



**CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES**

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

**Nineteenth Tri-Annual Report of the Federal Receiver's  
Turnaround Plan of Action  
For September 1 – December 31, 2011**

**January 13, 2012**

# California Correctional 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>3</b>
<b>3. Status and Progress Toward the Turnaround Plan Initiatives.....</b>	<b>4</b>
<b>GOAL 1 Ensure Timely Access to Health Care Services.....</b>	<b>4</b>
<i>Objective 1.1</i> Screening and Assessment Processes.....	4
<i>Objective 1.2</i> Access Staffing and Processes.....	4
<i>Objective 1.3</i> Scheduling and Patient-Inmate Tracking System.....	4
<i>Objective 1.4</i> Standardized Utilization Management System.....	5
<b>GOAL 2 Establish a Prison Medical Program Addressing the Full Continuum         of Health Care Services.....</b>	<b>6</b>
<i>Objective 2.1</i> Primary Care.....	6
<i>Objective 2.2</i> Chronic Care.....	6
<i>Objective 2.3</i> Emergency Response.....	6
<i>Objective 2.4</i> Specialty Care and Hospitalization.....	6
<b>GOAL 3 Recruit, Train and Retain a Professional Quality Medical Care         Workforce.....</b>	<b>8</b>
<i>Objective 3.1</i> Physicians and Nurses.....	8
<i>Objective 3.2</i> Clinical Leadership and Management Structure.....	8
<i>Objective 3.3</i> Professional Training Program.....	8
<b>GOAL 4 Implement a Quality Assurance and Continuous Improvement         Program.....</b>	<b>9</b>
<i>Objective 4.1</i> Clinical Quality Measurement and Evaluation Program.....	9
<i>Objective 4.2</i> Quality Improvement Programs.....	11
<i>Objective 4.3</i> Medical Peer Review and Discipline Process.....	14
<i>Objective 4.4</i> Medical Oversight Unit.....	14
<i>Objective 4.5</i> Health Care Appeals Process.....	14

<i>Objective 4.6</i>	Out-of-State, Community Correctional Facilities and Re-entry Oversight.....	15
<b>GOAL 5</b>	<b>Establish Medical Support / Allied Health Infrastructure.....</b>	<b>16</b>
<i>Objective 5.1</i>	Pharmacy.....	16
<i>Objective 5.2</i>	Medical Records.....	16
<i>Objective 5.3</i>	Imaging/Radiology and Laboratory Services.....	16
<i>Objective 5.4</i>	Clinical Information Systems.....	17
<i>Objective 5.5</i>	Telemedicine.....	18
<b>GOAL 6</b>	<b>Provide for Necessary Clinical, Administrative and Housing Facilities.....</b>	<b>19</b>
<i>Objective 6.1</i>	Upgrade Administrative and Clinical Facilities.....	19
<i>Objective 6.2</i>	Expand Administrative, Clinical, and House Facilities.....	19
<i>Objective 6.3</i>	Finish Construction at San Quentin State Prison.....	20
<b>4.</b>	<b>Additional Successes Achieved by the Receiver.....</b>	<b>21</b>
A.	Office of the Inspector General – Update on the Medical Inspections of California’s 33 Adult Prisons.....	21
<b>5.</b>	<b>Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented By Institutions Or Individuals.....</b>	<b>22</b>
<b>6.</b>	<b>An Accounting of Expenditures for the Reporting Period.....</b>	<b>23</b>
<b>7.</b>	<b>Other Matters Deemed Appropriate for Judicial Review.....</b>	<b>24</b>
A.	Coordination with Other Lawsuits.....	24
B.	Master Contract Waiver Reporting.....	24
C.	Consultant Staff Engaged by the Receiver.....	24
<b>8.</b>	<b>Conclusion.....</b>	<b>25</b>

## Section 1: Executive Summary

In our first Tri-Annual report for 2012, the accomplishments for the period of September 1 through December 31, 2011 are highlighted. Progress continues toward implementing the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights for this reporting period include the following:

- RTPA - Substantial completion of 77 percent of the action items with seven ongoing items and four items under reevaluation by the State.
- Office of the Inspector General (OIG) Inspections – completion of the 2<sup>nd</sup> Cycle Inspections at 33 institutions.
- Health Care Services Dashboard – incorporation of additional performance measures to evaluate appropriate housing of patient-inmates based on medical needs, and the continuity and coordination of health care.
- Integrated Health Care Delivery System – adopting the nationally recognized Advanced Primary Care Model, we initiated implementation of this model with our clinically complex patient-inmates and are monitoring to evaluate the effectiveness in managing care while reducing costs.

