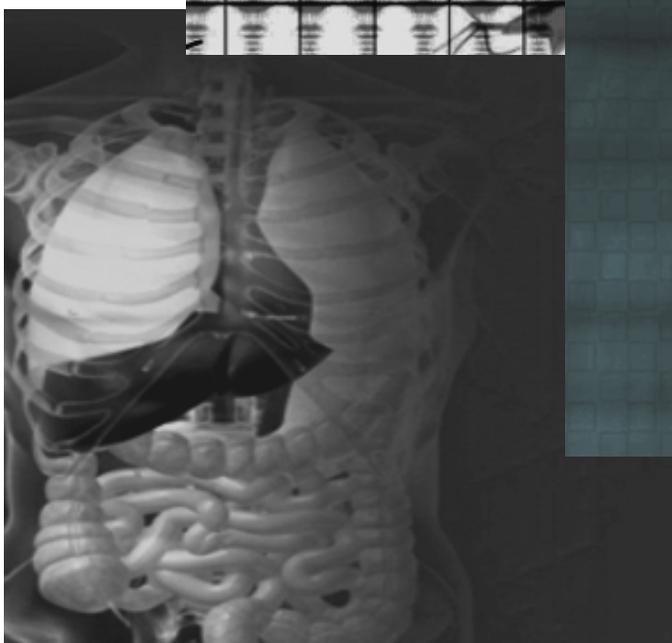
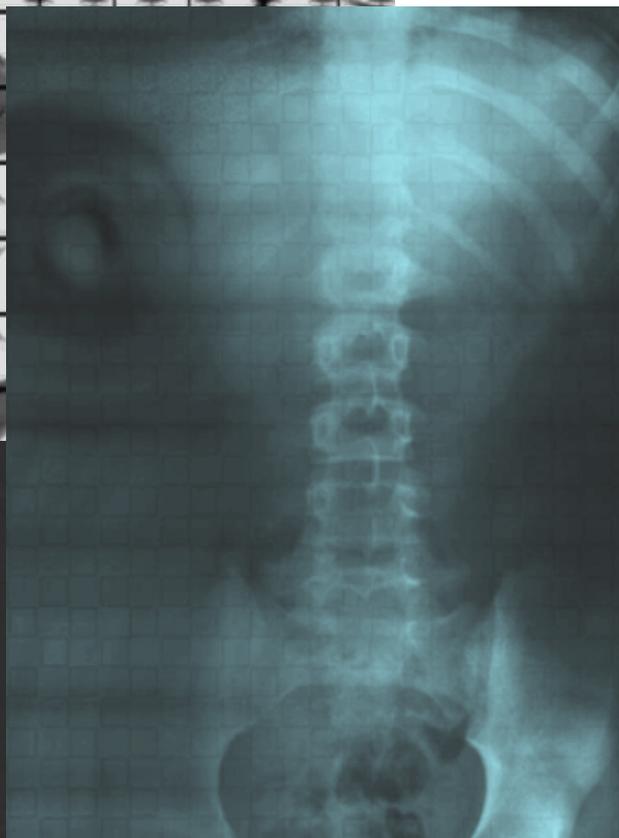
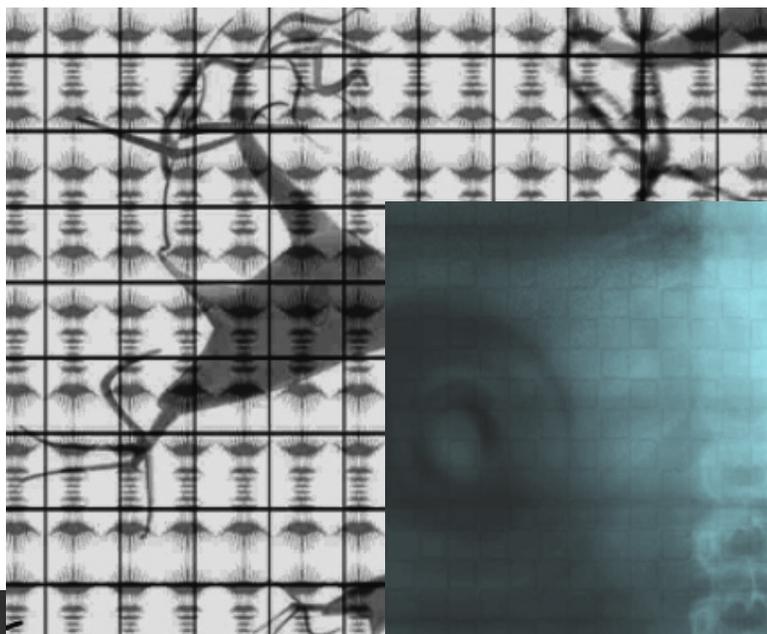


APPENDIX 6

High Risk Patient Performance Report

Appropriate Placement in the CCHCS Primary Care Environment



California Correctional Health Care Services
Quality Management Section
P.O. Box 4038
Sacramento, CA 95812
August 2012

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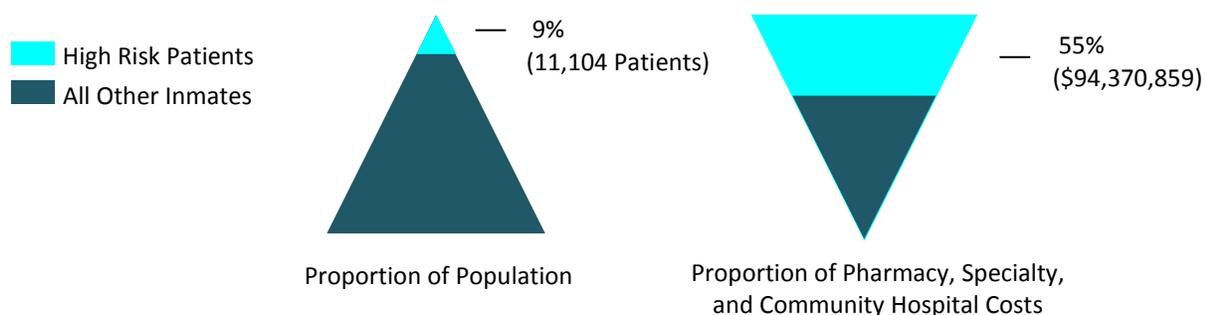
This report is the first of a series of reports to evaluate the care provided to high risk patients, and focuses specifically on appropriate placement of high risk patients. Subsequent reports will assess other important performance factors, such as access, continuity, coordination, quality, utilization, and cost of care. Beyond performance data, this report discusses characteristics of high risk patients, as well as specific recommendations which institution managers and care teams should consider to improve outcomes for this population.

