

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

**Seventeenth Tri-Annual Report of the  
Federal Receiver's Turnaround Plan of Action  
For  
January 1 – April 30, 2011**

**May 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>5</b>
<b>3. Status and Progress Toward the Turnaround Plan Initiatives.....</b>	<b>6</b>
<b>GOAL 1 Ensure Timely Access to Health Care Services.....</b>	<b>6</b>
<i>Objective 1.1</i> Screening and Assessment Processes.....	6
<i>Objective 1.2</i> Access Staffing and Processes.....	6
<i>Objective 1.3</i> Scheduling and Patient-Inmate Tracking System.....	8
<i>Objective 1.4</i> Standardized Utilization Management System.....	9
<b>GOAL 2 Establish a Prison Medical Program Addressing the Full</b>	
<b>Continuum of Health Care Services.....</b>	<b>11</b>
<i>Objective 2.1</i> Primary Care.....	11
<i>Objective 2.2</i> Chronic Care.....	11
<i>Objective 2.3</i> Emergency Response.....	11
<i>Objective 2.4</i> Specialty Care and Hospitalization.....	11
<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.....	16
<i>Objective 3.3</i> Professional Training Program.....	17
<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.....	25
<i>Objective 4.4</i> Medical Oversight Unit.....	27

<i>Objective 4.5</i>	Health Care Appeals Process.....	29
<i>Objective 4.6</i>	Out-of-State, Community Correctional Facilities and Re-entry Oversight.....	31
	<b>GOAL 5 Establish Medical Support / Allied Health Infrastructure.....</b>	<b>34</b>
<i>Objective 5.1</i>	Pharmacy.....	34
<i>Objective 5.2</i>	Medical Records.....	35
<i>Objective 5.3</i>	Imaging/Radiology and Laboratory Services.....	36
<i>Objective 5.4</i>	Clinical Information Systems.....	38
<i>Objective 5.5</i>	Telemedicine.....	38
	<b>GOAL 6 Provide for Necessary Clinical, Administrative and Housing     Facilities.....</b>	<b>41</b>
<i>Objective 6.1</i>	Upgrade Administrative and Clinical Facilities.....	41
<i>Objective 6.2</i>	Expand Administrative, Clinical, and House Facilities.....	41
<i>Objective 6.3</i>	Finish Construction at San Quentin State Prison.....	42
<b>4.</b>	<b>Additional Successes Achieved by the Receiver.....</b>	<b>43</b>
A.	Office of the Inspector General – First Cycle Inspections of California’s 33 Adult Prisons.....	43
<b>5.</b>	<b>Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented By Institutions Or Individuals.....</b>	<b>45</b>
<b>6.</b>	<b>An Accounting of Expenditures for the Reporting Period.....</b>	<b>46</b>
<b>7.</b>	<b>Other Matters Deemed Appropriate for Judicial Review.....</b>	<b>47</b>
A.	Coordination with Other Lawsuits.....	47
B.	Master Contract Waiver Reporting.....	47
C.	Consultant Staff Engaged by the Receiver.....	47
<b>8.</b>	<b>Conclusion.....</b>	<b>48</b>

# Section 1

## Executive Summary

In our second Tri-Annual report for 2011, the accomplishments for the period of January 1 through April 30, 2011 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, 529 CEO applicants have been added to the certification list. Based on current pairing of institutions, the total number of CEOs hired was 24. Since the last report, two CEOs have left their posts and recruitment efforts are under way to fill these vacancies.
- Prison Health Care Nurse Executive - Since the Receiver's Nurse Executive examination commenced in September 2008, 453 Nurse Executive applicants have been added to the certification list and 18 Nurse Executives have been hired of the 25 positions to be filled statewide.
- Prison Health Care Medical Executive - Since the Receiver's Medical Executive examination was launched in December 2008, 162 Medical Executive applicants have been added to the certification list. Twenty-eight Medical Executives have been hired of the 26 positions to 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 and Pharmacy disciplines are filled. The Laboratory and Imaging disciplines are vacant and interviews are in process to fill those disciplines.
- Chief Support Executive (CSE) – The CSE is a new addition to the institution leadership infrastructure. The CSE is a Career Executive Assignment that will serve as the chief operating officer to the institution CEO, for Health Care Services, and is responsible for plant operations, fiscal services, budgets, contracts, procurement, and administrative and fiscal policy development. Efforts to fill 24 positions, one under each CEO, have begun.
- Accreditation with Commendation – February 24, 2011, the Continuing Medical Education Program was notified by the Institute for Medical Quality/California Medical Association that “Accreditation with Commendation” six-year accreditation had been awarded. Accreditation with Commendation is the highest level of accreditation requiring compliance with 22 individual standards. Less than 10% of the providers nationwide are granted this level of accreditation.
- Medical Savings - The two-year post audit effort has resulted in twenty-eight million dollars in refunds as of April 2011. These refunds represent overpayments recovered by Equicclaim (formerly Viant) during the two-year post audit period of July 1, 2007 through June 30, 2009, as well as voluntary provider refunds and ongoing retrospective audits. 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.

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. 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.

The Office of the Inspector General (OIG) completed its first round of medical inspection results during 2010. It released a report titled *Medical Inspection Results, Summary and Analysis of the First Cycle of Medical Inspections of California 33 Adult Prisons* on May 4, 2011, a copy of which is posted on OIG's website. The following paragraph from the Executive Summary gives a high level overview:

Only nine of the 33 prisons met or exceeded the 75 percent minimum score for moderate adherence, and no prison achieved high adherence. Twenty-four of the 33 prisons performed below the minimum score for moderate adherence, but 12 were close, with scores of 70 percent to 74 percent; the average overall weighted score was 72 percent. Prisons' scores ranged from 83 percent for Folsom State Prison down to 62 percent for High Desert State Prison. Folsom State Prison is the only prison to achieve moderate or high adherence in the six most heavily weighted components of the inspection program.

In addition, the OIG reviewed its data from the perspective of five general medical categories: medication management, access to medical providers and services; primary care provider responsibilities; continuity of care; and nurse responsibilities. Two of these five areas, medication management and timely access to medical providers, have been particularly resistant to improvement, and the OIG report documents poor performance in these areas. Overcrowding, along with persistent and widespread lockdowns, materially interfere with our ability to improve in these areas.

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. Since the last report, CDCR took the lead and worked with CPHCS to write emergency regulations for the new medical parole process. To date, CPHCS has identified 44 potential candidates for medical parole and is working to get each of these cases to the Board of Parole Hearings (BPH) for consideration.

Earlier 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 three forms of supporting data:

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions. Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the CPHCS website ([http://www.cprinc.org/receiver\\_mo.aspx](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](#).

In support of the coordination efforts by the four federal courts responsible for the major health care class actions pending against the CDCR, the Receiver files the Tri-Annual Report in four 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 15 and 16. ([http://www.cphcs.ca.gov/receiver\\_tri.aspx](http://www.cphcs.ca.gov/receiver_tri.aspx))

Four court coordination activities include: facilities and construction; telemedicine and information technology; pharmacy; recruitment and hiring; and credentialing and privileging.

#### 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 seventeenth report filed by the Receivership, and the eleventh submitted by Receiver Clark Kelso.

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

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

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

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

In support of the coordination efforts by the four federal courts responsible for the major health care class actions pending against the CDCR, the Receiver files the Tri-Annual Report in four 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 on pages 15 and 16. ([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 of the revised policy and procedures.

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

This action is completed.

*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.

During this reporting period, all except one institution has passed the certification for Medical Classification. The remaining facility is diligently striving to pass certification and is expected to do so soon.

**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

CPHCS continues to be effective in facilitating inmate access to care for scheduled appointments, which involves guarded escorts to 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.

### Operational Assessments

The process of reviewing 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. Since the last report, Operational Assessments have been conducted at California Substance Abuse Treatment Facility and State Prison, Corcoran (SATF), High Desert State Prison, Pleasant Valley State Prison (PVSP), North Kern State Prison, Valley State Prison for Women (VSPW), Chuckawalla Valley State Prison (CVSP), Kern Valley State Prison (KVSP), Pelican Bay State Prison (PBSP), Sierra Conservation Center (SCC), Ironwood State Prison, Correctional Training Facility, and California Correctional Institution (CCI). Operational Assessments for all 33 institutions are scheduled to be completed by July 2011. A follow-up visit will be conducted at each institution to ensure Corrective Action Plan (CAP) items have been addressed.

Additionally, the Webinar training that was tentatively scheduled for January 2011, for all Health Care Access Unit Associate Wardens and Captains, was postponed due to scheduling conflicts. This training has been rescheduled, with a tentative start date of May 1, 2011. Training to the field will be scheduled in small groups in an effort to facilitate greater participation and better interaction. As part of this training, a copy of the assessment tool and all elements assessed as part of the Operational Assessment will be provided to all participants. This will assist those institutions that have not yet participated in the Operational Assessment and all institutions with the follow-up assessment process. Follow-up assessments are currently scheduled to begin in September 2011, with anticipated completion by March 2012.

### Monthly Health Care AQR - Data Collection Instrument

AQR data remained stable during this reporting period. February's AQR indicated that 92% 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 0.7% 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. A comparison of MHTS and AQR data has been conducted that led to an alignment of service sites within the MHTS to match those in the AQR for consistency of data collection. Data collection for the AQR via the MHTS is anticipated this fiscal year.

Incorporation of the AQR into COMPSTAT (CDCR database) had been delayed due to technical issues. CDCR and CPHCS worked collaboratively toward a resolution. Technical issues with data entry have been resolved, as have most of the report production issues. Collaboration is

continuing. 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 November 2010 through March 2011.

### Vehicles

Effective February 4, 2011, the following six medical transportation vans have been distributed to their designated institutions: one to Central California Women's Facility (CCWF), one to CCI, one to California Institution for Women (CIW), one to VSPW, and two to PBSP. This effectively completes the distribution of vehicles by CPHCS. Health care vehicle resources and their subsequent responsibilities were defined for transition back to the oversight of the CDCR in December 2010. CPHCS is awaiting CDCR's response.