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 overcrowding in several 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 reflects extensions on some of the objectives and action item dates to fulfill the goals.

As mentioned in prior reports, our OIG scores in the areas of timely access to primary care physicians and timely access to medications continue to lag. With the implementation of realignment on October 1, 2011, the population, as of December 28, 2011, has dropped by 11,301 from the previous year. We are monitoring and evaluating the impact of overcrowding reduction upon our ability to provide more timely access to care and better medication management. We also continue with our focus on "getting back to basics" in these two critical areas where it appears the other initiatives of the Turnaround Plan have simply not achieved much traction.

## Format of the Report

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

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions. Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the California Correctional Health Care Services (CCHCS) website [http://www.cphcs.ca.gov/receiver\\_mo.aspx](http://www.cphcs.ca.gov/receiver_mo.aspx).
2. *Appendices*: In addition to providing metrics, this report also references documents in the Appendices of this report.
3. *Website References*: Whenever possible website references are provided.

## RTPA Matrix

In an effort to provide timely and accurate progress reports on the RTPA to the Courts and other vested stakeholders, this format provides an activity status report by enterprise, for statewide applications/programs, and by institution, as appropriate for and in coordination with that operation.

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

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

## Information Technology Project Matrix

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

## Section 2: The Receiver's Reporting Requirements

This is the nineteenth report filed by the Receivership, and the thirteenth 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 at

<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))

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

## **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.

***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.***

This action is completed.

#### **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.***

This action is completed.

Refer to [Appendix 3](#) for the Executive Summary and Health Care Access Quality Reports for August 2011 through November 2011.

#### **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.***

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

The Health Care Scheduling System (HCSS) establishes a shared multi-discipline patient-inmate calendar, where healthcare and custody staff will view existing patient-inmate appointments and activities, prior to scheduling new and/or rescheduling existing events. The expected benefits of a shared calendar are: 1) Eliminates wasteful double-booking of patient-inmates by making patient-inmate schedules visible through a single enterprise system and 2) Improves continuity of care by having an appointment requirement follow a patient-inmate when an institution transfer occurs. In addition to the shared calendar requirement, HCSS must provide operational and court mandated reporting and tracking of patient-inmate appointments. To reflect this requirement, the HCSS will now be referred to as the Health Care Scheduling and Tracking System (HCSTS).

As an initial pilot, the HCSS project deployed medical scheduling and a custody ducating solution at three women's institutions (California Institution for Women, Central California Women's Facility, & Valley State Prison for Women). Once deployed, the project team performed lessons learned sessions at the three institutions to acknowledge success and identify areas of improvements, prior to deploying the solution to the remaining 30 institutions. In the success category, the project team provided extensive on-site data migration support, end user training and obtained detailed user analysis and feedback. In the areas of improvement category, dental and mental health scheduling, tracking and reporting functionality was insufficient, therefore the two disciplines used the HCSS ducating function only.

Based on institution customer input and Executive Core Leadership guidance, a HCSS redesign was approved. The redesign builds upon the existing work performed by the third-party software integrator and ensures that the all shared multi-discipline calendar, tracking and reporting requirements are addressed. The redesign will deliver shared multi-discipline calendar functionality to the men's institutions by Spring 2012 and provides enhanced business tracking and reporting functionality in Fall 2012. In addition, projected spending, including the development changes, will not negatively affect the budget and the project will remain within budget.

**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.

## **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.***

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

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.***

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

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.

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

This action is completed.

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

This action is completed.

## **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**

For details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for August 2011 through November 2011. These reports are included as [Appendix 4](#).

***Action 3.1.1. By January 2010, fill ninety percent of nursing positions.***

This action is completed.

***Action 3.1.2. By January 2010, fill ninety percent of physician positions.***

This action is completed.

### **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.

### **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.

***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.

## 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.***

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

#### Health Care Services Dashboard

Issued monthly since September 2010, the Health Care Services Dashboard consolidates strategic performance information across all clinical program areas into a single report. The primary goal of the Dashboard is to provide CCHCS staff with information that can be used to improve the health care delivery system and patient-inmate outcomes.