Introduction

In health systems, a small subset of patients disproportionately contributes to health-related risk and cost, a concept commonly referred to as the “Pareto principle.” Within the California prison system, a small group of patients diagnosed with complex clinical conditions, referred to as high risk patients¹, disproportionately consume the use of health care resources. Within California’s prison system, nine percent of the patient population who are considered high risk utilizes more than half of the organization’s pharmaceutical, specialty, community hospital, and emergency costs. See Figure 1.

Therefore, even small improvements in the way CCHCS staff place and manage high risk patients have the potential of both improving health outcomes and greatly reducing avoidable costs for this population.

Figure 1. High Risk Patients: Proportion of Total Population vs. Proportion of Pharmacy, Specialty, and Community Hospital Cost² between October 2011 and March 2012.



¹ For the purposes of this report, “high risk” refers to a subset of patients identified as high risk per the Clinical Risk Classification System.

² Pharmacy, specialty, and contract hospital services. Pharmacy costs do not include human resources costs for staff who process medications, such as pharmacy technicians; specialty and contract hospital costs include third party off-site medical claims and exclude on-site registry and specialty services expenses.

In its annual Performance Improvement Plan for 2011-2012, California Correctional Health Care Services (CCHCS) focuses on improving care for high risk patients as a major statewide initiative. The High Risk Initiative promotes placement of high risk patients at institutions best resourced for their care, access to a consistent interdisciplinary care teams, and enhanced care coordination and care management for this population. Under the High Risk Initiative, CCHCS will:

- Assist institutions in appropriately placing high risk patients,
- Provide institutions and care teams with decision support, such as continuously updated patient registries, to help health care staff identify and manage high risk patients, and
- Redesign core health care processes that focus on this patient population.

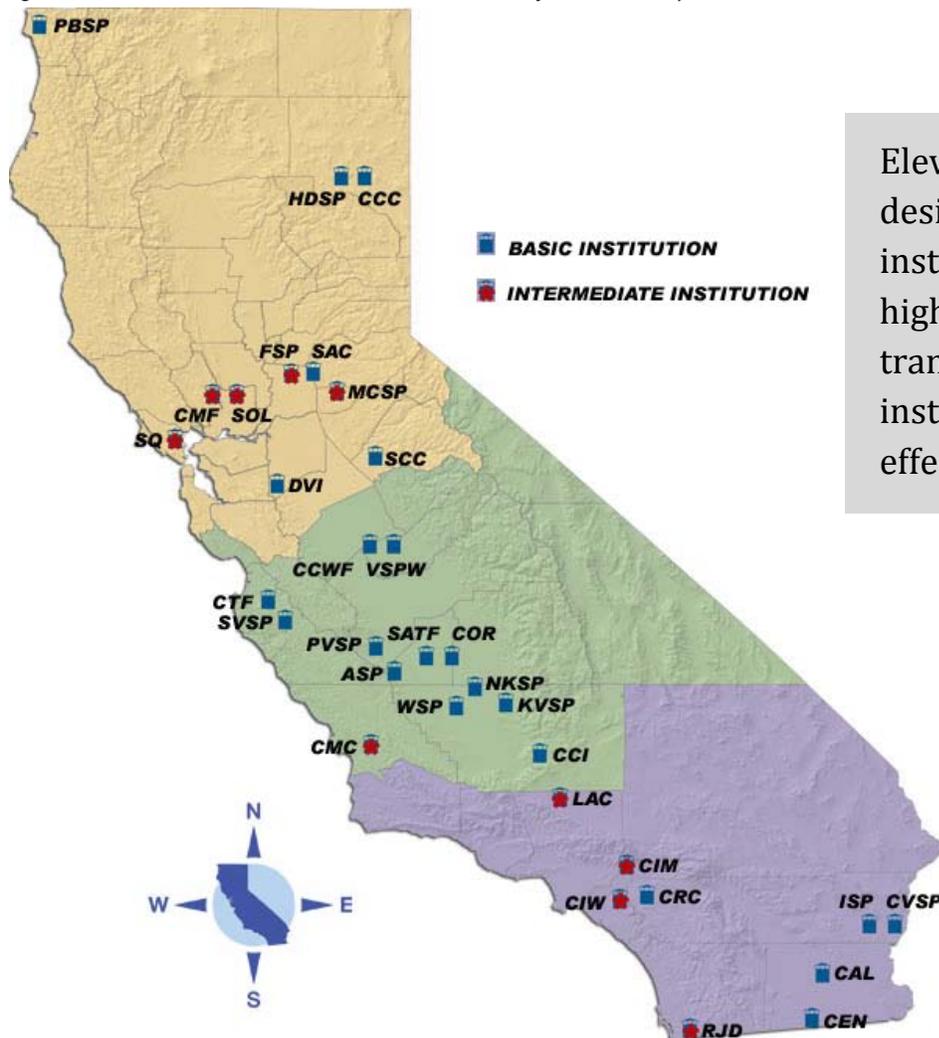
Over the next 18 months, CCHCS will closely monitor placement of high risk patients and implementation of critical Primary Care Elements, with results published monthly in the Health Care Services Dashboard.

Classification and Placement of High Risk Patients

Since November 2010, CCHCS staff have used the Medical Classification System (MCS) as a standardized method for determining each inmate's risk level. Under the MCS, patients are assigned one of three risk categories: High Risk, Medium Risk, and Low Risk. Please see Table 1 for a description of the factors associated with each risk level.