### 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. The recommendations are currently in the process of approval at CDCR.

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

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

During this reporting period, the CPHCS Health Care Scheduling System (HCSS) Project Team has been testing the initial version of the Strategic Offender Management System (SOMS)/HCSS software and reporting defects or needed changes where appropriate. In addition, the HCSS Team has been working with technical staff of CPHCS and MHTS team to test an interface between MHTS and SOMS/HCSS, using the Clinical Data Repository (CDR) as a common point of access. The testing has run longer than expected and may not be concluded until May. The interface will supply scheduling information to the MHTS reporting system.

The first modules of SOMS – Intake, Movements, and Counts – were successfully deployed to the women's institutions on March 28, 2011. The HCSS Project Team trained and assisted Health Care staff in the women's institutions with the changes to their duties that have been brought about by the new technology. Initially, CPHCS expected to provide SOMS access to fewer than 100 users who are directly or indirectly involved in intake processes. However, because SOMS is now the system of record for many other functions that are no longer provided through legacy systems, over 400 users need to have access. In addition, immediately following the SOMS initial deployment, the HCSS team assisted the Public Health Nurses (PHN) in the women's institutions with preparations and execution of the annual TB testing program. The testing lists were generated from SOMS and the test results were entered into SOMS, where they are immediately available to all who need to see them.

System problems identified during testing are being corrected by the SOMS vendor. It is now anticipated that the system will be ready for use in late May. The initial deployment of HCSS to CIW is scheduled for May 25, 2011, subject to a final review of the readiness of the software and the institution. The precise deployment date will be determined when all conditions required to go live have been met. To reduce risk during the initial implementation, the HCSS team will deploy to the CIW health care disciplines sequentially, beginning with Dental and Medical. Deployment to Mental Health will occur two weeks later. 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, the project team plans to deploy Health Care and Custody Scheduling to VSPW in June 2011 and to CCWF in July 2011. The Project Team has visited all three 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 system.

The roll-out will proceed to the men's institutions starting in the summer of 2011. The exact sequence of the deployment is currently in planning. When the deployment procedures become fully repeatable, the current plan is to roll-out Health Care Scheduling to two institutions per month using two deployment teams, with direction and oversight from a Headquarters project management team. Implementation at all institutions would be completed in the spring of 2013. A proposal is currently pending with the Turnaround Plan Executive Committee (TPEC) for the addition of two more deployment teams as a means of expediting the deployment. Under this plan, the last men's institution would transition to HCSS in late summer 2012.

In preparation for HCSS deployment, the HCSS Project Team is assembling a Clinical Deployment Support Team. The team will be comprised of four CPHCS employees who will be assigned to HCSS and will assist with all the site preparation, training, change management, and user support activities at each site.

The HCSS Core Leadership Team is now meeting monthly and holds special meetings when major issues arise and decisions are needed.

#### **Objective 1.4. Establish a Standardized Utilization Management System**

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

This action is completed.

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

This action is completed.

The CPHCS Utilization Management (UM) Program, now required by law per AB 1628, has outlined in its Annual Workplan, activities to standardize operations and implementation across

33 institutions. These activities continued to focus on the top two drivers of utilization: hospitalization and specialty referrals.

Hospital bed rounds in 12 high volume hospitals across the state occur on a daily basis. Institutional Chief Medical Executives (CME) or the Chief Physician and Surgeons (CP&S) are expected to actively participate in the treatment and management of their patients while in community hospitals to facilitate return of patient inmates to their institutions once medically stable. Timely return of patient inmates to their institutions once medically stable has improved (refer to Table 2, Administrative Bed Data, on pages 11-12); total community hospital bed days has also decreased (refer to Table 1, Community Hospital Bed Utilization Data, on page 11).

Individual institutional conferences with medical leadership have been initiated to discuss service utilization, barriers to contain cost and unnecessary referrals, and ways to collaborate and support institutional staff. Volume and cost based utilization reports, with the diagnostic and patient drivers of high cost, high volume and high risk specialty categories, are continued to be made available monthly to executive and institutional leadership to assist institutional leadership in achieving the Receiver's access, outcomes and cost avoidance goals.

Institutional bed and community hospital census, currently tracked through the Census and Discharge Data Information system (CADDIS), will soon migrate to a Web based system. Pilot testing of Web CADDIS is currently ongoing. The goal is to implement Web CADDIS in all 33 institutions by July 1, 2011.

UM continues to collaborate with the Prison Health Care Provider Network (PHCPN) in mentoring and monitoring the institutional transition to the new network. In addition, UM has been actively involved in the deployment of the Medical Parole legislation. UM has begun the identification of potentially eligible Medical Parole inmate patients, process the initial paperwork, find appropriate placements for their medical condition, and coordinate with CDCR staff to move the cases forward for BPH review.

## **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.*

The Episodic Care Policy and Procedure is in the final review and approval phase. Upon approval, we will proceed with the rollout and implementation.

*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 seven institutions. Full implementation at all institutions will follow.

### **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: Community Hospital Bed Utilization Data**

Institution	Total Admits	Total Discharges	Total Census Days	Average Daily Census	Average Length of Stay	Inmate Population	Bed Days per 1000 Inmates Projected for the Year
Aug-09	1,102	1,001	9,913	332	9.0	152,072	782.2
Sep-09	1,107	1,129	9,206	302	8.3	152,870	722.7
Oct-09	1,027	1,060	8,567	261	8.2	153,906	668.0
Nov-09	1,004	995	8,253	275	8.2	153,203	646.4
Dec-09	1,065	1,085	8,256	266	7.8	154,154	642.7
Jan-10	990	978	7,430	240	7.5	153,261	581.8
Feb-10	963	956	6,973	249	7.2	152,501	548.7
Mar-10	1,126	1,133	7,676	248	6.8	151,972	606.1
Apr-10	1,124	1,113	7,505	250	6.7	151,759	593.4
May-10	1,044	1,058	7,534	243	7.2	151,396	597.2
Jun-10	1,155	1,142	7,772	259	6.7	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	6.7	148,003	500.3
Dec-10	977	982	6,522	210.4	6.7	146,632	533.7
Jan-11	935	943	6,325	204.0	6.8	145,719	520.9
Feb-11	779	780	5,135	183.4	6.6	145,704	422.9
Mar-11	957	965	5,764	185.9	6.0	146,590	471.8

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: Community Hospital Administrative Bed Data\***

	Amount Paid	Number of Administrative Days
Sep-09	\$446,233	391
Oct-09	\$434,200	446
Nov-09	\$414,818	482
Dec-09	\$660,083	609
Jan-10	\$551,917	571
Feb-10	\$438,981	410
Mar-10	\$867,543	882
Apr-10	\$676,804	729
May-10	\$552,492	571
Jun-10	\$630,997	741
Jul-10	\$371,100	385
Aug-10	\$631,293	575
Sept-10	\$581,539	604
Oct-10	\$483,145	462
Nov-10	\$337,688	385
Grand Total	\$8,078,832	8,243

\*This table is based on all claims paid by the Third Party Administrator as of Mar 2, 2011 and may not reflect all activity. This table is based on paid claims, not billed amounts.

**Table 3: Specialty Referral Volume - Requests For Services (RFS) - Total Volume**

	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
Dec-10	2,937	3,053	5,618	*	11,608	79.2
Jan-11	2,980	2,726	4,561	*	10,267	70.5
Feb-11	2,437	2,921	4,682	*	10,040	68.9
Mar-11	3,161	3,188	5,233	*	11,582	79.0

\*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 is completed. Progress during this reporting period is as follows:

ProdÁgio Contract Processing System

The ProdÁgio will be considered as a possible CPHCS acquisition solution as the Contract Management Team explores integrating and standardizing all procurements of goods and services organization-wide.

CDCR's Business Information System (BIS)

CPHCS completed its business requirements and gathering and analysis efforts toward migration of the medical contracts to BIS, and has begun the next steps of identifying options to meet

functional requirements as well as restraints which might prohibit migration of medical contracts to BIS.

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

CPHCS entered into a partnership with Health Net Federal Services, LLC (Health Net) to develop and maintain a statewide PHCPN of health care providers for California's 33 correctional facilities. CPHCS and Health Net developed a plan to streamline CPHCS' ability to provide enhanced access to care and improved quality of care in the institutions and the community at sustainable rates.

On January 1, 2011, Health Net fulfilled the requirements for Phase One of the plan by having 66% of the provider network in place while ensuring patient-inmates' access to and continuity of care. In addition, a robust listing of network medical service providers was made available to institution staff statewide through a web-based directory for scheduling of patient-inmates. CPHCS Medical Contracts continues to ensure access to medical care services in the interim of Health Net completing Phase Two by June 30, 2011, when 100% of the provider network will be in place.

At this time, CPHCS Medical Contracts continue 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 34 new and amended statewide contracts for hospital, specialty physician and ambulance services.
- Execution of 29 amended competitively bid medical contracts and four competitively bid ambulance contracts through centralized coordination with Medical Program Services and individual institutions.

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

This action is completed.

#### Two-Year Post Audit

The two-year post audit effort has resulted in twenty-eight million dollars in refunds as of April 2011. These refunds represent overpayments recovered by Equicclaim (formerly Viant) during the two-year post audit period of July 1, 2007 through June 30, 2009, as well as voluntary provider refunds and ongoing retrospective audits. 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. This bill is currently moving through the legislative process.

## **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 March 2011, 94% of the nursing positions have been filled statewide, a nearly 3.5% increase since the last report at 90%. This percentage is an average of six State nursing classifications.

More specifically, the goal of filling 90% or higher of the Registered Nurse (RN) positions has been achieved at 26 institutions (79% of all institutions). Eight institutions (24%) have filled 100% of their RN positions during this reporting period.

The goal of filling 90% or higher of the Licensed Vocational Nurse (LVN) positions has been achieved at 26 institutions (79%). The balance of seven institutions (21%) has filled 80 to 89% of their LVN positions.

