

# APPENDIX 5



# Performance Improvement Plan 2011-2012

## Improvement Strategies

## PERFORMANCE IMPROVEMENT PLAN 2011-2012: OVERVIEW

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Each year, California Correctional Health Care Services (CCHCS) reviews health care processes and services considered to be high risk, high cost, high volume, or problem-prone, and selects priority areas to be targeted in improvement initiatives organization-wide. CCHCS produces an annual Performance Improvement Plan comprised of three major elements:

- Priority areas for improvement,
- Major Strategies that will be used to accomplish performance improvement goals and objectives,
- Specific performance objectives within each priority improvement area and associated timeframes.

Statewide performance improvement initiatives slated for implementation in 2011-2012 support or serve one of four functions:

- Establish improvement priorities at the institution level and align program activities with priorities,
- Integrate health care processes across disciplines and programs,
- Provide information and tools to support process improvement, and
- Monitor and evaluate delivery system performance.

## STRATEGIC ALIGNMENT

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Improvement efforts are most effective when all levels of an organization are informed of improvement priorities and rally around a core set of improvement goals. Under this strategy, institutions identify improvement priorities, communicate priorities to staff at all levels of the organization, and ensure that program planning and day-to-day operations and supervision align with these priorities.

Institution Improvement Plans. Each institution is required to establish an annual improvement plan which defines improvement priorities, performance objectives, and proposed strategies. Institution improvement plans take into consideration statewide performance objectives, but are customized for the institution's particular mission, resources, and needs of the patient population and staff. Quality Management Section staff, Compliance Unit staff, and staff from various clinical services areas will work with a subset of institutions to assist them in establishing and implementing improvement plans.

Communication and Alignment. Upon developing an improvement plan for the year, institution leadership is responsible for communicating improvement priorities to staff at all levels of the health care system and helping staff understand their role in achieving improvement objectives. Institution leadership will also guide the process of strategic alignment, by which managers and supervisors determine how program operations and day-to-day supervision will support performance objectives, and how care teams and other staff incorporate improvement activities for priority areas into their day-to-day work.

Quality Management Program Governance. CCHCS will finalize the Quality Management Program Policy and Procedures. Headquarters and Institution Quality Management Committees will meet regularly to determine improvement priorities and strategies, regularly review performance data and take action to improve performance, coordinate the activities of quality-related committees, and ensure that staff are trained in quality improvement concepts, tools, and techniques. Quality Management Committees ensure that staff at the headquarters or local level receive the orientation and training necessary to participate in improvement activities and apply improvement skills, such as problem analysis and system redesign, in their day-to-day work.

# INTEGRATED HEALTH CARE DELIVERY SYSTEM

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CCHCS delivers a continuum of health care services to inmate-patients by many different professional disciplines across multiple levels of care in both outpatient and inpatient settings. In order to improve care, and avoid unnecessary morbidity, mortality and costs, CCHCS will need to fully implement sustainable strategies that improve processes and systems that strengthen continuity and coordination of care as well as communication and collaboration among all professional disciplines and with the patient.

An overarching strategy that CCHCS will use is the establishment of a primary care model, which is not based on a traditional medical model that organizes services around acute and episodic events. Rather the primary care model is especially useful for providing continuous services to patients with chronic and complex physical and behavioral health conditions who disproportionately drive risk and resources.

The primary care model is based on a number of nationally recognized models and paradigms that emphasize (1) risk stratification of individual patients and patient populations; (2) a comprehensive patient focus; (3) interdisciplinary team-based care; (4) evidence-based practices; (5) active patient involvement and self management; and (6) decision support and information systems to assist in managing individual patients and patient populations, and facilitating continuous improvements in patient outcomes, clinical practice and processes of care.

Care Teams. At a subset of institutions, CCHCS will work with interdisciplinary care teams to test and implement continuity and care coordination processes. Care teams at the selected institutions will develop or refine processes for planned, proactive care of patients within an assigned patient panel as well as processes to enhance communication, coordination and collaboration among care teams as patients move in and out of different levels and settings of care. From this group of institutions and others across the state, CCHCS will identify best practices that can be used by care teams to plan and coordinate services. Additional activities in this area may include changes in existing statewide processes, policies, and procedures to facilitate system integration and standardization.

Complex Patients. A subset of clinically complex patients is particularly vulnerable to poor health outcomes and account for the majority of inpatient bed, specialty care, and pharmaceutical usage. Because clinically complex patients frequently move from one level of care to another or require specialty and inpatient care, these patients are at higher risk for lapses in care that occur during “handoffs” when a patient transitions from one care setting to another. As part of the 2011-2012 performance improvement strategies, CCHCS will assist care teams in identifying the clinically complex patients that have been assigned to them through monthly patient lists, create decision tools to support monitoring and management, assist with redesign of core processes, and develop tools to assess how well tracking and follow-up systems are working.