During this reporting period, CCHCS added performance measures to the Health Care Services Dashboard to assess whether certain aspects of the Advanced Primary Care Model, the delivery system design adopted by CCHCS in 2009, have been fully implemented at the 33 California prisons. Through the Advanced Primary Care Model, multi-disciplinary teams manage patient-inmates as they move through the continuum of care. Among other elements, the Advanced Primary Care Model emphasizes risk stratification of individual patient-inmates and patient-inmate populations, a consistent relationship between the patient-inmate and an assigned interdisciplinary care team, and coordination of services for patient-inmates as they move from one health care setting to another.

The Dashboard now incorporates measures to assess various aspects of the primary care model, including:

- Health Risk Stratification. The Health Care Services Dashboard now reports on the percentage of clinically complex/high risk patient inmates who are appropriately housed – placed at institutions with intermediate medical missions. The statewide goal is for three-fourths of this patient-inmate population to reside at intermediate facilities, which have health care resources that may support more efficient and cost-effective care, such as close proximity to a large network of specialty providers and tertiary care centers.

In addition, the Dashboard monitors the number of mental health high utilizers – patient-inmates who experience frequent deterioration in their condition, are vulnerable to self-harm/suicide, require repeat admissions to higher levels of care – per 1,000 patient-inmates, statewide and at each institution. Mental Health High Utilizers use most of the suicide watch and mental health outpatient/inpatient resources, and tend to have health issues that overlap with other problem areas, such as pain management. Knowing which institutions have high rates of Mental Health High Utilizers helps CCHCS to determine which institutions might benefit from interventions targeted to this population.

- Continuity of Care. The Dashboard now includes three measures to determine whether patient-inmates are receiving services consistently from assigned medical and mental health providers. Under the CCHCS Primary Care Model, each patient-inmate is assigned to a consistent interdisciplinary care team, which increases the likelihood that clinicians will have the information they need to determine effective treatment and patient inmates will comply with treatment and participate in self-management.
- Coordination of Care. The CCHCS Primary Care Model calls for assigned care teams to manage patient-inmates as they move from one health care setting to another, including transfers to another care team, consultation with a specialist, and treatment at higher levels of care. Care coordination services are particularly important for clinically complex patient-inmates, whose frequent visits to urgent or emergency services, specialists, and higher levels of care leave them vulnerable to lapses in care during care transitions. Within the California prison population, patient-inmates frequently transfer from one cell bed to another, from one institution to another, between health care settings, or in and out of the prison system. The Dashboard now incorporates measures that assess whether patient-inmates are receiving follow-up services after returning from a hospitalization or specialty services consultation within required timeframes.

Please see the updated Health Care Services Dashboard, [Appendix 5](#).

#### Patient-Inmate Registries

CCHCS produces lists of patient-inmates with certain common chronic conditions or who are eligible for certain preventive services on a monthly basis. During this reporting period, CCHCS consolidated chronic disease data into one Chronic Care Master List for each institution, incorporating information about clinically complex medical and mental health patient-inmates and new chronic disease categories, such as seizure disorder, hypertension, hyperlipidemia, chronic pain, and HIV. Please see a sample Chronic Care Master List in [Appendix 6](#). CCHCS also introduced a registry of patient-inmates taking psychotropic medications.

Institution care teams use the chronic disease and preventive services registries to manage patient-inmate subpopulations within a patient-inmate panel. Patient-inmate registries assign “flags” to patient-inmates who have not received services per guidelines or who show abnormal results, helping care teams to recognize which patient-inmates may require treatment modifications. Because patient-inmates frequently move from one care team to another, the monthly patient-inmate registries also provide a valuable tool for identifying new and potentially complex patient-inmates who may have recently joined the assigned panel and may require close monitoring.

In addition, some institutions use the patient-inmate registries to develop customized performance reports, such as reports comparing adherence to CCHCS clinical guidelines by care team. During this reporting period, CCHCS developed a User’s Guide for the Chronic Care Master List, which provides detailed information about the exception “flags” for each chronic

condition and instructions for sorting and analyzing registry data. Please see the Chronic Care Master List User's Guide, [Appendix 7](#).