The following hiring-related initiatives took place during the reporting period: A variety of online job postings were the focus of hiring activities during the reporting period. 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.

For details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for December 2010, January 2011, February 2011, and March 2011. 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 March 2011, just over 88% of physician positions are filled, virtually unchanged from the previous report. This percentage is an average of all three State physician classifications. More specifically, 65% of the Chief Medical Officer (CMO)/Receiver’s Medical Executive positions

are filled, a slight decrease from 67% since the last report. Note that the CMO positions are being abolished through attrition since the role of the CME is no longer filled with the CMO classification, but rather, the Receiver's Medical Executive classification. CP&S positions were unchanged at 86% filled; and 93% of the P&S positions are filled, an overall increase of 1%.

Twenty-five institutions (76%) have achieved the goal of filling 90% of their P&S positions; 21 of these institutions (66%) have filled 100% of their P&S positions. Four institutions (12%) have filled 80 – 89% of their P&S positions, with four institutions having less than 80% filled.

While the Central Valley region continues to be “hard-to-fill,” the following institutions decreased their vacancy rate during this reporting period: California Medical Facility (CMF), California Men's Colony, California State Prison Los Angeles, California State Prison Sacramento, California State Prison San Quentin, and PBSP. Cejka Search, a vendor for physician and executive search services, continues to conduct physician searches for PVSP and the SATF.

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.

For details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for December 2010, January 2011, February 2011, and March 2011. 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.*

These actions are completed. Progress during this reporting period is as follows:

Since the CEO examination was launched on December 24, 2008, 529 CEO applicants have been added to the certification list. Based on current pairing of institutions, the total number of CEOs hired was 24. Since the last report, two CEOs have left their posts and recruitment efforts are underway to fill these vacancies.

Strategically, CEO positions have been filled statewide and these individuals are playing a pivotal role in establishing the remainder of the clinical leadership structure. Twenty-four CEO positions have been filled statewide. There are nine pairings of institutions (18 institutions) that will be under the direction of one CEO at each of the paired institutions.

Since the Receiver's Nurse Executive examination commenced in September 2008, 453 Nurse Executive applicants have been added to the certification list and 18 Nurse Executives have been hired. Due to the varying institutional medical missions and physical distance between Centinela

and Calipatria State Prison, it was determined that they should not be paired. As a result, it was determined that eight pairings (16 institutions) was appropriate for the purpose of hiring Institution Chief Nurse Executives. Therefore 25 Institution Chief Nurse Executives will be filled statewide.

Since the Receiver's Medical Executive examination was launched in December 2008, 162 Medical Executive applicants have been added to the certification list. Twenty-eight Medical Executives have been hired. Due to the varying institutional medical missions and physical distance between SCC and Mule Creek State Prison and the distance between Centinela and Calipatria State Prison, it was determined that seven pairings of institutions (14 institutions) was appropriate for the purpose of hiring Institution CMEs. Therefore, 26 Institution CMEs will be filled statewide.

The Receiver's Clinical Executive examination was launched in November 2009 for four disciplines: Laboratory, Imaging, Dietary, and Pharmacy. The Dietary and Pharmacy disciplines are filled. The Laboratory and Imaging disciplines are still vacant and interviews are in process to fill those disciplines.

The CSE is a new addition to the institution leadership infrastructure. The CSE is a Career Executive Assignment that will serve as the chief operating officer to the institution CEO, for Health Care Services and is responsible for plant operations, fiscal services, budgets, contracts, procurement, and administrative and fiscal policy development. Efforts to fill 24 positions, one under each CEO, have begun.

### **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 completed. Progress during this reporting period is as follows:

#### **Status of New Employee Orientation and Training**

In January 2010, all 33 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 in part 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. Additional topics necessary to appropriately orient health care new hires were added to the curriculum.

The last report noted a drop from 27 to 13 institutions providing HCNEO; now dropping to only seven. Headquarters HCNEO is ongoing and continues to be well received by staff. Factors contributing to the decline of institutions' implementing HCNEO continue due to delays in the approval of the program specific orientation, scheduling issues, lack of available resources dedicated to health care training, and site specific challenges. Additional efforts to resolve obstacles have been ongoing and currently CPHCS is doing the following:

- Initiating dialogue with the institutions' CEOs and other Institution leadership on the most efficient delivery of the HCNEO curriculum to all health care staff.
- Conducting a side-by-side review of CDCR IST and HCNEO lesson plans to identify curriculum that is applicable to all staff and recommend a collaborative training effort where new health care staff and new CDCR staff can attend together for portions of new employee orientation; avoiding unnecessary overlap, additional hours of training, and non-efficient use of training resources.
- Reviewing, updating (if necessary) and submitting all lesson plans through the CPHCS curriculum review and approval process to ensure they are in compliance.
- Providing all institution CEOs with a Pre-Orientation Guide to use for new health care staff.
- Discussing with CDCR training delivery options to enhance the efficiency and consistent delivery of new employee training that meets state, departmental, and court requirements.
- Developing a SharePoint site where all institution staff can access HCNEO training materials, schedules, instructor listings, etc.

#### 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.

Provisional Accreditation was granted on March 31, 2009 for a two-year period after successful compliance of Institute for Medical Quality/California Medical Association standards and co-sponsorship program. In December 2010, CPHCS applied for reaccreditation with the Institute for Medical Quality/California Medical Association.

February 24, 2011, the Continuing Medical Education Program was notified by the Institute for Medical Quality/California Medical Association that "Accreditation with Commendation" six-year accreditation had been awarded. Accreditation with Commendation is the highest level of accreditation requiring compliance with 22 individual standards. Less than 10% of the providers nationwide are granted this level of accreditation. The CPHCS Continuing Medical Education Program surpassed Objective 3.3.2 when receiving excellence in both the paper and face-to-face survey conducted by the Institute for Medical Quality/California Medical Association.

In this reporting period the Continuing Medical Education program conducted 686 hours of education on "Hepatitis C Virus" and "An Update in Anticoagulation Management". These educational activities were provided in eight sessions to 510 licensed health care staff of which 375 were physicians.

Continuing Medical Education is an on-going program and as such the administrative support staff and committee members are constantly working on the next educational activities that will provide departmental specific education for providing health care to the patient/inmate setting.

The following six educational activities are in various stages of development, review, approval and implementation.

- Personality Disorders
- HIV Medicine for the Primary Care Provider
- Introduction to the MHSDS for Medical Staff
- Insomnia
- Behavioral Pain Management
- *Clark* Training for Mental Health

As a continuous effort to improve patient-inmate health care, the CPHCS Continuing Medical Education administrative program staff and committee members continue to work with other programs to assess the education needs of the departmental clinicians. To fully recognize and combine the various clinical disciplines within the department, the committee includes physician and surgeons, mental health, dental, and nursing providers. Additionally, these classifications have been successful in obtaining continuing education credit for their respective licensing boards by attending the CPHCS Continuing Medical Education activities.

## **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 February 2011, CPHCS and the Division of Correctional Health Care Services (DCHCS) issued Performance Improvement Objectives for fiscal year 2011-2012. In addition to initiatives continued from 2010, nine high priority areas for improvement were added, including areas impacting patient safety, such as anticoagulation care (involving patients on blood-thinners), suicide prevention and management of high-risk mental health patients, and medication administration; and public health areas, such as Human Immunodeficiency Virus (HIV) screening.

Effective April 2011, all priority improvement areas outlined in the 2011-2012 Performance Improvement Objectives, which are benchmarked have been incorporated into the Health Care Services Dashboard, a monthly report of key performance indicators that are typically monitored by health care organizations, including availability, appropriateness, safety, cost-effectiveness, and efficiency of care.

The Dashboard consolidates performance data into one document to make that information easily accessible to stakeholder groups and health care staff at all reporting levels. Integrating information from the medical, mental health, dental, and allied health programs, the Dashboard encompasses more than 100 measures in 9 domains, including, but not limited to, disease management, access to care, utilization management, cost, and human resources. Measures related to Performance Improvement Objectives are color-coded to indicate progress towards performance goals.

Another way that CPHCS reports on progress towards improvement objectives is through the issuance of performance management reports, which describe statewide and institution-specific performance within a specific program area or topic. During this reporting period, CPHCS issued three performance management reports to promote improvement in treatment of patients on anticoagulation therapy, prescribed pain medications, or using psychotropic medications. These management reports analyze performance trends over time, identify best practices, provide strategies for improving performance, and refer institutions to available tools and training resources. Generally, performance management reports are part of a larger improvement initiative that includes issuance of decision support, such as customized patient lists with flags for patients who have abnormal laboratory values or who have not receive important services, clinical care guides, and chart review tools, and statewide continuing education sessions.

During this reporting period, CPHCS also introduced a baseline performance report for the management of patients on anticoagulation therapy. Within the California prison population, there are a number of patient-inmates at risk for blood clots. Those patient-inmates require anticoagulation or “blood-thinning” therapy, a high-risk treatment which typically lasts from

three to six months or indefinitely depending on clinical diagnosis. Among other treatment issues, anticoagulant dosing can be complex, made more so by numerous drug interactions; patients taking anticoagulants must be monitored closely, and at least monthly, which can be difficult to accomplish in a correctional environment, where patients frequently transfer from one institution to another. Because of these issues, monitoring patients on anticoagulation therapy is considered a patient safety priority for many health care organizations. In addition, appropriate management of these patients can avoid more costly treatments. To improve monitoring and treatment of this patient population, CPHCS issued an anticoagulation care guide and chart review tool, established a list of patients on anticoagulation therapy that is updated monthly, and provided statewide training for primary care teams. Please see [Appendix 5](#).