Classification Subsystems. Currently CCHCS has several health risk classification subsystems that are not completely aligned, which leads to suboptimal placement of patients who have competing physical and behavioral health needs. In 2010, CCHCS instituted a Medical Classification System which evaluates each patient’s medical risk and matches the patient with an institution that can best meet his or her medical care needs. Performance data indicates that the Medical Classification System is not fully implemented statewide, and that many clinically complex inmates are currently housed at “basic” institutions not designed to optimally manage care. To support appropriate placement for these patients and full implementation of the Medical Classification System, CCHCS will produce patient registries monthly that identify clinically complex patients housed at basic institutions and will work with custody, classification staff, and other stakeholders to move these patients to settings appropriate for their health care needs. Ultimately to optimize patient outcomes and economies of scale, the various health classification subsystems should evolve into a comprehensive Health Care Classification System.

## PROCESS IMPROVEMENT TOOLS AND TRAINING

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CCHCS will continue to build performance improvement capacity in 2011-2012 by providing health care staff with quality improvement tools and staff development programs that teach process improvement skills and techniques. These tools will help individual care teams and institution-wide improvement teams develop new health care processes and redesign existing processes as necessary to establish a well functioning integrated health care system.

Quality Improvement Toolkit. Within the health care industry and quality improvement field of expertise, there are nationally-recognized methods for problem analysis and process improvement. CCHCS will establish tools for institution staff to use during process improvement including basic statistical analysis flow diagramming, cause and effect diagramming, root cause analysis, failure mode effect analysis as well as set up forums for sharing information about improvement initiatives and results.

Training and Professional Development. CCHCS will partner with nationally recognized experts in quality improvement and patient safety initiatives including the Department of Veterans Affairs, Joint Commission and Institute for Health Care Improvements to develop, implement and evaluate staff training and development program.

## PERFORMANCE MONITORING AND EVALUATION

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Health Care Services Dashboard. CCHCS will continue to produce a Health Care Services Dashboard, a report that consolidates more than 70 performance measures into one document, with information available at statewide and institution levels, and trended over time. Updated monthly, the Dashboard will facilitate identification of improvement opportunities and monitor progress towards the achievement of 2011-2012 Performance Improvement Objectives.

Morbidity and Mortality Studies. CCHCS will issue reports that analyze patterns and trends in inmate morbidity and mortality, including ambulatory care-sensitive conditions that attribute to potentially avoidable hospitalizations, system gaps that are prevalent in potentially preventable deaths and sentinel events, and analysis of inmate suicides. These reports are intended to inform the prioritization of quality improvement initiatives and determine the need for new system and process improvements and patient safety programs.

Performance Reports. Performance reports issued in 2011-2012 will focus on the core delivery system processes, such as providing timely access to health care services and continuity of care for patients assigned to clinical teams and providers. In addition, CCHCS will begin monitoring the care and placement of clinically complex patients.



# Performance Improvement Plan 2011-2012

## Priority Improvement Areas

### GOAL

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Support continuous organizational learning and performance evaluation and improvement in order to:

- Optimize patient outcomes, and access to and quality and safety of services
- Enhance efficiencies and reduce waste
- Comply with regulatory and legal requirements

### PROPOSED PRIORITY IMPROVEMENT AREAS

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The proposed priority areas were chosen for improvement based on evidence that they pose quality and safety concerns and are high risk, high volume, high cost, and/or otherwise high impact areas. Many of these areas are integral to a well-functioning primary care system. For each of the items within the priority areas, there are one or more performance objectives or leading indicators, which are listed in the following pages (benchmarked measures only) and/or the Health Care Services Dashboard (benchmarked and leading indicators).

#### Risk Stratification and Continuity of Care

- Medical Classification System
- Consistent Care Teams

#### Optimizing Patient Services and Outcomes

- Asthma
- Anti-Coagulation
- Cardiovascular Disease / Diabetes
- Chronic Pain and Cancer Pain
- Cirrhosis and Hepatitis C Virus (HCV)
- Colon and Breast Cancer Screening
- HIV Screening
- Influenza Vaccination
- High Utilizers of Mental Health Services
- Dental Health Services
- Potentially Avoidable Hospitalizations
- Patient Safety

#### Optimizing Access and Managing Demand and Utilization

- Access to Medical Services, including Telemedicine
- Access to Mental Health Services, including Telemedicine
- Access to Dental Services
- Access to Medications including Formulary Management
- Specialty Referrals, including Telemedicine

#### Enhancing Efficiencies, Reducing Waste and Optimizing Human Resources

- Staff Vacancies
- Overtime and Registry Cost
- Other Cost Measures – Pharmaceuticals, Specialty Services, Hospital and ED services

#### Ensuring Compliance

- Medical Inspections, Dental Perez Audits, and Mental Health Coleman Monitoring



# Performance Improvement Plan 2011-2012

## Specific Objectives

### *Risk Stratification and Continuity of Care*

#### *Medical Classification System*

- By December 31, 2012, greater than 75% of clinically complex patients will be housed within the most appropriate care setting.