During the next reporting period, as part of a larger initiative on patient-inmate safety, CCHCS will add a registry for patient-inmates with potentially avoidable hospitalizations to the existing set of registries. "Potentially avoidable hospitalizations" are hospital admissions that may be linked to quality of outpatient clinical care and might have been prevented if primary care at the prison was appropriate prior to the hospitalization. On a monthly basis, CCHCS uses nationally-recognized criteria from the Agency for Healthcare Research and Quality and the National Quality Forum to track potentially avoidable hospitalizations and identify and address areas of the primary care model that may not be functioning as effectively and efficiently as possible. Potentially avoidable hospitalizations include patient-inmates who returned from a community hospital but are re-admitted to the community hospital within 30 days. A registry of patient-inmates with potentially avoidable hospitalizations identifies individual patient-inmates who may require additional services or monitoring to prevent further referrals to a higher level of care, and helps institution to identify diagnostic categories and specific health care processes that might be targeted for improvement.

***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**

***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, CCHCS moved forward with initiatives to establish quality management programs locally and fully implement the Advanced Primary Care Model, in keeping with the four major statewide strategies to improve health care system performance listed in the 2011-2012 Performance Improvement Plan:

- Establish performance improvement priorities at institution level and align program activities with priorities.
- Integrate health care processes across disciplines and fully implement both the CCHCS Primary Care Model and the Healthcare Classification System.
- Provide information and tools to support process improvement.
- Monitor and evaluate delivery system performance.

### Establishing Quality Improvement Programs at Institution Level

Updated Quality Management Program Policies, currently in the last stages of finalization with the Policy Development Section, define elements that can be found in a well-functioning institution quality management program, including:

- An annual improvement plan with measurable performance objectives
- Staff at all reporting levels who are informed about improvement plan objectives and understand their role in supporting improvement activities
- A multi-disciplinary committee structure that manages improvement projects and coordinates improvement activities across the major health care programs
- Institution staff with the skills to isolate the root causes of quality problems, implement program changes and redesign health care processes, and evaluate results
- A reliable measurement system that evaluates progress toward improvement objectives and provides ongoing surveillance of critical health care processes
- A culture of continuous learning and improvement, under which health care staff consider the improvement of health care processes a routine part of day-to-day operations

During this reporting period, CCHCS continued to test and refine quality improvement toolkits, such as forms, samples, and instructions for completing rapid-cycle improvement projects and root cause analysis, in preparation for the statewide implementation of new quality management and patient-inmate safety policies in 2012. CCHCS developed an assessment tool to determine areas of strength and weakness in the institution's quality management program, and designed a curriculum for on-site technical assistance to institutions. During the next reporting period, CCHCS will establish templates for improvement plans and committee documentation, conduct site visits at a subset of institutions to build local improvement capacity, and develop a series of training programs to promote the development of improvement skills at all reporting levels.

### An Integrated Health Care Delivery System – Advanced Primary Care Model

In December 2011, CCHCS entered the planning phase of a statewide initiative that will strengthen the health care delivery system at each institution, using the nationally-recognized Advanced Primary Care Model. One of the major improvement strategies in the 2011-2012 Performance Improvement Plan, implementation of the Advanced Primary Care Model will include, but is not limited to:

- Baseline self-assessment. Each institution will evaluate its adherence to primary care requirements through a standardized assessment tool, which will help identify performance gaps leading to individualized improvement plans.
- Orientation, training, and tools. Following the local self-assessment activities, statewide and targeted local training will be delivered to primary care teams to provide skills, processes and tools that will help institutions close known performance gaps.

- Dissemination of best practices. CCHCS will work with high-performing institutions to document successful processes, compile tools used effectively in the field, and establish a forum for sharing best practices information and resources with the field.
- Technical assistance. Technical assistance will be targeted to those prisons with existing performance issues or that have relatively high numbers of clinically complex patient-inmates for whom effective primary care is essential.
- Performance monitoring and evaluation. Information on the status of each institution's primary care performance, including targets, current status, local improvement activities, and recommended actions, will be managed by the QM Section and reported statewide monthly.

CCHCS convened a Primary Care Advisory Team in December 2011 to provide input and guidance during initiative planning from experienced staff in the field and at headquarters. Chosen by CCHCS executives because of their experience in change management, implementation of major initiatives, correctional health care operations, and non-clinical health care programs, will help to design an implementation plan, and will provide input into both the development of major deliverables, such as the institution assessment tool, and the techniques used to disseminate tools and information.