In February 2011, CPHCS issued a baseline report on psychotropic medication prescribing practices at California prisons. The monitoring of psychotropic medications is an important area for patient safety and cost containment because some psychotropic medications can be associated with potentially harmful and costly side effects and under-prescribing may exacerbate mental illness, placing patients at risk for self harm and costly crisis interventions. Along with the release of this report was statewide education on current prescribing guidelines, and institution-specific provider list to give psychiatry leadership at the institutions a view of prescribing activities amongst clinicians in order to support more appropriate formulary choices.

CPHCS issued the second of a series of pain care reports in March 2011. CPHCS has targeted pain care as an area for improvement in part because drug overdose is the 5<sup>th</sup> leading cause of death for California prison inmates, and many overdoses are caused by diversion of prescribed pain medications. In addition, processing of pain medication is workload-intensive for pharmacy and nursing staff due to dispensing and administering requirements for controlled drugs, including crushing and observation. The second pain care report compares pain medication prescribing rates in April 2010 and November 2010 and describes changes in prescribing practices between those months. Please see [Appendix 6](#).

During the next reporting period, CPHCS will issue baseline performance reports on the management of mental health high-risk patients, HIV screening, and the treatment of patients with hepatitis C. Progress reports for ongoing improvement initiatives, including pain care, diabetes, anticoagulation therapy, and cancer screening are also expected to be released during the next reporting period.

***Action 4.1.2. By July 2009, work with the Office of the 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:

#### Initial Appointment to the Medical Staff

The initial appointment to medical staff consists of a formal credential review process of obtaining, verifying, and assessing the qualifications of an applicant to provide patient care, treatment, and services in and for CPHCS. All initial appointment activity is reported monthly to the Professional Practice Executive Committee and the Governing Body for approval. Within this reporting period, there were 389 credential applications received: 310 initial appointments to the medical staff, 20 lateral transfers, four promotions, and 55 credential file updates. Of these, 266 were approved, three denied, 87 were closed due to incomplete applications or at the request of the hiring authority. Additionally, 33 applications are pending completion at the time of report. The most common reasons for a pending status are incomplete applications and awaiting recommendations from previous employment.

#### Two-Year Reappointment Compliance

In order to maintain compliance with California Code of Regulations, Title 22, a two-year reappointment to medical staff is completed. Additionally, the two-year reappointment is standard practice in all health care settings, therefore the Credentialing and Privileging Unit has established this process requirement.

During this reporting period, 249 civil service providers were notified to complete their two-year reappointment, of which 145 reappointments have been received and reviewed, and 104 reappointment applications remain pending. The most common reason for a pending status is the lack of a complete application.

During the previous reporting period, the Credentialing Program reported that there were 105 licensed independent practitioners whose reappointments were pending submission. The Credentialing Unit management continues to work with providers, as well as institutional management, to ensure the reappointment process is completed according to the required timelines. As a result of the collaborative efforts from all levels of leadership the 105 deficit has decreased to 90 pending reappointments broken down into the following classifications: 12 Dentists; four Nurse Practitioners; 19 Physician & Surgeons; two Physician Assistants; 15 Psychiatrists; 23 Psychologists; 15 Social Workers.

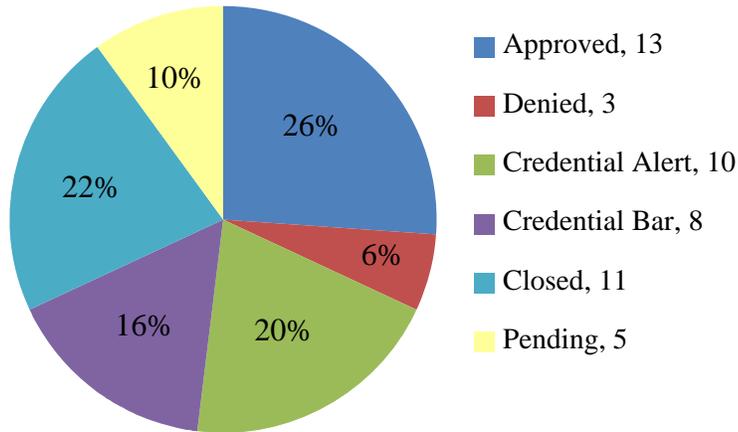
Finally, during this reporting period, 251 reappointments (pending and new requests) were completed by the Credentialing and Privileging Program.

#### Credentials Committee

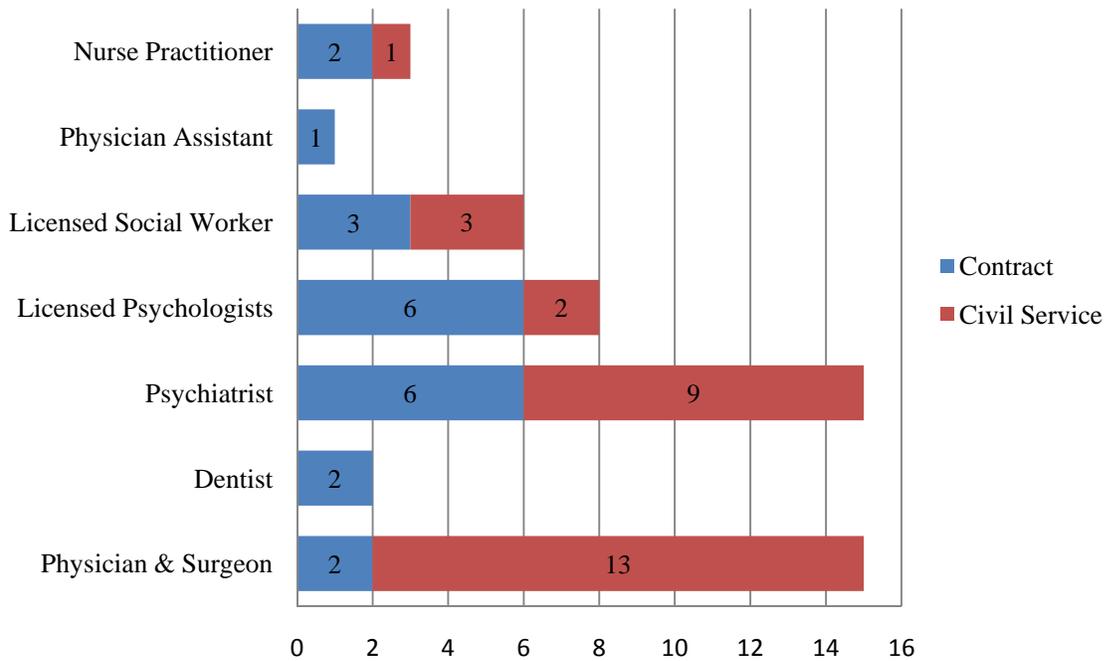
The committee is responsible for ensuring that only providers who meet the quality of care, professional conduct, credentialing requirements, and practice standards are granted credential approval and core privileges to provide health care services to patient-inmates.

During this review period, the Credentials Committee reviewed 50 provider cases as detailed in Tables 4 and 5 below.

**Table 4: Provider Case Outcomes**



**Table 5: Provider Cases Reviewed by Credentials Committee - January through April 2011**



### 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 on-going process with notifications being sent on a monthly basis to ensure that the practitioners have active and current credentials. During this reporting period, 64 Notice of Licensure Expirations were processed, and eight 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 continued to focus on building quality improvement capacity and capabilities at the institution level. In December 2010, a special workgroup of Chief Executive Officers was established 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 provision of quality improvement tools and training for institution staff, and updates to quality management policies and procedures. In April 2011, the workgroup met to follow up on the progress of implementation.

Among other activities during this reporting period, CPHCS developed a draft Quality Improvement Toolkit for use in process redesign and development of initiatives to improve health care processes. Employing well-known tools like process mapping and failure mode and effects analysis, the toolkit walks institution staff through a standardized process to identify, analyze, and address deficiencies in health care processes and patient safety concerns, and can be applied across all health care program areas and disciplines. The Quality Improvement Toolkit incorporates the FOCUS-PDSA (sometimes also called FOCUS - PDCA) model, an approach commonly used by health care organizations to organize improvement activities and ensure that certain principles, such as the use of inter-disciplinary teams, root cause analysis, and initiative testing and evaluation, are integrated into improvement initiatives. The Quality Improvement Toolkit will be tested at institutions prior to dissemination for statewide comment and formal implementation in the field.

For the past few months, Quality Management Section staff have been working to update existing quality management policies to align with professional standards for quality improvement and patient safety and to reflect changes in the organizational structure at

headquarters and in the field and an expanded capacity for performance measurement and evaluation. Draft policies will be vetted with health care staff and stakeholder groups as part of the formal policy approval process. In addition, CPHCS is exploring different reporting structures for the staff whose primary role is to support quality improvement activities or ensure compliance with laws, regulations, and policies.

***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 DCHCS adult institutions. The Governing Body has met four times during the period between January and April 2011 to take final action on recommendations from the Professional Practice Executive Committee (PPEC) regarding practitioners.