Upon entry into the prison system, health care staff assess each inmate to determine his or her health risk, and this information is used to match patients with prisons that will meet their health care needs in the most efficient and cost-effective manner. Per policy, most high risk patients should be transferred to an Intermediate Institution, which are predominantly located in urban areas close to tertiary care centers and specialty care providers, for the most cost-effective care. High risk patients will also be housed at the new California Health Care Facility (CHCF) in Stockton. Figure 2 shows Intermediate and Basic Institutions and their location in California.

Figure 2. Intermediate and Basic Institutions in the California Prison System



Eleven institutions have been designated as “intermediate” institutions; per policy, most high risk patients should be transferred to an intermediate institution for the most cost-effective care.

When the MCS policy was first implemented, the medical risk classification process was primarily paper-based. Institution health care staff were expected to assign patients a medical risk category based on information collected at health screenings and from available medical records, and record this information in a Medical Classification Chrono. In 2012, CCHCS applied widely-accepted and evidence-based predictive models to establish an automated system for identification and classification of an inmate’s health risk. Inmate risk levels are now determined using information from centralized laboratory, pharmacy, claims, and other databases, as well as clinical judgment. Please see Table 1 for a description of the factors associated with each risk level.

Table 1. Automated Classification System Risk Levels and Summary of Associated Criteria

<i>Risk Level</i>	<i>Summary of Associated Criteria</i>
High Risk	Patients who trigger one or more criteria, including: medications indicating High Risk medical condition, frequent hospitalizations, high risk specialty services, abnormal labs, high risk diagnosis or procedures, and age.
Medium Risk	Patients with one or more chronic illness (including mental health and permanent disability).
Low Risk	Patients who are otherwise healthy or identified as having well-controlled asthma or diabetes, and asymptomatic HCV patients.

CCHCS clinical staff now have access to a Patient Panel Registry which lists each patient at a given institution and their current risk level. Updated continuously, this patient registry provides clinicians and administrators with the information they need to identify and appropriately place high risk patients, ensuring the most efficient use of health care resources.

CCHCS Correction Services, in collaboration with health care leadership and Classification staff in the California Department of Corrections and Rehabilitation, has begun to reassign high risk patients now housed at Basic Institutions to Intermediate Institutions (and, in turn, move lower risk patients to Basic Institutions). In July 2012, CCHCS provided each institution with a list of patients determined to be high risk by the Automated Risk Classification System and required institutions to verify risk status of these patients within 30 days. The finalized high risk list for each institution becomes the basis for inmate transfers. Please see the Appendix (page 15) for the statewide memorandum that describes this initiative.

Characteristics of High Risk Patients

As would be expected, high risk patients are at greater risk for poor health outcomes than the average inmate (the selection methodology is described later in this report). Nearly half of the general inmate population is free of chronic disease, while all high risk patients have been diagnosed with either a serious medical condition and/or multiple chronic conditions. A number of other factors distinguish the over 11,100 high risk patients in the California prison system from the overall inmate population:

- They are older than the average inmate. The median age of California inmates is 38 years; for high risk inmates, the median age is more than 10 years older – 53 years of age (see Table 2).
- High risk patients are likely to remain under the Department’s jurisdiction. Thirty-five percent (35%) of high risk patients will serve life sentences³ compared to twenty-three percent (23%) of the general population.
- One out of every three high risk patients are enrolled in the Mental Health Program. Thirty-seven percent (37%) of high risk patients have been diagnosed with mental health conditions, a prevalence forty percent higher than what is found in the general population.
- Care management is complicated by frequent inmate movement. Between July 2011 and June 2012, CDCR inmates transferred an average of 4 times from one cell bed to another, from one institution to another, between health care settings, or in and out of the prison system. Even at the local level, movements within an institution can result in reassignment to a new health care team, and a lapse in care may result if the transition is not carefully coordinated.
- While a transition in care may not have a significant impact on healthier inmates, gaps in clinician services, medications, or diagnostic studies that may occur could result in adverse outcomes for high risk patients.

³ Includes life without parole.

Table 2. Offender Characteristics of High Risk Patients

	Number of Inmates	Median Age	Life Sentence	Serious Medical Condition	Mental Health Condition
General Population	113,405	38	23%	52%	25%
High Risk	11,104	53	35%	100%	37%

Although high risk patients comprise about nine percent (9%) of the total population, they drive over half of all expenditures for community hospitalizations, emergency department visits, specialty consultations, and medications. For the six months between October 2011 and March 2012, the costs for community hospital and emergency department visits, specialty consults and medications for the entire inmate population was approximately \$171 million; costs for high risk patients accounted for \$94 million⁴ (55%) of this amount.

Of the 9,661 hospitalizations that occurred in between April 2011 and March 2012, over 44% (4,270) involved High Risk patients. Additionally, a subset of **potentially avoidable hospitalizations** for high risk patients averaged about \$17,000 in community hospital costs per admission, for a total of nearly \$25 million.

Findings

As of July 2012, fifty percent (50%) of high risk patients are located in Basic Institutions. Meeting the statewide objective to house seventy-five percent (75%) of high risk patients at Intermediate Institutions by the end of the year means moving roughly 2,750 high risk patients from Basic Institutions to Intermediate Institutions over the course of the next seven months. See Figure 3 and Appendix Table A-1.