CCHCS initiated design of a new SharePoint site that will provide institutions with reference materials, tools, training presentation, and best practices information, among other resources, as the statewide initiative is implemented. During this reporting period, CCHCS continued to produce a number of decision support materials and staff development programs to facilitate implementation of the Advanced Primary Care Model, including Care Guides and continuing education presentations on asthma and chest pain that promote evidence-based practice at the point of care, and patient-inmate registries, such as the recently-issued potentially avoidable hospitalization registries, which assist institutions in population management and improvements in care for patient-inmates with specific conditions.

During the next reporting period, institutions will use a standardized assessment tool and performance metrics to evaluate whether primary care model elements have been put into place locally. Identified gaps in health care services will be prioritized and incorporated into institution improvement plans. CCHCS will continue to compile local processes, procedures, forms, tracking systems, and other tools into a best practices library that will be shared with all institutions.

#### An Integrated Health Care Delivery System – Clinically Complex Patient-Inmates

A critical aspect of Advanced Primary Care Model implementation is effective management of clinically complex patient-inmates who are most at risk for adverse health outcomes. Diagnosed with serious health care conditions or multiple chronic diseases, clinically complex patient-inmates require more intensive monitoring and patient-inmate management services than other populations. Within California prisons, patient-inmates identified as clinically complex comprise less than four percent of the total patient-inmate population, but consume nearly one

third of the prison system's resources related to pharmaceutical, specialty, and community inpatient services; carefully monitoring and managing these patient-inmates is also important for reducing health care costs.

During the previous reporting period, a multi-disciplinary workgroup of custody, classification, and CCHCS staff convened to identify clinically complex patient-inmates at institutions with basic medical missions, and, where appropriate, move these patient-inmates to intermediate institutions. Effective October 2011, CCHCS began providing a list of medically high risk patient-inmates to this workgroup monthly to facilitate evaluation of high-risk patient-inmates by local care teams and transfers. Also in October, CCHCS disseminated a Chronic Care Master List to all institutions care teams, which, among many other data elements, identifies clinically complex and mental health utilizer patient-inmates within assigned patient-inmate panels, supporting local efforts to improve services for these patient-inmate populations and better coordinate care.

During the next reporting period, CCHCS will begin monitoring the quality of care provided to clinically complex patient-inmates in domains such as continuity of care and potentially avoidable hospitalizations through a series of performance reports.

***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.

**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.

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

This action is completed.

Refer to [Appendix 8](#) for health care appeals, and habeas corpus petition activity for September 2011 through December 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.

## **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 continues 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.***

This action is completed.

Refer to [Appendix 9](#) for Top Drugs, Top Therapeutic Category Purchases, and Central Fill Pharmacy Service Level for September 2011 through December 2011.

#### ***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.

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

This action is completed.

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

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

This action has been completed.

### **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**

The replacement of priority Medical Imaging equipment is currently in the procurement “Post and Bid” process. Three of the nine sites designated as needing replacement or upgrades, have been awarded and the other locations are in the process of evaluation with projected completion of this project by February 2012.

Mobile pad construction is on track with 80 percent completion projected by April 2012. The mobile pad improvement project will improve the workflow of the specialty modalities (MRI, CT and Ultrasound) and reduce the turnaround-time dramatically in combination with the RIS/PACs implementation.

Three clinical information systems have been procured to support the workflow of Medical Imaging Services, one for dental services and two for radiology.

*Major Accomplishments This Reporting Period:*

- Completed business requirements document (BRD) of radiological information system and picture archiving system (RIS/PACS) and submitted approved core team.
- Completed business requirements document (BRD) of dental picture archiving system (MiPACS) and approved by core team.
- Given access to federated data center (FDC) to start build of RIS/PACS and MiPACS servers in January 2012.
- Completed conversion of institutions from analog film to digital laser film, base for building connecting the RIS/PACS for the elimination of film usage and annual film costs.

Laboratory Services

The transition to Quest Diagnostics (Quest) as the sole provider of off-site clinical laboratory services for all CDCR institutions is complete. All 33 institutions have been trained and are using Quest's Care360 web-based application to view results, print bar code specimen labels, and manage patient-inmate clinical laboratory results. In addition, 45 percent of all Quest Laboratory test requisitions are now being completed electronically using the Care360 system. Laboratory Services is working with Information Technology to implement a real time download of patient-inmate information from Strategic Offender Management System (SOMS) to populate a master patient-inmate index with Care360 to simplify electronic requisitioning and reduce data entry errors. Full implementation of electronic test requisitioning will be implemented in early 2012.