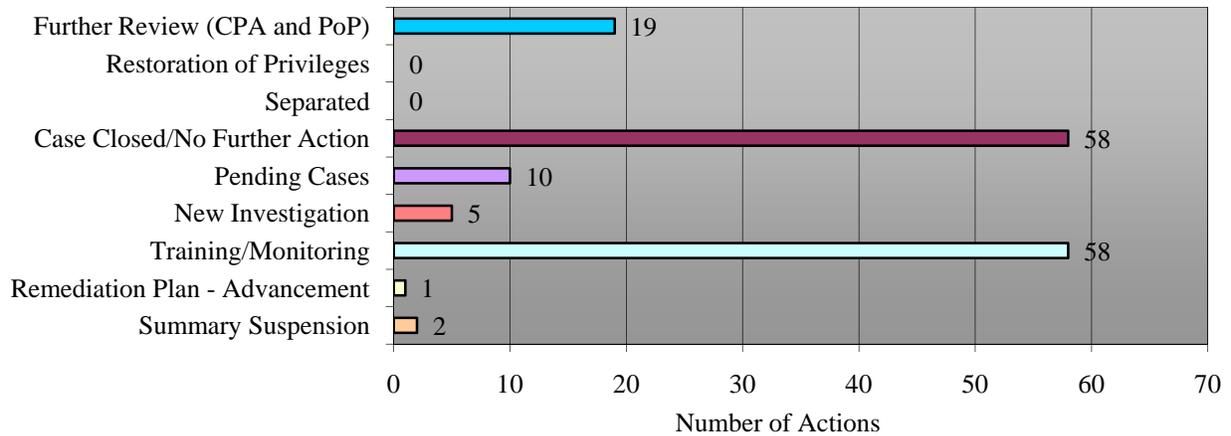
The PPEC and Peer Review Subcommittee (PRSC) met 16 times during the period of January through April 2011. The committees reviewed 142 referrals regarding clinical practice concerns resulting in 153 actions. PRSC closed 42 referrals and PPEC made 16 recommendations to the Governing Body for case closure following review of the provider successfully completing training plans or resigning. Governing Body approved the 16 recommendations for case closures of providers whose clinical practice was deemed to meet an appropriate standard of care following the peer review investigation for a total of 58 closures during this reporting period. There were three training and education plans and 16 monitoring plans initiated by PPEC, and 39 training and education plans initiated by PRSC for those providers whose standard of practice warranted closer review for a combined total of 58 action items for training and monitoring.

In this reporting period, the PPEC summarily suspended the privileges of one practitioner and zero providers were separated from State service while under investigation. The Governing

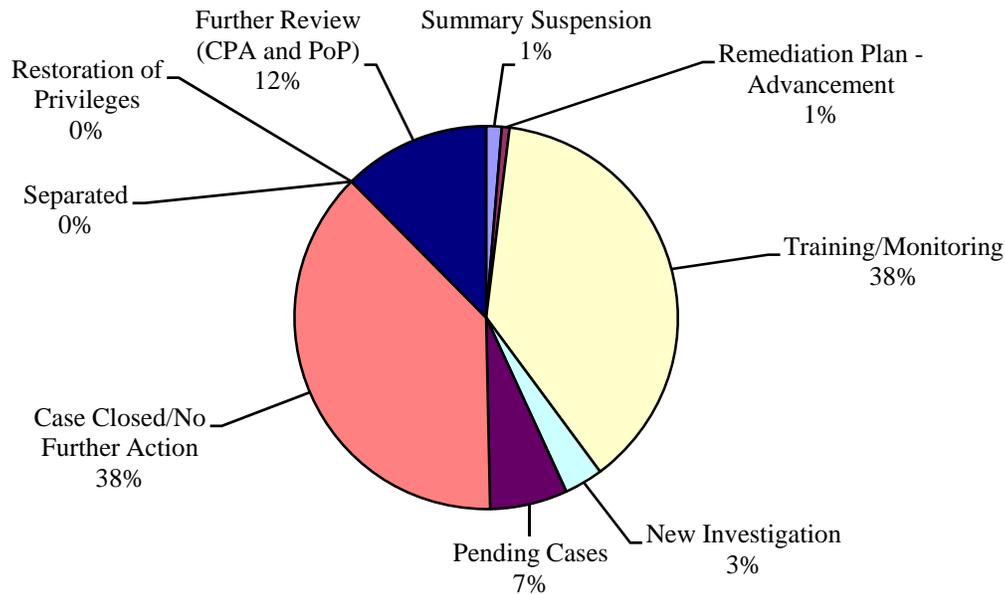
Body did not issue any Notices of Final Proposed Action under the Federal court ordered physician policies that would have resulted in the revocation of privileges and termination of employment.

Graphical displays of PPEC and PRSC outcomes for the period January 2011 through April 2011 are presented in Tables 6 and 7.

**Table 6: Peer Review – January through April 2011**



**Table 7: Peer Review Activity by Percentage - January through April 2011**



**Tables 6 and 7 Results Explanation:**

The data represented pertains to licensed independent practitioners including, physicians and surgeons, psychiatrists, psychologists, dentists, nurse practitioners, physician assistants and licensed and unlicensed 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 further information is 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 is responsible for conducting 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 Medical Oversight Program (MOP) continues to utilize both CPHCS headquarters and regional clinicians as MOP team members in order to maximize the clinical resources. This approach was implemented to utilize physicians and nurses as subject matter experts in medical investigations while also directing their clinical expertise to the Clinical Support Unit (CSU) to a variety of initiatives for CPHCS.

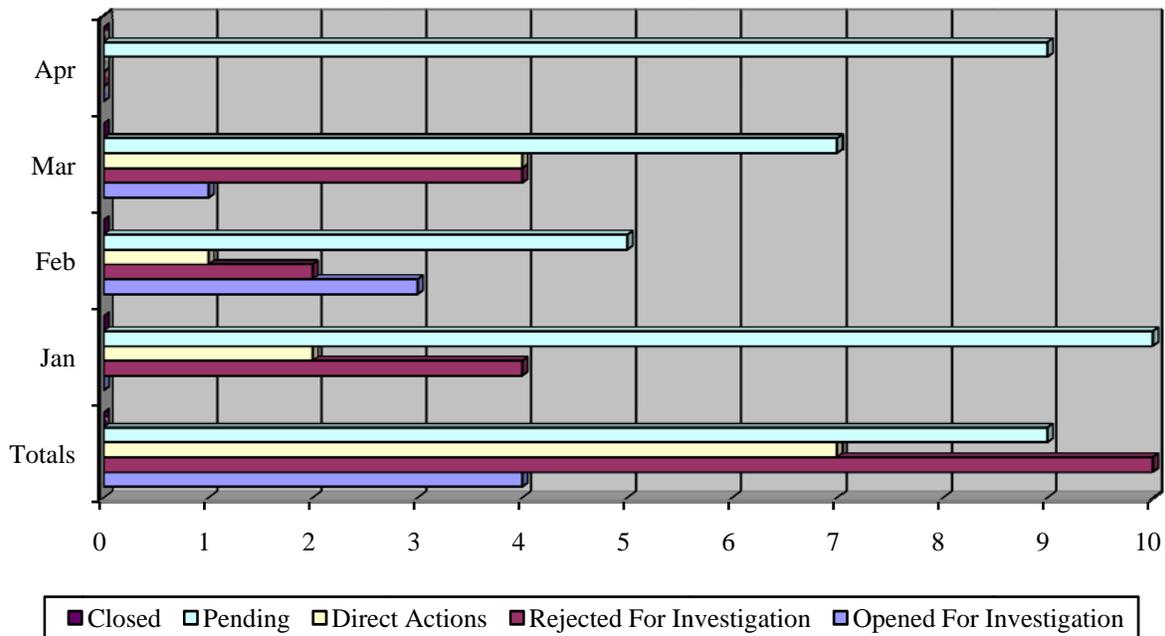
CPHCS Clinicians and the Office of Internal Affairs (OIA) continue to work collaboratively and have combined the Central Intake and Medical Intake Consent Calendar in a joint effort to expedite investigative decisions for medical cases. The aim of this endeavor is to ensure

thorough review and investigation of allegations of misconduct related to health care delivery by institution staff.

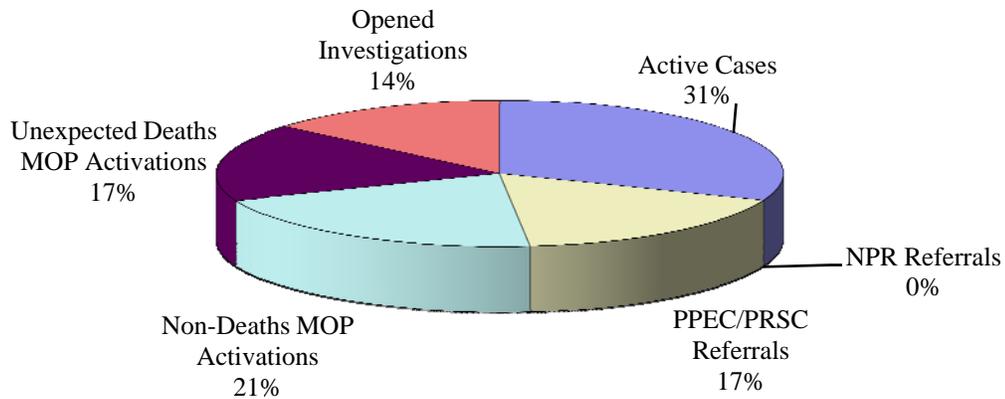
MOP activations continue to review the most egregious of sentinel events. During this reporting period the MOP was activated for 11 cases. One case was transferred from Central Intake that was submitted by institutional managers; three activations were referred through the death review process, two activations were referred by the Receivership and five activations were called by the MOP Physician and Nursing Executive Leadership. The Medical Intake Panel convened and opened four cases for investigation, rejected 10 cases for investigation, and nine cases were pending for further review at the end of this reporting period. Seven “Direct Actions” were referred back to the hiring authority; zero subjects were referred to Nursing Practice Review and five subjects were referred to the Professional Practice Executive Committee.

A graphical display of MOP outcomes for January thru April 2011 is presented in Tables 8 and 9.