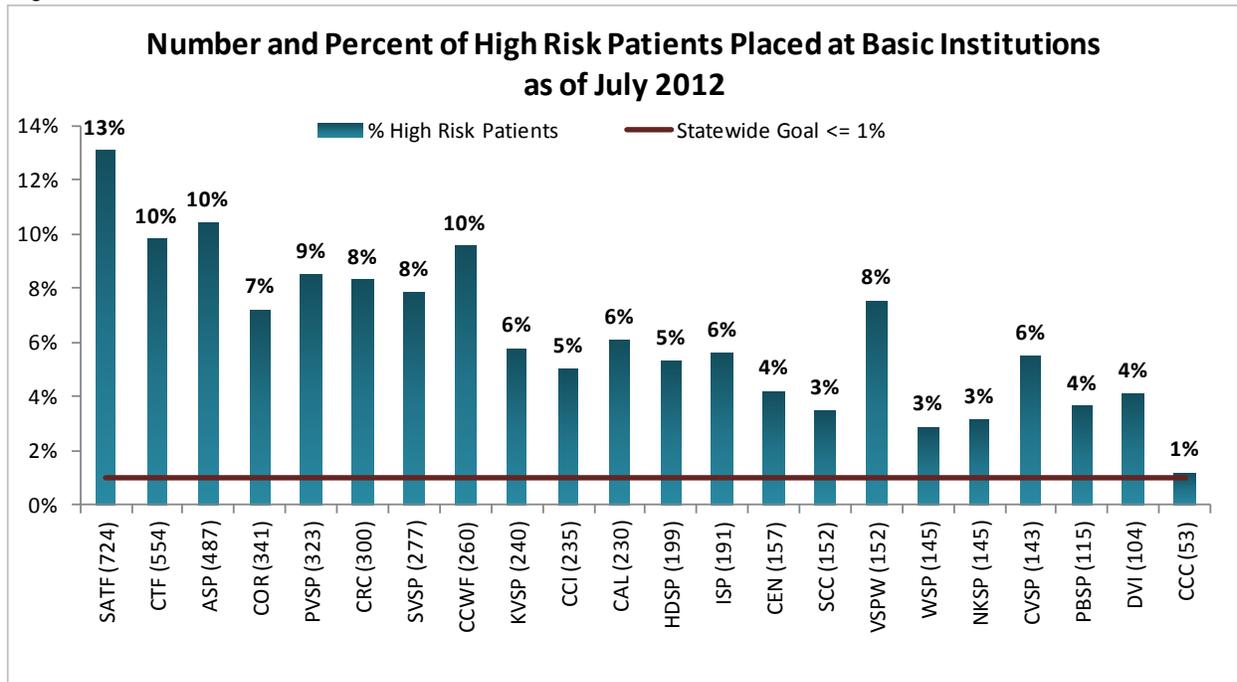
2011-2012 Performance Improvement Plan Objective:

By December 31, 2012, greater than 75% of high risk patients will be housed at Intermediate Institutions or CHCF.

The twenty-two Basic Institutions still house half of the high risk patient population. Most of those high risk patients are housed at seven of the 22 Basic Institutions: SATF, CTF, ASP, COR, PVSP, CRC, and SVSP. Among the four Basic Institutions with the most high risk patients (SATF, CTF, ASP, COR), at least one in every ten inmates falls into the high risk category. See Figure 3.

⁴ A lag in billing receipt may result in figures lower than annualized figures reported elsewhere.

Figure 3.



* Figures shown in Figure 3 may under represent high risk patients, specifically those who have entered the CA correctional system within the last 6-12 months, as data may not yet be available to adequately classify them.

Recommendations

Statewide High Risk Initiative - Placement

For several months now, CCHCS and CDCR staff has been working together to move high risk patients to Intermediate Institutions, and replace these patients with others at medium or low health risk.

- **Basic Institutions** can support this statewide initiative by working closely with The Medical Placement Unit and custody classification staff to facilitate movement of high risk patients to other institutions, making it a priority to complete these transfers.
- **Intermediate Institutions** can support the statewide initiative to appropriately place high risk patients by ensuring that high risk patients newly transferred to the institution are promptly assigned to a care team, are scheduled for timely evaluation with the assigned primary care provider, and receive medications and diagnostic services as required.

In addition to the statewide initiative to appropriately place high risk patients, CCHCS has developed specific tools and strategies to assist institutions in properly placing and managing high risk patients.

Tools and Strategies for Appropriate Placement: New Patient Registries

In May 2012, CCHCS released a new set of patient registries with enhanced features for managers and health care teams. These new registries:

- Are updated continuously, as soon as pharmacy, laboratory, inmate movement, and other relevant data become available.
- Can be easily customized to show a specific health care team's assigned patients, patients with a particular condition, patients flagged for abnormal laboratory results, among other options.
- Identify new patients who have transferred to the patient panel within the past 30 days.
- Provide more information than has been offered before, including each patient's risk level.

Care teams can review the risk level of all patient assigned them using the Patient Panel Registry. Through the Chronic Care Master Registry, care teams can access a list of patients with common chronic diseases, their risk level, and other important clinical information, such as abnormal clinical findings or missing services. Viewers can click on the risk designation of any registry patient, bringing up a comment box that specifies the criteria that caused the patient to be placed in the risk category. See Figure 4.

CCHCS recommends that institutions use registries to:

- Identify high risk patients, verify that the risk level is appropriate, and support efforts to transfer high risk patients to an Intermediate Institution or CHCF.
- Identify patients who have recently transferred to their current care team and ensure that these patients are evaluated by the assigned Primary Care Provider within appropriate timeframes based on clinical need and policy requirements.
- Follow up on "flags" that appear for High Risk patients on the Chronic Care Master Registry. The flag may indicate that a recommended service has not been provided, or may highlight an abnormal result.

Figure 4: View of Chronic Care Master Registry, with Risk Criteria comment box

The screenshot displays the 'Avenal State Prison (ASP) Master Registry - Chronic Conditions' interface. The patient count is 3167. The main table lists patients with columns for CDCR#, Last Name, DOB, Cell Bed, Care Team or Yard, Clinical Risk, and MI High. A 'Risk Criteria' pop-up window is open, showing a 'Risk Level: HIGH 1' and 'Medical High Risk Factors: MULTIPLE HOSPITALIZATIONS, SENSITIVE MED COND (IBD)'. A red arrow points to the 'HIGH 1' risk level in the table.

