statewide Information Technology initiatives.

**Prison Health Care Provider Network Project** – CPHCS and Health Net are collaborating to develop and recruit specialty providers statewide.

**Equipment Upgrades** – CPHCS continues within the budgeted plan to purchase for expansion or refresh as scheduled telemedicine equipment and peripherals. This increased availability of equipment ensures that telemedicine equipment is not a barrier to telemedicine expansion.

**Scanned UHR (E-UHR)** - This system-wide project touches more than just Telemedicine services, and is of particular interest to the CPHCS because it will increase efficiencies relating to medical record management. CPHCS program experts are currently contributing to process definitions required for appropriate system customization.

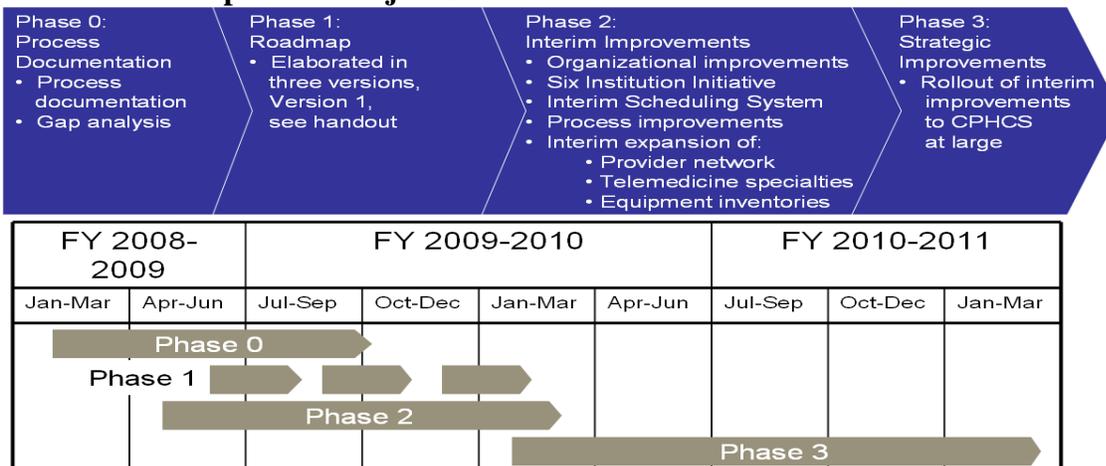
**Primary Care Telemedicine** – In an effort to provide access to care support for institutions with severe Primary Care physician shortages and chronic recruitment challenges, a primary care physician pilot has been developed to improve patient access. The concept is to offer Telemedicine Primary Care to provide physician access for institutions with physician vacancies. The Primary Care pilot is completed and successful. Rollout to additional institutions in need of this service is underway. Two additional primary care providers will be recruited to support this concept.

**HIV and HCV** – CPHCS HIV has increased the number of sessions per week to provide services onsite. HIV and HCV websites are established and monitored for timely responses. A HIV Telemedicine Clinical Work Up check list and HIV Telemedicine Services Consultation referral guidelines have been established. These services are supported internally with the expiration of the University of California, San Francisco (UCSF) contract.

CPHCS completed transition of services previously offered telephonically by CMCN/UCSF to CPHCS onsite and Telemedicine physicians.

A diagram showing system-wide telemedicine expansion is located in Table 11. 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 11**  
**Telemedicine Expansion Project Schedule**



A collaborative Telemedicine network initiative to support the needs of the Office of Telemedicine Services with PHCPN (Health Net) will begin early 2011, as Information Technology improvements are implemented.

During the next reporting period, the move from the pilot phase of specialty expansion to a 'continuous improvement' approach as these system defaults become the standard for chosen Telemedicine services, is expected. Also, another release of the current scheduling system that includes institution-available reports is anticipated.

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

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

Progress on this objective continues to be impacted. Assessments, planning, design and construction timeframes originally established in the action items are no longer feasible and are currently under revision. The submittal of the Statewide Master Plan to the Department of Finance was delayed pending the authorization of the asset transfer bill, which allows CDCR to encumber existing assets for bond sales as a method of financing the renovation component of the Health Care Facilities Improvement Projects (HCFIP).

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

The 30-Day Letters have been submitted to the Department of Finance for the following:

- CMF and SOL projects submitted in July 2010.
- Folsom State Prison and California State Prison, Sacramento projects submitted in August 2010.
- CIW submitted in September 2010.
- RJD Donovan and California Institution for Men submitted in December 2010.
- The remaining 4 intermediate care institutions are still in the planning phase.

The first project approvals are scheduled for the April 2011 Public Works Board (PWB) meeting.

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

The design, bid, and construction phases for each project will begin once PWB project approval and Pool Money Investment Board (PMIB) loan approval have been acquired. The typical duration for these activities is 2 to 3 years from PMIB loan approval.