#### *Continuity of Care*

- By June 30, 2012, greater than 85% of chronic care patients taking essential medication will have fewer than 3 primary care providers prescribing these medications within the past six months.
- By June 30, 2012, greater than 85% of EOP patient encounters will occur with one Mental Health Primary Clinician within the past six months.
- By June 30, 2012, greater than 85% of EOP patient will occur with one primary psychiatrist within the past six months.

### *Optimizing Patient Services and Outcomes*

#### *Asthma Care*

- By June 30, 2012, greater than 85% of patients with persistent asthma will be prescribed an inhaled corticosteroid.

#### *Anticoagulation*

- By March 31, 2012, greater than 75% of all patients on Warfarin will have most recent INR result within 30 calendar days at therapeutic levels.

#### *Cardiovascular Disease/ Diabetes Care*

- By June 30, 2012, greater than 75% of diabetic patients will have hemoglobin A1c, cholesterol, and blood pressure levels in good control and an annual eye examination completed (composite diabetes measure).

#### *Cancer Screening*

- By June 30, 2012, greater than 85% of inmates 50 years and older will have colon cancer fecal occult blood testing performed within the appropriate time frame.
- By September 20, 2011, greater than 85% of eligible female inmates 50 years and older will be offered a mammogram in the preceding 24 months.

#### *Chronic Pain*

- By June 30, 2012 greater than 85% of a sample of patients prescribed opiates for more than 30 days will have documented evidence of severe disease, treatment goals, and a completed pain agreement.

#### *Cirrhosis and HCV*

- By March 31, 2012, greater 85% of HCV patients on combination therapy will have a viral load testing within 14 weeks of starting combination therapy.

#### *HIV*

- By March 31, 2012 greater than 85% of inmates going through the Reception Center will have a HIV screening test.

#### *Mental Health High Utilizers*

- By March 30, 2012, there will be greater than 50% reduction in suicide watch hours and MHCB use by patients who required these services 2 or more times within 6 months.

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### *Influenza Vaccination*

- By December 31, 2011, greater than 75% of inmates will be provided influenza vaccination.
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### *Sentinel Events*

- By December 31, 2012, there will be a reduction in avoidable hospitalizations to less than 2 per 1,000 inmates per year.
  - By December 31, 2012, a system will be in place to report, analyze and act upon close calls (near misses) and adverse events including aggregate reviews for medication errors, potentially avoidable hospitalizations, and preventable deaths.
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## *Optimizing Access and Managing Demand and Utilization*

### *Access to Medical Services*

By March 31, 2012, greater than 85% of patients will have timely access to primary care and specialty services, as defined by policy timeframes.

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### *Access to Dental Services*

- Refer to Dental Services section "Ensuring Adherence."
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### *Access to Mental Health Services*

- Refer to Mental Health Services under the section "Ensuring Adherence."
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### *Medication Services*

#### **Access:**

- By June 30, 2012, greater than 85% of chronic care patients will receive all essential medications within the past 3 months including psychotropic medications.
- By June 30, 2012, greater than 85% of patients will receive medications within 1 calendar day of return from a higher level of care including community emergency departments and hospitalizations at DMH.
- By June 30, 2012, greater than 85% of patients will receive medications within 1 calendar of transfer to an institution or new arrival.

#### **Formulary Usage:**

- By June 30, 2012, non-formulary medications ordered by medical providers will comprise less than 4% of prescriptions per month.
  - By December, 2012, second tier antidepressant medications and non-formulary medications ordered by psychiatrists will comprise less than 35% of prescribed psychotropic medications.
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### *Specialty Services*

#### **Specialty Referrals:**

- By December 31, 2011, the average number approved routine requests for specialty services will be less than 60 per thousand inmates per month.

#### **Telemedicine Usage:**

- By December 31, 2012, greater than 30% of off-site specialty consultations will be provided via telemedicine.
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## *Enhancing Efficiencies, Reducing Waste and Optimizing Human Resources*

### *Overtime, Registry, and Position Control*

- By December 31, 2011, overtime costs for FY 11/12 will be 10% less than FY 10/11.
  - By September 30, 2011, registry costs for FY 11/12 will be 20% less than FY 10/11.
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### *Cost Control*

- By June 30, 2011, expenditures for FY 10/11 will be 5% less than expenditures for FY 10/11.
- By June 30, 2012, expenditures for FY 11/12 will be 10% less than expenditures for FY 10/11.

### *Medical Program*

- By December 30, 2012, the average score for the OIG Medical Inspections will be greater than 85%.
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### *Dental Program*

- By December 31, 2011, 11 institutions will successfully pass the Perez audit in three of three categories of the Dental Readiness Assessment Tool.
  - By December 31, 2012, all institutions will successfully pass the Perez audit in three of three categories of the Dental Readiness Assessment Tool.
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### *Mental Health Program*

- By December 31, 2011, greater than 90% of patients at each institution will have timely access to initial and routine contacts with IDTT, mental health clinician evaluations and treatment plans, and referrals to higher levels of care and subsequent follow-up, as defined by Coleman requirements and policy timeframes.
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