Identification & Housing				Risk Gr		Selected Chronic Conditions										
CDCR#	Last Name	DOB	Cell Bed	Care Team or Yard	Clinical Risk	MI High	CCCMS	ADJ	OPI	Ab+VI-	Ab+VL+	Ab+VL-	ACE	Diureti	Warfarin (INR)	ADA/DPP
				Yard A Clinic	MED											
				Yard A Clinic	HIGH 1											
				Yard C Clinic	MED											
				Other	HIGH 1		7	CCCMS	2.0:0	ADJ	5.6	Ab+VI-	103	Multi-3	Dilant	
				Yard A Clinic	MED		6	CCCMS		ADJ	5.7		41	Multi-3		4.6
				Yard B Clinic	MED		6	CCCMS		ADJ	9.2		47	Multi-4		
				Yard B Clinic	MED		6	CCCMS		OPI	8.5	Ab+VL+	99	Multi-2		
				Yard B Clinic	MED		6	CCCMS		OPI	6.9	Ab+VL+	114	Ca-Bikr	Dilant	
				Yard C Clinic	MED		6	CCCMS	0.3:1		6.9		92	Multi-3		DNM
				Yard C Clinic	HIGH 1		6	CCCMS		OPI		Ab+VL+	52	Diureti	2.7	DNM
				Yard C Clinic	MED		6	CCCMS		ADJ	5.7	Ab+VI-	52	Multi-2		
				Yard C Clinic	MED		6	CCCMS		OPI ADJ	5.6		100	Multi-3		Multi-2
				Yard C Clinic	MED		6	CCCMS			5.6	Ab+VI-	112	ACE		DNM
				Yard C Clinic	MED		6	CCCMS		ADJ	7.8		135	Multi-3		DNM
				Yard D Clinic	HIGH 1	2	6	CCCMS			8.1	Ab+VL+	39	Multi-5		DNM
				Yard E Clinic	MED		6	CCCMS		OPI	6.1	Ab+VL+				DNM

Click here to access the new patient registries: [Master Chronic Care Registry](#)

To ensure optimal use of the new registries:

- Provide all care team members with access to registries. All clinicians and many administrative staff already have access to these registries; please contact Ryan Jones at Ryan.Jones@cdcr.ca.gov if a team member needs access but has not been granted it.
- Ensure that care teams at your institution know how to use the new patient registries. Designate a group of staff well-versed in registry features to mentor other staff.
- Ensure that staff know where to find the User's Manual, which describes registry features. Click here for the User's Manual: [Registry User's Guide](#)

Performance Monitoring

CCHCS monitors the percentage of high risk patients at each Basic Institution and updates this number monthly in the Health Care Services Dashboard. In the Monthly Comparison View of the Dashboard, institutions find a breakdown of the percentage of the total patient population that falls into each risk category allowing institutions to easily assess whether the institution is meeting the statewide performance goal of less than or equal to one percent of the patient population. All institutions' percentages are posted, allowing for comparison across facilities. See Figure 5.

Figure 5: Percentage of Patients in Each Risk Category, Per Institution, as Found in the Health Care Services Dashboard Monthly Comparison View

	ASP	GAL	CCC	CCI	CCWF	CEN	CHM	CIW	CNC	CNF	COR	CRC	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NGSP	PBSP	PVSP
INSTITUTION AND POPULATION CHARACTERISTICS																								
High Risk Priority 1	1%	1%	0%	1%	4%	1%	4%	2%	4%	14%	2%	2%	3%	2%	1%	1%	2%	1%	1%	3%	4%	1%	1%	2%
High Risk Priority 2	9%	5%	1%	4%	6%	3%	9%	6%	10%	20%	6%	6%	7%	5%	3%	4%	3%	4%	4%	6%	10%	3%	3%	6%
Medium Risk	4%	31%	23%	54%	51%	30%	51%	47%	50%	53%	55%	50%	52%	35%	39%	51%	43%	36%	54%	61%	64%	37%	43%	64%
Low Risk	4%	63%	76%	41%	39%	66%	35%	45%	36%	13%	37%	42%	38%	58%	57%	44%	52%	60%	40%	30%	22%	59%	54%	28%
Institutional Program - Mental Health	14	-	-	14	46	-	56	67	613	507	238	-	10	-	15	-	14	-	92	378	507	55	198	7
Patients with Disability (ADA)	451	101	38	138	213	101	400	78	291	768	275	144	270	118	113	110	260	82	208	184	200	115	59	443
Licensed Outpatient Beds	28	18	24	32	39	15	160	37	37	293	99	10	22	14	29	-	35	15	22	18	12	16	20	17
Inmates ≥ 50 years old	1,436	331	365	658	470	407	1,257	235	1,565	980	685	690	1,766	583	279	484	358	510	296	544	853	507	270	841
Women/Men Institutions	M	M	M	M	W	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Total Population	5,222	4,001	4,836	4,728	2,852	3,715	5,256	1,637	5,540	2,413	4,504	3,950	5,713	2,723	2,597	2,928	3,786	3,509	4,174	3,894	3,065	4,714	3,091	3,734

For each institution, the monthly Institution Scorecard shows a count of high risk patients, and provides a 6-month trend line to show whether this number is increasing (as would be expected for Intermediate Institutions) or decreasing (as would be expected for Basic Institutions) over time. See Figure 6.

Figure 6. Count of high risk patients housed at the institution

MAJOR COSTS PER INMATE PER MONTH				WORKLOAD PER DAY		
BOR	FY 10/11	YTD 11/12	Statewide (excluding HQ)	6 Month Trend	Feb. 2012	Statewide
Medical Staff	\$60.96	\$63.71	\$79.39		11	12
Nursing Staff	\$205.00	\$215.39	\$327.36		8	7
Pharmacy Staff	\$16.43	\$14.74	\$26.95		13	10
Mental Clinical Staff	\$75.47	\$70.67	\$70.70		227	121
Mental Health Clinical Staff	\$57.82	\$62.55	\$146.19			
Mental Support Staff	\$9.80	\$9.57	\$18.46			
Admin. Support Staff	\$70.89	\$75.63	\$93.17			
NON-LABOR				OTHER TRENDS		
Hospital	\$146.82	\$113.44	\$91.00		2	9
Emergency Department	\$7.47	\$5.94	\$4.11		38	36
Specialty	\$30.07	\$30.78	\$30.24		0.0%	1.9%
Education	\$79.34	\$75.05	\$102.57		183%	155%
Diagnostics	\$57.91	\$15.25	\$21.17		40%	53%
					2.6	3.8
MODERATE ADHERENCE				LOW ADHERENCE		
				*Per 1,000 inmates		

Please click here to access the Health Care Services Dashboard: [Dashboard](#)

At [Basic Institutions](#), review the percentage of high risk patients at the institution during the institution's regularly-scheduled Quality Management Committee meeting or other appropriate performance management committee meeting. Track this measure as the institution makes efforts to exchange high risk patients for medium and low risk patients to ensure that the percentage of high risk patients decreases over time. Consider tracking other metrics for high risk patients, such as whether these patients were seen within 14 days of assignment to a new care team, and whether these patients received diagnostic services, medications, and specialty consultations per policy and guidelines. Institutions may wish to use a tracer methodology, which assesses the effectiveness of health care processes by following the care provided to an individual patient, to review services provided to high risk patients.