**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 and CDCR have developed a finalized bed plan that provides medical and mental health facilities for the projected patient-inmate population through 2013. The approved plan envisions 1 new facility of approximately one thousand seven hundred beds and the use of 3 former Division of Juvenile Justice (DJJ) facilities, which would be converted to accommodate inmates with medical and mental health conditions.

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

Public Works Board (PWB) project and Pooled Money Investment Board (PMIB) loan approvals were granted for the California Health Care Facility (CHCF), DeWitt Nelson, and Estrella Correctional Facility.

The Joint Legislative Budget Committee (JLBC) disapproved the 30-Day Letter for Heman G. Stark on September 15, 2010 citing concern over the scope and budget and recommending lower cost alternatives be explored.

***Action 6.2.2 By February 2009, begin construction at first site.***

A groundbreaking ceremony was held on October 15, 2010 for the CHCF. Contractors have submitted statements of qualifications in response to CDCR's competitive solicitation for Design/Build Bid Package 1 (site work and nonsecure support buildings). Selection of a contractor is scheduled to occur in April 2011. Statements of qualifications were also received for Design/Build Bid Package 2 (housing and health care) and selection should occur in May 2011.

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

Occupancy for Heman G. Stark will be delayed beyond the scheduled completion date of December 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 is completed.

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

This action is completed.

## **Section 4**

### **Additional Successes Achieved by the Receiver**

#### **A. Correctional Medical System Personnel Comparison**

In January 2010, CPHCS contracted with the Office of State Audits and Evaluations (OSAE) to conduct a comparative review of California prison system health care costs in relation to peer organizations around the country. Due to the complex enormity of comparing all components that drive prison health care costs, we focused on personnel costs as the critical first step in addressing comparisons. While we were able to gain insight into similarities and differences between the various health care delivery models, we were limited in our ability to conduct a complete and robust staffing analysis for comparison. This report will be released in the 1<sup>st</sup> quarter of 2011.

Key points for consideration upon review of the report include the following:

- The study only considered data for fiscal year 2008/2009.
- A comprehensive survey developed by OSAE and CPHCS was sent to all of the peer organizations identified for comparison.
- Peer organizations provided relevant data regarding clinical staffing patterns; however, many provided only limited or no data at all regarding non-clinical staffing.
- Due to the scope of our research and amount contracted, OSAE was not able to conduct site visits to validate data from peer organizations.

While we are unable to draw any comparative assessments about non-clinical staff, we do believe that valid conclusions may be drawn regarding clinical staffing patterns.

In addition, it is important to consider that this study did not contemplate that California was in 2008/2009 and is currently under the authority of the federal court and an appointed Receiver.

Through our Tri-Annual Reports to the Court, we continue to report on the progress of initiatives to improve health care services outlined in the Receiver's Turn Around Plan of Action. We have also continued to report on successes achieved through implementation, while increasing efficiencies and reducing expenses. California's prison health care system is undergoing a complete transformation, including but not limited to the introduction of health care technologies coupled with the consolidation and centralization of many services. To complete such a large undertaking, additional administrative staff are needed. We continually examine clinical and institution staffing models to ensure our resources fulfill the core clinical functions. At the same time, we have succeeded in reducing administrative staff in headquarters, as new initiatives reach completion. In fact, the fiscal data related to this report are from 2008/09, and since that time we have succeeded in implementing permanent operational efficiencies and reductions that have resulted in savings of \$408 million for fiscal year 2009/10.

## **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 health care within California's adult correctional system, the State's fiscal crisis has and will likely have continued impact on CPHCS, 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 and the reasons for change. While blame for these failures cannot be placed solely on fiscal challenges, there is little doubt that budget cuts and mandates have contributed to these setbacks.

The budget forecast coupled with California's low financial rating will present challenges for all in 2011 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 4 month period from September through December 2010 were \$1,112,820 and \$4,059 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 8](#).

#### B. Revenues

During the 4 month period ending December 31, 2010, the receiver requested transfers totaling \$1,051,380 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 2010-2011 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 4 courts, *Plata, Coleman, Perez, and Armstrong* (“Coordination Group”) class actions have continued. Coordination Group meetings were held on September 7<sup>th</sup> and October 26<sup>th</sup>. Progress has continued during this reporting period and captured in meeting minutes.

#### **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 9](#) is a summary of the contract the Receiver awarded during this reporting period, including a brief description of the contract, which project the contract pertains to, and 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:

No contracts to report this period.

## **Section 8**

### **Conclusion**

The most significant improvement during this reporting period was the completion of our initiative to put health care CEOs in place for each institution. The appointment of these CEOs improves our ability to hold institutions accountable for performance, both in terms of quality improvements and in terms of budget management. They bring an unprecedented level of institutional focus on health care issues.

Quality management and accountability will take another big step forward in the next reporting cycle as we publicly unveil a “performance dashboard” that has been developed over the last year. The next tri-annual report will describe that dashboard in detail. The dashboard will set a new standard for transparency and accountability in California state government by giving everyone the opportunity to assess our progress in much greater detail on an ongoing basis.