Laboratory Services has coordinated with Medical Services and Quest to customize several clinical laboratory test panels to better meet the needs of CCHCS physician providers in the institutions.

Laboratory Services has also coordinated with Medical Services to establish clinical laboratory support at Quest, for dialysis program activities in institutions offering these services, and Coccidioidomycosis and tuberculosis testing strategies for providers in all institutions.

Laboratory Services is defining specifications for procurement of clinical laboratory equipment, reagents, and maintenance to improve testing quality and reduce costs. This procurement is anticipated in the third quarter of FY 2011-12.

Laboratory Services will hire a Project Manager to lead a procurement and implementation of an enterprise Laboratory Information System.

**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. During the initial development and partial rollout of the clinical data repository, we identified areas that needed to be reassessed and coordinated with other strategic initiatives to ensure a fully integrated and functional data repository. The following restates the project requirements and ongoing progress.

Brief Project Description: The Clinical Data Repository (CDR) will provide a single source of clinical information, patient-inmate demographics, laboratory results, pharmacy records and other patient-inmate data for the patient-inmate population.

Project Benefits:

- Improves continuity of care and patient-inmate safety via online access to medical records.
- Speeds time to obtain lab, imaging, and pharmaceutical data; reduces waste from duplicate requests.
- Consolidates access to clinical applications and provides single sign-on and patient-inmate-in-context capability supporting users who logon once to access information on a patient-inmate across multiple applications.
- Immediate access to clinical problems across the organization

Major Accomplishments This Reporting Period:

- A pilot of the Patient Health Information Portal (PHIP) was implemented at one institution in November 2011.
- Clinical data issues encountered have been resolved.

Scope: The vision of the PHIP to “provide a single location for access to clinical applications and information” remains aligned with the original CDR project scope; however, the project, as originally scoped, is being re-evaluated as part of a CCHCS strategic planning effort. The overall project scope remains unchanged at this time.

Schedule: The project estimated completion date is June 30, 2014. A pilot of PHIP was implemented at one institution in November 2011. An electronic Problem List is under development with target implementation in December 2011. The clinical data issues encountered earlier this year have been resolved and the user Acceptance Testing of the resolution is completed.

**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.

## **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. CDCR is working with the Department of Finance (DOF) to finalize the project approval packages (30-Day Letters) for submittal to the Joint Legislative Budget Committee (JLBC). Once approved by the JLBC, projects will be scheduled for the soonest Public Works Board (PWB) available to receive project approval.

***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.***

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

CMF and SOL project approvals did not occur at the October 2011 PWB meeting. CDCR continues to answer questions from DOF in order to secure release of the 30-Day Letters to the JLBC. Submission of 30-Day Letters for the remaining projects will be delayed pending clarification/comments from DOF.

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

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

Lack of project approvals continues to delay progress on this objective. The design, bid, and construction phases for projects at each of the 33 institutions will begin once PWB project approvals and Pooled Money Investment Board (PMIB) loan approvals have been obtained. The typical project duration 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 developed a bed plan in January 2011 that provides medical and mental health facilities for the projected patient-inmate 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. Since then, the JLBC has denied approval of the DJJ Heman G. Stark (Stark) and DJJ Estrella Correctional Facility (Estrella) projects. At the present time, the State will not commit funding to renovate the DeWitt Nelson Youth Correctional Facility (DeWitt).

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

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

The State will not commit funding to renovate the DeWitt until bed needs are clearly demonstrated due to Assembly Bill 109, *2011 Public Safety Realignment*, passing on

April 4, 2011. The Request for Proposal competition for DeWitt was completed on December 14, 2011 and Hensel Phelps Construction Company was selected as the Design-Build firm. The contract may be awarded once the Administration and the Receiver have agreed upon bed needs. Alternatives for Stark and Estrella continue being explored.

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

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

The California Health Care Facility (CHCF) is on schedule for full occupancy by December 2013. Contractor O. C. Jones & Sons, Inc. completed demolition and abatement work. Hensel Phelps/Granite Joint Venture (JV) is ahead of schedule for Design-Build Package #1 (Site Work and Non-Secure Support Buildings). Clark/McCarthy JV began civil/site work for Design-Build Package #2 (Housing, Kitchen, and health care support buildings).