Click here for more information on the tracer methodology: [Joint Commission Tracer Methodology](#)

In summary, High Risk Patients represent a small proportion of the inmate population, but disproportionately carry the burden of health risk and consume the majority of non-labor costs. Although the High Risk patients should be housed at Intermediate Institutions best resourced to provide cost-effective care, only 50% are currently housed within these institutions. As described in this Report, there are a several tools and strategies that headquarter and institution staff should use to ensure appropriate placement and clinical management of this patient population.

Please share this performance report with institution staff and discuss in a variety of forums including the Quality Management Committee, program subcommittees, and supervisors' and care team meetings focusing on how best to implement the tools and strategies currently available to optimally place and clinically manage High Risk patients.

Appendix

Mission Average	Institutions	Number of High Risk Patients	Total Inmate Population	Prevalence of High Risk Patients
WOMEN 9%	CCWF	260	2724	10%
	CIW	129	1515	9%
	VSPW	152	2011	8%
RC BASIC 3%	DVI	104	2535	4%
	NKSP	145	4616	3%
	WSP	145	5052	3%
RC INTERM 14%	CIM	841	4940	17%
	LAC	396	3961	10%
	RJD	523	3285	16%
	SQ	454	3665	12%
BASIC 7%	ASP	487	4684	10%
	CAL	230	3785	6%
	CCC	53	4479	1%
	CCI	235	4669	5%
	CEN	157	3742	4%
	COR	341	4720	7%
	CRC	300	3620	8%
	CTF	554	5654	10%
	CVSP	143	2596	6%
	HDSP	199	3737	5%
	ISP	191	3405	6%
	KVSP	240	4156	6%
	PBSP	115	3159	4%
	PVSP	323	3790	9%
	SATF	724	5539	13%
SCC	152	4369	3%	
SVSP	277	3535	8%	
INTERMEDIATE 16%	CMC	844	5383	16%
	CMF	857	2357	36%
	FSP	149	2863	5%
	MCSP	469	3058	15%
	SAC	302	2684	11%
	SOL	613	4221	15%
	Statewide	11104	124509	9%

Methodology

To produce the performance data used in this report, CCHCS first established criteria for identifying High Risk patients. A team of clinicians and analysts developed the criteria used to identify High Risk patients based upon requirements in the Medical Classification policy and procedure, evidence in the medical literature and existing predictive models, and clinical experience (see Table A-2 on page 21). The criteria for classification of High Risk rely upon pharmacy, laboratory, third-party claims and referral data as indicators of chronic, sensitive or high-risk conditions.

For the purposes of this report, a "High Risk" patient generally refers to those who have multiple acute or chronic conditions (or ambulatory care sensitive conditions) that require extended medical or rehabilitative treatments. CCHCS data provide guidance with regard to diseases that contribute most to illness, death, avoidable hospitalizations and increased costs. Patients were considered High Risk when they met one or more of the specified criteria.

The percentage of High Risk patients by institution was computed by dividing the number of High Risk patients at each institution by the prison population at the time of the analysis times 100.

Criteria and Data Sources

The classification criteria are based on pharmacy, laboratory, third-party claims and referral data as indicators of chronic, sensitive or high-risk conditions.⁵ Data sources included:

- Third Party Administrator (TPA) Claims — Emergency Department, Hospitalizations and Specialty Provider Billing (includes diagnosis and procedure coding).
- Census and Discharge Data Information System (CADDIS) — CCHCS Bed Management (identifies community hospital admissions).
- InterQual — CCHCS Specialty Referral criteria.
- Guardian Pharmacy — Pharmacy data.
- Quest Diagnostics — Laboratory reports.

⁵ This method has been applied in other research. See, for example, Fishman P, Goodman M, Hornbrook M, Meenan R, Bachman D, and O'Keefe Rosetti M. Risk adjustment using automated ambulatory pharmacy data: The Rx Risk model. *Med Care* 2003; 41:84-99.

- Mental Health Tracking System (MHTS.net) — Patients enrolled in the Mental Health Program.
- Disability Effective Communications Tracking System (DECS) — Information on disabilities.
- Distributed Data Processing System (DDPS) — Information on inmate placement.

Sensitive Medical Conditions

These were identified using a list of medications that are associated with important diagnoses such as ALS, cancer, hemophilia, HIV, organ transplant or HCV treatment and that, if the medications were missed, could result in serious health effects.

Memo to the Field – Centralized Automated Risk Classification System**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES****MEMORANDUM**

Date: July 25, 2012

To: Chief Executive Officers
Chief Medical Executives
Deputy Medical Executives

Subject: **CENTRALIZED AUTOMATED RISK CLASSIFICATION SYSTEM**

Effective immediately, this memorandum supersedes the California Correctional Health Care Services (CCHCS) Centralized Automated Risk Classification System memorandum dated May 16, 2012 (attached). After further analysis related to the implementation of the May 16, 2012 memorandum, the following actions are to occur upon the receipt of this memorandum and attachments.

The attached Centralized Automated Risk Classification System list contains High Risk (HR) Inmate – Patients (IPs) currently housed at your institution that have been identified as requiring transfer to an appropriate intermediate-level medical care institution. Please review the attached list to ensure the IP's current California Department of Corrections and Rehabilitation (CDCR) Medical Classification Chrono (128 C-3) reflects the IP's Medical Risk: High Risk status. If the CDCR 128 C-3 does not reflect HR, the institution primary care provider (PCP) staff is required to complete one or more of the following actions within **30 days of receipt of the IP list**:

- The PCP staff will complete a new CDCR 128 C-3 that documents the inmate's current medical classification factors, including the Medical Risk: HR factor. A copy of the completed CDCR 128 C-3 will be routed to the institution Classification and Parole Representative who will utilize the CDCR 128 C-3 as a trigger to initiate a classification action.
- If the institution PCP disagrees with the IP's HR designation, the provider shall discuss the case with the Chief Physician and Surgeon and the Chief Medical Executive (CME).
- If the CME believes the IP is medium or low risk, he/she will case conference with their designated Deputy Medical Executive (DME) and Douglas C. Peterson, DME to come to a consensus on the IP's medical risk status.
- If all parties agree the IP is not HR, the IP will be removed from the automated HR list. If a consensus cannot be reached, the IP will retain the HR designation and be transferred to an appropriate intermediate-level medical care institution.