**Table 8: Medical Oversight Program Quality Review Activity January through April 2011**



**Table 9: Medical Oversight Program Quality Review Activity – January through April 2011**



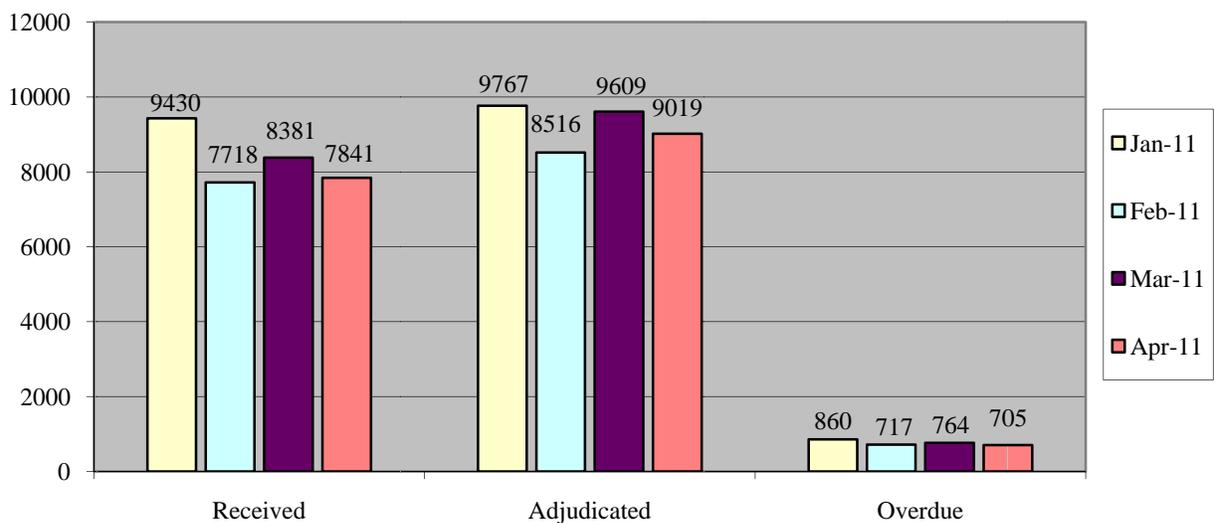
**Objective 4.5. Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative**

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

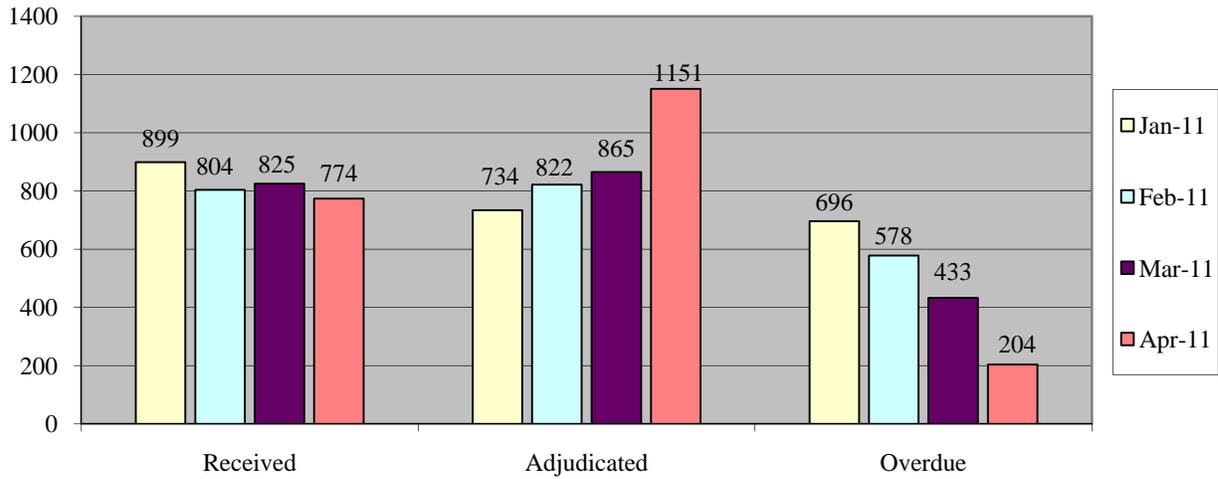
This action is completed.

Activity for this reporting period is shown in Tables 10-12.

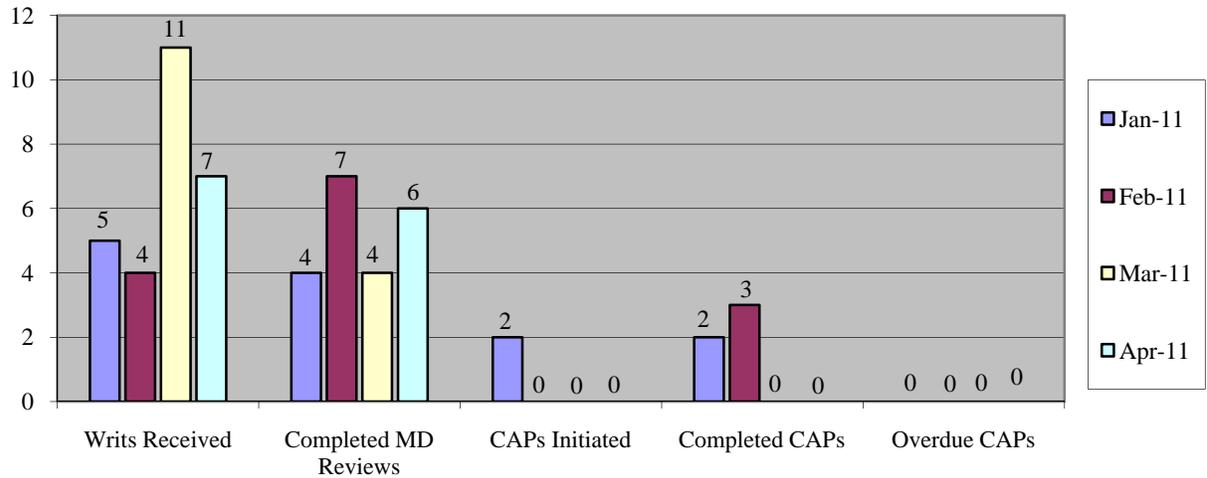
**Table 10: Health Care Appeals Statewide (Institutions) - January through April 2011**



**Table 11: Office of Third Level Appeals - January through April 2011**



**Table 12: Habeas Corpus Cases - January through April 2011**



***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.

The week of April 11, 2011, CPHCS, Private Prison Compliance and Monitoring Unit (PPCMU) staff met with Corrections Corporation of America (CCA) staff and finalized all pending policies. We anticipate CPHCS approval and CCA implementation of these policies before the next reporting period.

Current Activities

The following provides an overview of the current activities PPCMU staff are involved in to ensure CCA's compliance with the Remedial Plan developed in July 2008, as well as 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 10 Clinical Performance Appraisals as captured through Private Prison Compliance and Monitoring Unit's monthly monitoring process. Of the 10 CPAs completed, three were initial reviews, five were annual reviews, and two were follow-up reviews.

CCA has submitted seven completed Peer Reviews to the Private Prison Compliance and Monitoring Unit for the same reporting period. Of the seven Peer Reviews completed, two were initial 10-day reviews, three were 60-day reviews, and two were annual reviews. The PPCMU will continue to monitor this process on a monthly basis.

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

An average of 15 medical cases per week were discussed on the weekly Physician's Collaborative Conference Call. These discussions have resulted in an average of four inmate-patients per month being returned to California for medical reasons.

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

The PPCMU staff, CPHCS clinical leadership, and CCA has finalized the credentialing and privileging policy. It is anticipated that the policy will be approved by CPHCS clinical leadership within the next reporting period.

Three credentialing packets were received from CCA and reviewed by the CPHCS Credentialing Committee. Of the three packets reviewed, two were approved to provide medical care to California inmate-patients housed in out-of-state institutions and one is currently under review by the CPHCS Credentialing Committee.

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

Nursing staff has completed an average of 330 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 one inmate-patient 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, he is eligible to remain out-of-state.

The Medical Classification System was rolled out in all 33 CDCR institutions statewide effective March 2010. During the current reporting period, PPCMU nursing staff identified no institutions continuing to utilize the dual screening process for COCF placement. It is to be noted that all inmate-patients UHRs reviewed for eligibility by PPCMU Nursing staff for the months of January and February 2011 were screened using only the Medical Classification System screening criteria. March and April UHR reviews are pending. Reporting on this activity will continue.

5. Establishment of Monitoring Reports:

PPCMU has developed Monitoring Logs to track the associated information, i.e. Sick Call, Medical Transports, Watch List, Specialty Care, etc. However, the Information Technology Section has been encountering problems extracting the information into reports. There are some technical glitches that are being worked through, as errors have been identified in the draft reports. Information Technology staff continues to work on resolving these issues. Additional information will be provided during the next reporting period.

6. COCF Compliance Audits for Fiscal Year 2010/11:

PPCMU completed the remaining three on-site out-of-state facility audits at Florence Correctional Center, La Palma Correctional Center, and Red Rock Correctional Center. The final audit reports for all five out-of-state facilities were completed during this reporting period and have been reviewed and approved by executive staff and were submitted on March 18, 2011, to the Division of Adult Institutions to be distributed to the above out-of-state facilities.

Upon receipt of the report, the California Out-of- State Facility staff is given 60 days to submit a CAP addressing all ratings falling below 85%. The PPCMU will work closely with the COCFs until all deficiencies have been adequately addressed and documented.

7. Community Correctional Facilities Audits Beginning January 2011:

During this reporting period, the PPCMU completed the remaining four on-site facility audits at Shafter Community Correctional Facility, Desert View Modified Community Correctional Facility, Golden State Modified Community Correctional Facility, and Delano Community Correctional Facility. Final audit reports for all 10 facilities audited were submitted and approved by CPHCS executive staff and have been distributed to Community Correctional Facility Administration, Division of Adult Institutions, CDCR for completion and submission of by the impacted facilities.

A review of the compliance review findings of the two audits previously completed at the CCFs resulted in the remaining FY 2010/11 scheduled audits being modified from a formal audit process to an on-site follow-up review. The follow-up review process will consist of PPCMU staff providing comprehensive training, guidance, and assistance to the Community Correctional Facilities in various program areas to assist them with understanding the requirements of achieving compliance with the Inmate Medical Services Policies and Procedures. Additional information will be provided regarding the results of this process during the next reporting period.