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

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

Occupancy for Stark, Estrella, and DeWitt remain delayed beyond the scheduled completion dates.

**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 – Update on the Medical Inspections of California’s 33 Adult Prisons**

To evaluate and monitor the progress of medical care delivery to inmates at each prison, the Receiver requested that the California OIG conduct an objective, clinically appropriate, and metric-oriented medical inspection program. To fulfill this request, the Inspector General assigns a score to each prison based on multiple metrics to derive an overall rating of zero to 100 percent. Although only the federal court may determine whether a constitutional standard for medical care has been met, the Receiver’s scoring criteria for adherence to medical policies and procedures establish the minimum score for moderate adherence to that standard to be 75 percent. Scores below 75 percent denote low adherence, while those above 85 percent reflect high adherence.

Using this tool, the Inspector General has rated California’s 33 adult institutions for the first cycle of inspections (September 2008 – June 2010) at 72.9 percent, on average. High Desert State Prison scored lowest, at 62.4 percent, and Folsom State Prison (FSP) received the highest score, at 83.2 percent. The Inspector General found that nearly all prisons were not effective in ensuring that inmates receive their medications. In addition, prisons were generally not effective at ensuring that inmates are seen or provided services for routine, urgent, and emergency medical needs according to timelines set by CCHCS policy. However, the Inspector General did find that prisons generally performed well in areas involving duties performed by nurses, and continuity of care.

Second cycle inspections began September 2010 and OIG has completed 33 inspections as of December 31, 2011 and issued 23 final inspection reports. Summary results of these final reports show that three of the 23 institutions achieved a score higher than 85 percent placing them in the category of high adherence and 16 of the 23 institutions achieved a score of 75 percent or higher placing them in the moderate adherence area. FSP achieved the highest score of 89.1 percent. Of the four institutions scoring less than 75 percent, Richard J. Donovan Correctional Facility scored the lowest at 73 percent but improved by 5 percent over their previous score of 68 percent. With 23 finalized inspections reports, the overall statewide average for the second cycle inspections is 78.7 percent which reflects an improvement of 6.8 percent over the first cycle statewide average of 71.9 percent.

## **Section 5: Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals**

While the Receivership has made 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 CCHCS, 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 and will likely continue to contribute to these setbacks.

The budget forecast coupled with California's low financial rating will present challenges for all in 2012 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 to 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 September through December 2011 were \$703,286 and \$0 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 10](#).

### **B. Revenues**

For the months of September through December 2011, the Receiver requested transfers of \$550,000 from the State to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the office of the Receiver. Total year to date funding for the FY 2011/2012 to the CPR from the State of California is \$675,000.

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 September 7<sup>th</sup>, October 12<sup>th</sup>, and December 15<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 not used the substitute contracting process for any solicitations relating to services to assist the Office of the Receiver in the development and delivery of constitutional care within CDCR and its prisons.

### **C. Consultant Staff Engaged by the Receiver**

During this reporting period, the Office of the Receiver has not engaged any consultant staff.

## **Section 8: Conclusion**

It is clear that we have made significant progress towards full implementation of the Turnaround Plan of Action and towards our ultimate goal of providing a constitutionally adequate level of medical care within California's adult prisons. With the scores reported by the OIG showing consistent improvement, the number of clearly avoidable deaths remaining at a consistently low rate, and the progress being made by the State in reducing overcrowding, we are now in a position to start contemplating the end of the Receivership, the transition from day-to-day management by the Receiver back to day-to-day management by the State and, ultimately, the conclusion of the case.

However, there remain a number of unresolved issues that are of notable concern, including the following: First, the State has not yet followed through with all of the terms of the agreement reached with the Receivership several years ago on construction. That agreement included, in addition to the CHCF in Stockton (which is moving forward as planned), renovations of three juvenile justice facilities for use by medical and mental health patients and construction of upgrades at each adult institution. Neither the renovations nor the upgrades have secured final approvals by the State, which has expressed concerns about the continuing need in light of population reductions. Second, the State and the Receiver have not yet reached an agreement about post- Receivership organization and governance. The Receiver hopes to engage constructively with the State on these issues during the next reporting period.