MEMORANDUM

Page 2 of 2

- Upon completion of the institution medical review, an updated IP HR list based on the CDCR 128 C-3 will be provided by the institution to the Quality Management Unit and the Medical Classification and Case Records Unit (MCCRU). This updated list will then be provided to CDCR's Population Management Unit to be utilized by classification staff to transfer the identified HR IPs.

Should you have any questions or concerns, please contact Douglas C. Peterson, M.D., Deputy Medical Executive, Activations & Classification – Private Prison Compliance and Monitoring Unit, Corrections Services, at (916) 324-6833; after August 6, 2012, at (916) 691-9574 or via email at Douglas.Peterson@cdcr.ca.gov, or Dennis Gunter, Correctional Counselor III, MCCRU, Field Operations, Corrections Services, at (916) 648-8256 or via email at Dennis.Gunter@cdcr.ca.gov.

Attachments

Original signed by:

RICHARD KIRKLAND, Chief
Construction Oversight, Field Operations
and Activation Management, Correction
Services

Original signed by:

STEVEN THARRATT, MD
Statewide Chief Medical Executive

cc: Clark Kelso
David Runnels
Diana Toche
Liana Bailey-Crimmins
Tim Belavich
Jared Goldman
Mitzi Higashidani
Renee Kanan
Evelyn Matteucci
Yulanda Mynhier
Karen Rea
Lance Jensen
Theresa Kimura-Yip

John Dovey
Steven Ritter
Dennis Gunter
Rick Johnson
Ricki Barnett
Elizabeth dos Santos Chen
Alan Frueh
Ellen Greenman
Janet Lewis
Janet Mohle-Boetani
Douglas Peterson
John Zweifler



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES



MEMORANDUM

Date: May 16, 2012

To: Chief Executive Officers
Chief Medical Executives

From: Richard Kirkland, Chief of Construction Oversight, Field Operations, and Activation Management *RK*
Steven Tharratt, Statewide Chief Medical Executive *ST*

Subject: Centralized Automated Risk Classification System

In November 2010, California Correctional Health Care Services (CCHCS) established the Medical Classification System (MCS) to ensure appropriate placement and management of California's prison inmates. Under the MCS, patients are assigned a number of medical classification factors, including a medical risk category. Patients are routed to the facilities best situated to manage individual health care needs, and primary care teams can use medical risk categories to determine which patients will receive more intensive care coordination and case management services. Satisfaction of Turnaround Plan of Action Goal 1.4, which calls for appropriate identification and housing of long-term care patients, depends upon a fully implemented MCS.

A standardized, reliable medical risk categorization system is important for both improving patient outcomes and reducing costs. In correctional healthcare environments and the non-correctional health care settings, a small subset of patients is at higher risk for poor health outcomes and disproportionately drives health care costs. Placing as many high risk patients as possible at Intermediate institutions brings these patients to urban areas close to tertiary care centers and specialty care providers, which is expected to improve cost effectiveness, operational efficiencies and quality of care. As a result, CCHCS has set the following goal for placement of high risk patients:

By December 31, 2013, greater than 90% of High Risk patients will be housed at an Intermediate institution or California Health Care Facility (CHCF).

With initial implementation of the MCS policy, institution health care staff was expected to assign patients a medical risk category based on information collected at health screenings and available in medical records, and document this information on a Medical Classification Chrono (128-C3). CCHCS now has the technical capacity to determine patient risk from centralized electronic data sources. Applying widely-accepted and evidence-based predictive models,

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CCHCS has developed standardized criteria for each medical risk category. Under the new automated system, risk stratification will become consistent across all institutions, and inmate risk levels will be regularly updated with the most recent pharmacy, laboratory, hospitalization, and specialty services data as well as other data sources. Please see Attachment 1 for a description of the risk categories and associated risk factors.

Stratification and Placement of High Risk Patients

The new automated medical risk stratification system can support clinicians in accurately determining the risk of patients assigned to them in several ways. The new system:

- Makes important clinical data readily available to clinicians and care teams promoting proactive planned care for those patients with complex chronic conditions.
- Reduces the workload involved in updating the “Medical Risk” item on the Medical Classification Chronos as patients move from one risk level to another – the system performs this function on a continuous basis, ensuring that clinicians have the most updated risk status for each patient.
- Provides standardized criteria for medical risk determinations, bringing greater consistency to the medical risk stratification process.

The automated system also helps to prevent inefficiencies in patient transfers. Right now, when a high risk patient is transferred to an Intermediate facility, that patient should be exchanged with a medium or low risk patient. With the continuously updated information in the automated system, there should be fewer circumstances in which a high risk patient is moved from a Basic facility, only to be replaced by another high risk patient. In addition, the automated system will support efficient use of the new licensed inpatient beds under construction in Stockton and other locations.

The Health Care Placement Oversight Program (HCPOP), in collaboration with health care leadership, already has begun to reassign high risk patients to Intermediate institutions and, in turn, move lower risk patients to Basic institutions using the automated system. **During this transfer process, the sending institutions’ staff does not have to review or revise existing Medical Classification Chronos that have been completed for individual patients.**

However, to be consistent with CCHCS policies and good patient care, **Intermediate institutions receiving high risk patients, shall ensure that the primary care physician (PCP) assigned to manage the high risk patient evaluates this patient as soon as possible but no later than fourteen (14) days after arrival to the Intermediate institution. During the initial evaluation**

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with the PCP, the patient’s Medical Classification Chrono shall be reviewed and if necessary revised to ensure that the Chrono reflects the appropriate risk designation.