8. COCF Expansion:

The CDCR has approved a contract with The GEO Group, Inc. to house California inmate-patients at the North Lake Correctional Facility (NLCF) located in Baldwin, MI. The NLCF has a proposed activation date of May 15, 2011 and will initially house 270 inmates who will be transferred from the Florence Correctional Center in Arizona. The PPCMU is currently reviewing policies and procedures submitted by The GEO Group, Inc. 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. 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) continues 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. The P&T Committee is presently engaging with a cost-effective effort. The P&T Committee is actively considering therapeutic equivalent products in an effort toward cost effective care. CPHCS pharmacy services has an agreement with the school of pharmacy at the University of California in San Diego, where faculty and senior pharmacy students are collaborating by introducing evidence to inform the Committee's decision for the therapeutic interchange questions.

The Committee has also initiated an effort to establish a patient safety infrastructure to reduce the possibility of pharmacy error. Several systemic issues have been identified and solutions are presented for the Committee to adopt. Two significant efforts are to prohibit "hold orders" and to define the rationale when Nurse Administered (NA) or Keep-on-Person (KOP) should be ordered.

#### ***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 continues 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 to other facilities starting in June 2011. The present plan is to support the facilities by dispensing and delivering prescriptions from Central Pharmacy on an institution by institution basis.

By the end of FY 2010/11, the pharmacy can support four additional facilities.

## **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 below.

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

This action is completed.

CPHCS continues to move forward with plans for an enterprise-wide electronic Unit Health Record (eUHR). The project has advanced through the design and development phases and completed the initial rollout to the women's institutions on March 29, 2011. Implementation of the system at the men's institutions is planned to be completed by the end of June 2011.

The project team completed the configuration and implementation of the infrastructure required for test, pre-production and production environments in early 2011. In addition, various activities regarding implementation and deployment have also been completed. Having previously distributed assessment reports for the women's institutions, the Health Records Readiness Team (HRRT) has completed onsite assessments regarding the "readiness" of health records departments for all 30 men's institutions. The team continues to monitor activities at the institutions to ensure that paper UHRs are prepared for implementation. Mentors for the men's institutions have been trained by the vendor and are prepared to be deployed to the men's institutions to begin training scanning operators in the local health records departments in advance of the men's roll-out. The training team has completed training at 25 of the 30 men's institutions; the remaining staff will be trained before the end of April.

The CPHCS IT infrastructure team has completed construction activities at all institutions to ensure network capabilities. Deployment of equipment to support the eUHR rollout continues, with 21 of 30 men's institutions reporting that they have completed the installation and configuration of equipment, and seven others reporting that they are more than 90% complete. All women's institutions will be completed prior to the men's roll-out.

Additional efforts focused on the HRC include the planned acquisition of a new 3<sup>rd</sup> storage bay to receive the 150,000+ paper UHRs that will be transferred from the institutions to the HRC beginning 9 to 12 months after the eUHR go-live. In addition, a dedicated health record scanning center will be established in this new space to accommodate a multi-shift scanning team that will ultimately be assigned responsibility for scanning health records for Parole Violators Returning to Custody and Re-commitments. The scanning center will also be responsible for scanning on-demand scanning requests, ROIs (Release of Information Requests), MDOs, etc.

**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:

**Imaging/Radiology Services**

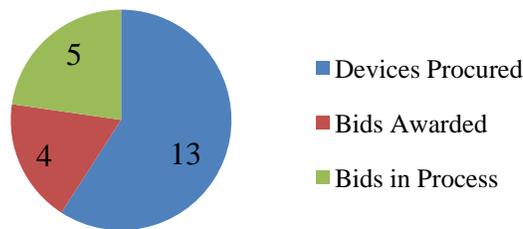
CPHCS is currently interviewing for the replacement Clinical Executive of Medical Imaging Service.

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

Film filing at the institutions has achieved standardization at 30 of 33 institutions. Efforts to include centralized management of parolee film files are underway at the Health Records Center (HRC). Currently many institutions are critically low on film storage space with concerns that parolee films may be stored in inadequate locations.

Replacement of medical equipment continues to progress according to the project schedule and milestones as indicated in Table 13. Currently 13 devices have been procured with installations underway at 10 different institutions. Another 4 equipment bids have been awarded and are in process of contract finalization. In addition, 5 bids are underway with awards expected to be announced in the next 30-45 days.

**Table 13: Equipment Procurement for FY 10/11**



Radiology equipment maintenance will be awarded for existing equipment. A recent bid request for Fuji CR devices did not render any qualified bidders. As a result, AHS is pursuing a REMI contract that will provide umbrella support for existing CR devices. Once this contract is in place all existing medical imaging devices will be covered by updated state contracts that have more robust language addressing costs, invoicing policies, vendor performance requirements and service level agreements.

The Health Net PPO contract has been activated with a significant impact to Radiology and Imaging Services. Professional Services (Radiology Interpretation), Technical Services (Off Site Procedures) and Mobile Services (On Site Mobile CT/MRI) were determined to be covered under the PPO contract with Health Net. This required a complete revision of workflow policies

and replacement of vendors and services. Currently the transition to the Health Net subcontracted groups for these services are underway with full cutover of services expected to complete within the next 30-60 days.

Mobile pad construction has made progress but some institutions have had delays completing the requisite paperwork (Section 6) to qualify for funding. AHS continues to work with these institutions to answer questions and remove roadblocks, ensuring all institutions that require mobile pad new construction are eligible for funding in this fiscal year.

Several key Clinical Information System procurements are in the process of being selected. The Dental Imaging System is expected to announce the award and formalize the contract by the end of May. The Radiology Information System (RIS) and Picture Archival and Communication System (PACS) bids have been scored with award announcements expected during the same period. Once contracts are finalized all three systems will enter the build phase which is expected to take 9-12 months.

#### Laboratory Services

Listed below is a brief explanation of the most recent progress made for Laboratory Services as it relates to the RTPA and more specifically the CPHCS Reference Laboratory Contracts.

In January 2011, CPHCS entered into a contractual agreement with Health Net to provide medical services for the 33 institutions in the CDCR system. Subsequently, Health Net has contracted with Quest Diagnostics (Quest) to provide off-site laboratory services for all CDCR institutions. Installing the Quest Care360 computer application, at each institution, provides access to all clinical staff. Care360 is a Web-enabled computer application that supports on-line order entry, bar-coded order label printing, and results reporting that can be printed or viewed from any internet connected computer display. The following list describes the status for this project:

- All sites have been migrated to Quest as of Jan 3, 2011.
- Nearly all off-site laboratory testing is now being done by Quest laboratories.
- Foundation equipment has been removed from all sites.
- All sites have received training on the Care360 system for inquiry and reporting.
- Authorized users from all sites have access to the Quest Care360 system.
- Final reports are now printed at all sites using Quest's Auto print application.
- Planning is now underway for electronic test ordering. This is expected to be in use at all sites by the end of May 2011.
- A study has been launched to load Quest laboratory results to the CPHCS CDR.

#### **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.

The CDR project completed Launch 1.0 in 2010 to 12 institutions. The launch made available data for custody, disability, pharmacy, and laboratory information capabilities. During the course of the deployment, data anomalies were discovered. This led to analysis about the root causes of the unexpected results and the Data Validation and Integrity (DVI) sub-project was initiated. During this time user logons were suspended. The reduction in project activity from November 2010 through March 2011 resulted in a 35% expense decrease from the planned budget.

The current plan is to prepare for Launch 2.0 which will include the above capabilities and a component of the Clinical Documentation sub-project called 'Problem Lists.' Launch 2.0 includes completing the Data Validation and Integrity analysis and related system changes, verify Program needs and requirements, and ensure prior to deployment a comprehensive User Acceptance Test is successful. Beginning in June 2011, Launch 2.0 is expected to be available to the first 12 institutions and deployment to the remaining 21 will begin. While Launch 2.0 is being deployed to all 33 institutions, the project team will prepare for the next version release.

The next version release is targeted for the winter of 2011 and will feature enhanced GuardianRx data and enhanced Quest lab data. This release will make automated clinical forms, graphical displays, and work processes available to Primary Care, Dental Health, Nursing, and OB/GYN. The release will enable enhanced sharing of health care information by geographically dispersed health care providers.

The project team will complete FY 11/12 and begin FY 12/13 with the next major release and the availability of automated forms and workflow for Mental Health, Public Health, and Telemedicine. FY 13/14 will complete the last release and provide these capabilities to Allied Health Services and Therapy.

#### **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.

Strong leadership has been secured and is in place. In addition a Telemedicine Steering Committee has been formed and is working in collaboration with institutional leadership to develop their business plans to expand Telemedicine Services across both Mental Health and Medical disciplines.

**Telemedicine Interim Scheduler** – In January 2011 version 2.0 of the Telemedicine Interim Scheduler was implemented, which had the following enhancements: all scheduling functions in

one location (no longer need to toggle between two systems), application of business rules, ability to group schedule rather than on an individual basis, database reconfigured, system response time streamlined, and greater ease for data entry. In February, 2011 version 2.1 was implemented. This was a “reports” release. The Telemedicine Interim Scheduler captures a robust amount of information that can be reported. Several scanned reports have been created which allow for drill-down. These reports will be further specified for more functionality in a later release. In March, 2011 version 2.2 was implemented. This release included minor efficiencies according to user preference, for example, combining functionalities onto one form and reorganizing the location of the forms more intuitively.

Future versions are being worked on to further the system and reporting capabilities, as well as to improve user efficiency.

**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. Twenty-four out of 33 institutions were upgraded to IP. It is expected that all 33 institutions will be converted by June 30, 2011.

**Prison Health Care Provider Network Project** – CPHCS and Health Net are collaborating to develop and recruit specialty providers statewide. CPHCS and Health Net have decided to utilize a regionalized HUB based approach. In addition to the current six HUB sites, the network has recently added two new HUBS: Tri-Cities Medical Center (Oceanside, CA) and San Joaquin General Hospital (Stockton, CA). Several other HUBS are in negotiations.

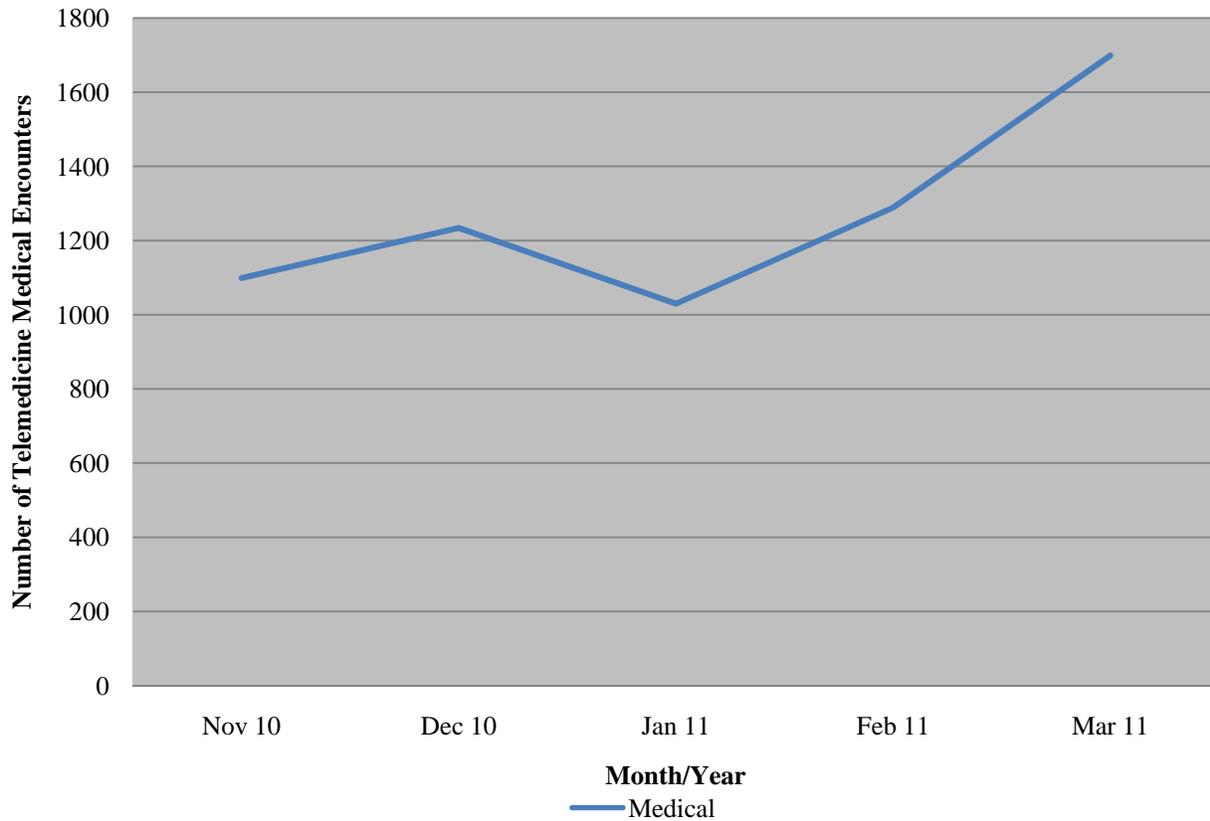
**Equipment Upgrades** – CPHCS continues to roll out endpoints and peripherals to meet institutional needs. Increased availability of equipment ensures that telemedicine equipment is not a barrier to telemedicine expansion.

**Scanned UHR (e-UHR)** – the scanned UHR will provide the ability for the medical record to be viewed from any authorized users computer. The e-UHR is currently being rolled out to the women institutions. Work flow changes to enhance efficiencies for the telemedicine program will be assessed and piloted over the next quarter.

**Primary Care Telemedicine** – The goal of providing access to care support for institutions with severe Primary Care physician shortages and chronic recruitment challenges has been achieved. This has been the result of successfully implementing our Primary Care physician pilot as well as the addition of two primary care telemedicine providers, in all, supporting a total of three institutions.

**HIV and HCV** – HIV and Hepatitis C support have been successfully transferred to CPHCS Physicians at CMF and select CPHCS Physicians statewide under the direction of CMF leadership. Utilizing a *reciprocal institutional HUB support model* has proven to be the best method for providing this service.

**Table 14: Telemedicine (Medical) Encounters Statewide – November 2010 through March 2011**



As reflected in Table 14, a significant increase in the usage of telemedicine specialty services was realized in mid-January and continued up to March. The increase is attributed to several factors, including: the expansion of the provider network, renewed commitment from various institutions, the addition of Primary Care services and the initial phase of equipment expansion and technology upgrade (IP conversion). The Office of Telemedicine Services expects this increase to continue.

## **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 asset transfer bill passed and the Statewide Master Plan was submitted to the Department of Finance (DOF). CDCR is working with DOF to finalize the project approval packages (30-day Letters) for submittal to the Joint Legislative Budget Committee (JLBC).

#### ***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.***

Site specific master plans have been developed for all 11 Intermediate Care Institutions.

On February 4, 2011, in response to DOF comments received in December 2010, CDCR resubmitted the revised 30-Day Letter for CMF and California State Prison, Solano (SOL). Submission of the 30-Day Letters for the remaining projects will be delayed pending clarification/comments for the CMF/SOL projects from DOF.

The project approvals for CMF and SOL are scheduled for the July 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 two to three 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 bed plan that provides medical and mental health facilities for the projected inmate-patient population through 2013. The approved plan envisions one new facility of 1,722 beds and the use of three 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.***

On April 6, 2011 the Joint Legislative Budget Committee (JLBC) notified CDCR that based on *Assembly Bill 109, Public Safety Realignment Trailer Bill*, Estrella Correctional Facility was

denied and should be re-examined based on realignment-driven population projections and bed needs assessment.

Alternatives for Herman G. Stark are still being explored.

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

The demolition and abatement contract was awarded to O.C. Jones & Sons Inc and the Notice to Proceed was issued on April 4, 2011. Hensel Phelps/Granite JV was selected as the contractor for the Design/Build Package 1 (Site Work and Non-Secure Support Buildings) and the Notice to Proceed is scheduled to be issued in May 2011. Contractors have submitted statements of qualifications in response to Design/Build 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 and Estrella Correctional Facility will be delayed beyond the scheduled completion date.

**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. Office of the Inspector General – First Cycle Inspections of California’s 33 Adult Prisons

The Federal Receiver’s Turnaround Plan of Action of June 6, 2008 required the following under Goal 4. Implement Quality Improvement Programs:

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

Working with the Receiver, Prison Law Office and the State’s representatives, the Office of the Inspector General has begun to establish an audit process of clinical performance in CDCR facilities. The process will be piloted in five facilities during the first six months of 2008. The results of the pilot will be used to improve the process. With the consent of the Court, the inspection program will then be rolled out to all CDCR facilities.

The OIG released their report on May 4, 2011 titled ***Medical Inspection Results, Summary and Analysis of the First Cycle of Medical Inspections of California 33 Adult Prisons***. The first cycle of inspections began in September 2008 with CSP, Sacramento and concluded in June 2010 with Wasco State Prison. See [Appendix 7](#) for the spreadsheet of first cycle of medical inspection results.

This first cycle of inspections by the OIG established a benchmark of performance by institution measuring the quality of medical care and compliance with medical policies and procedures. Overall weighted statewide score was 71.9% and is reflective of institutions receiving low scores in the heavily weighted areas of chronic care, clinical services and specialty services.

The findings in the first cycle of inspections verified areas of deficiencies and re-emphasized the importance of the quality management, information technology and clinical program initiatives and projects outlined in the RTPA. In addition, CPHCS has developed programs and processes to work with and address each of the institutions specific deficiencies and develop corrective action plans. The second cycle inspection scores reflect that improvements are being made in many areas of medical care. See [Appendix 7](#) for the spreadsheet of the second cycle inspection results.

Overall weighted score from the five, second cycle inspection, reports received is 76.3%, placing institutions in the range of moderate adherence. Individual overall scores show increases ranging from 2% to 11%. The upward trend continues with significant increases in areas of specialty services, preventative services, pharmacy services, and chemical agent contraindications. Challenges continue in areas of medication management, access to timely care, and documentation.

During this second cycle inspection schedule, CPHCS will be deploying a number of technology projects designed to address deficiencies in medical care delivery at the institutions operating in a high-volume paper dependent environment. As these technology systems are deployed and become embedded in the operation of the institution, we will anxiously await the OIG inspection and performance measurement results.

## **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 the four month period from January through April 2011 were \$709,108 and \$160,949 respectively. Additionally, certain completed projects with a net asset value of \$8,825,219 were transferred from CPRs records to CDCR accounting records. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 8](#).

#### **B. Revenues**

During the four month period ending April 30, 2011, the receiver requested transfers totaling \$825,000 from the state to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the office of the Receiver for the reporting period 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 four courts, *Plata*, *Coleman*, *Perez*, and *Armstrong* (“Coordination Group”) class actions have continued. Coordination Group meetings were held on January 11<sup>th</sup>, February 15<sup>th</sup>, March 29<sup>th</sup>, and April 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.

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

#### **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:

Under authority set forth in the Court’s Order dated May 12, 2010, the Receiver entered into consulting services agreements with Joe Goldenson, on September 10, 2010, and with Madie LaMarre, on September 20, 2010, to conduct site visits of California prison medical facilities and provide reports to the Receiver and the Plata Advisory Board concerning the quality of medical care being delivered in the facilities.

## **Section 8**

### **Conclusion**

The first cycle of medical inspections by the OIG set a baseline score for each institution. The system-wide information contained in those 33 reports, as reported by the OIG in its summary of first cycle inspections, confirmed many of our independent evaluations as well as helped us focus our attention on particularly problematic areas, such as medication management and timely access to physicians.

The second cycle of inspections is now well underway. For the next tri-annual report, we will have scores from enough institutions to assess the extent to which our efforts are being reflected in improved scores. This will be the first major objective indication of whether the substantial progress we have made in implementing the Turnaround Plan is successfully translating into improved performance in the delivery of medical care within California's prisons. The next four months will tell a big part of the story.