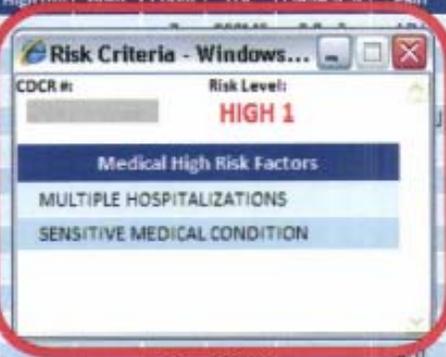
Risk Stratification Reports

Effective this month, CCHCS will make available patient registries that provide each patient’s medical risk category, updated on a continuous basis with the most recent centralized data. Specifically, under the column “Clinical Risk” on the CCHCS Master Registry, institutions will find the most current risk stratification of each patient listed. If a care team member wishes to know the criteria used to determine that particular patient’s risk stratification, he or she can click on the words “High” or “Med” and a pop-up window will appear with a description of the criteria (see image below). Patient registries can be sorted so that only a care team’s assigned patients are shown.

Patients who have been added to the patient panel within the past 30 days are marked with an asterisk (*) and shown in **bold font**. As high risk patients are transferred to Intermediate facilities, primary care teams will have the means to quickly identify these patients and schedule the patient to be seen.

[Click here to view the Master Registry](#)

Identification & Housing					Risk Group					Selected Chrono			
CDCR#	Last Name	DOB	Cell Bed	Care Team or Yard	Clinical Risk	MH High Risk	Avoid Medication	Cond Count	MH LOC	Asthma (SABA+LRA)	Chronic Pain	Diabetes (HbA1C)	HQ
			A 130	Yard A Clinic	MED							6.3	
			C 320	Yard C Clinic	MED							5.2	
			D 410	Yard D Clinic	MED							5.6	Ab+
			A 130	Yard A Clinic	HIGH 1							5.3	Ab+
			B 210	Yard B Clinic	MED							8.5	Ab+
			C 320	Yard C Clinic	MED							5.7	Ab+
			D 410	Yard D Clinic	HIGH 2							9.2	
			A 120	Yard A Clinic	HIGH 1							6.2	Ab+
			A 120	Yard A Clinic	HIGH 2							9.0	
			A 120	Yard A Clinic	MED							7.2	
			A 120	Yard A Clinic	HIGH 2								
			B 210	Yard B Clinic	MED								Ab+



On May 30th and June 5th, CCHCS will offer training on various aspects of the automated risk stratification system and its application at the institution. The training is open to all providers, but will be especially important for reception center providers who will need to assign classification to new patients entering our system.

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Clinical Risk Classification System Training

May 30th from 7:30AM-8:30AM

- OR -

June 5th from 3:00PM-4:00PM

To reach the webinar, please do the following:

Connect to audio via the phone:

Dial In = (877) 214-6371

Participant Code = 145230

Connect to video via the Internet:

www.webmeeting.att.com

Meeting Number = 8772146371

Participant Code = 145230

It is the expectation that no later than May 22, 2012, the institution's Chief Medical Executive and Chief Physician and Surgeon ensure that every medical provider at the institution has received a copy of this memorandum, and that the contents have been discussed with the provider staff as well as with the Quality Management Committee members.

We appreciate your feedback on the statewide effort to standardize the medical classification process and ensure appropriate placement and management of our patient population. Please send any comments or questions about this medical classification process to Dr. Doug Peterson at Douglas.Peterson@cdcr.ca.gov.

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Janet Lewis
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Attachment I
Appendix Table A-2

High Risk - Priority 1

Patients who are Clinically Complex -- triggering at least **2 flags** from the selection criteria found in the table below

High Risk - Priority 2

Patients who are Near Clinically Complex -- triggering only **1 flag** from the selection criteria found in the table below

Flag	Description	Data Source	Timeframe
Sensitive Medical Condition	Medications associated with important diagnoses which, if not taken, may lead to a serious adverse event (e.g. immunosuppressants, chemotherapy Rx)	Guardian	6 months
High hospital, ED, Specialty Care and Pharmacy Costs	Patients whose care in the past 6 months has a cost of more than \$100,000	Guardian, TPA Claims	6 months
Multiple Hospitalizations*	2 or more inpatient admissions	CADDIS	12 months
Multiple Emergency Department Visits*	3 or more emergency department visits	TPA Claims	12 months
High Risk Specialty Consultations	2 or more appointments to 'high risk' specialist(s) (e.g., oncologist, vascular surgeon)	TPA Claims	6 months
Significant Abnormal Labs	1 or more abnormal lab value that suggests poor control of a chronic condition or serious medical condition (most recent)	Quest	All - Most Recent or Any
Age	65 years of age or older	DDPS	Current Age
Specific High-Risk Diagnoses/Procedures	1 or more ICD-9 codes from ED visit, hospitalization or specialist visit, suggesting serious condition (e.g., cancer, SLE, dementia)	TPA Claims	All

*A patient with a point for 2 or more inpatient hospital admissions cannot receive a second point for 3 or more ED visits (and vice versa)

Medium Risk

Patients with at least 1 chronic condition who do not meet any selection criteria for Clinical High Risk Priority 1 or Priority 2
Excluded from the Medium Risk group are patients with only 1 chronic condition and identified as well-managed asthma or well-managed diabetes (consistent with the Medical Classification System Policy)

Flag	Description	Data Source	Timeframe
1 or More Chronic Conditions	1 or more chronic illnesses, based upon prescribed medications, laboratory tests, or MHTS enrollment (Includes MH High Utilization and Permanent ADA)	Guardian, Quest, MHTS	6 months

Low Risk

All patients who do not meet the selection criteria for the High Risk Priority 1, Priority 2, or Medium Risk categories
Included are patients identified as well-managed asthma or well-managed diabetes

Flag	Description	Data Source	Timeframe
Healthy Patients Including: Well Managed Asthmatics and Diabetics, and Asymptomatic HCV Patients	Otherwise healthy patients, including: Those who use <= 2 SABA dispenses in 12-months <u>and</u> not on an ICS Those with all HgA1C < 7.7 in 12-months <u>and</u> not on insulin Those who are HCV Ab+ but have a negative viral load (VL-)	Guardian, Quest	12 months