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**UNITED STATES DISTRICT COURT**

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**FOR THE NORTHERN DISTRICT OF CALIFORNIA**

10

**AND FOR THE EASTERN DISTRICT OF CALIFORNIA**

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MARCIANO PLATA, et al.,

Case No. C01-1351 TEH

12

*Plaintiffs,*

v.

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EDMUND G. BROWN, JR., et al.,

14

*Defendants.*

15

16

RALPH COLEMAN, et al.,

Case No. CIV S-90-0520 LKK JFM P

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*Plaintiffs,*

v.

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EDMUND G. BROWN, JR., et al.,

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*Defendants.*

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JOHN ARMSTRONG, et al.,

Case No. C94-2307 CW

22

*Plaintiffs,*

v.

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EDMUND G. BROWN, JR., et al.,

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*Defendants.*

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**NOTICE OF FILING OF RECEIVER'S  
TWENTY-SIXTH TRI-ANNUAL REPORT**

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1 PLEASE TAKE NOTICE that the Receiver in *Plata v. Schwarzenegger*, Case No. C01-  
2 1351 TEH, has filed herewith his Twenty-Sixth Tri-Annual Report.

3 Dated: June 2, 2014

FUTTERMAN DUPREE  
DODD CROLEY MAIER LLP

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By: /s/ Martin H. Dodd  
Martin H. Dodd  
Attorneys for Receiver J. Clark Kelso

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**CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES**

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

**Twenty-sixth Tri-Annual Report of the Federal  
Receiver's Turnaround Plan of Action  
For January 1 – April 30, 2014**

**June 2, 2014**

# 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 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.

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## Section 1: Executive Summary

In our second Tri-Annual report for 2014, the accomplishments for the period of January 1, 2014, through April 30, 2014, are highlighted. Progress continues toward fully implementing the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights for this reporting period include the following:

- The improvement continues related to custody and health care operations at the California Health Care Facility (CHCF). As stated in the last report, admission of new medical patient-inmates to the facility was halted due to serious, systemic issues. Since that date, the California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) have, and continue to, work together to address areas of concern that must be resolved. There have been improvements in many areas, and a "reboot" of each housing unit is solving many operational issues. However, there are concerns about whether these improvements are sustainable in the long-term, particularly since there will be turnover in health care leadership at CHCF beginning in July 2014. CCHCS will continue intensive monitoring of the situation.
- The DeWitt Nelson Correctional Annex (DNCA), which is the second of the two major projects planned for the purpose of adding new medical and mental health beds to the CDCR system, was completed in April 2014. In order to ensure that activation of the facility would not impact operations at CHCF, CDCR and CCHCS revised the activation schedule at DNCA. As a result, activation will be phased in slowly, with full activation to be completed in early 2015.
- Regarding the Health Care Facility Improvement Program (HCFIP), five projects remain to be authorized. As discussed in this report, due to a lack of existing funding, the Administration has proposed supplemental funding for the remainder of the projects. While the proposed funding has been approved by both budget subcommittees of the Legislature, the Legislature and the Governor must approve the funding for inclusion in the Governor's proposed 2014-15 budget.
- CCHCS continues its efforts at implementing an Electronic Health Records System (EHRS). This system will be pivotal for improving those elements of the RTPA that have yet to be completed. There have been a number of project management problems in the initial planning stages that have required high-level intervention. As a result, it is likely that we have lost several months in the project schedule.

- The Office of the Inspector General (OIG) continues to prepare for Round 4 of monitoring. At this point, it does not appear the parties or the *Plata* Court Experts have agreed with the modifications made to the OIG's audit instrument, and the OIG has delayed releasing a draft report from a pilot audit conducted at Deuel Vocational Institution (DVI), making it impossible for the parties or the *Plata* Court Experts to evaluate whether the changes to the methodology and the report structure are acceptable. There also does not appear to be any agreement regarding the meaning of whatever scoring methodology the OIG ultimately adopts. These serious uncertainties make it impossible to assess whether the OIG's Round 4 of inspections is going to be useful to the parties, the *Plata* Court Experts and the Court in evaluating the constitutional adequacy of care. The OIG intends to begin Round 4 in July 2014, and we will report on any progress on these issues in the next Tri-Annual report.
- On May 30, 2014, the Special Master in the *Coleman* case filed a comprehensive report on the adequacy of inpatient mental health care for CDCR inmates. Among other things, the report noted that the quality of inpatient care at California Institution for Women (CIW), which is exclusively managed by CDCR, was better than at several other institutions where inpatient care is jointly managed with the Department of State Hospitals. The Special Master suggested that the success at CIW "may serve as a useful model." (Special Master Report, page 50). The Receiver concurs. It is very difficult to jointly manage within CDCR's facilities what should be an integrated mental health care system. Since CDCR has demonstrated at CIW that it can successfully manage inpatient mental health care, it is time for CDCR to take primary responsibility for all inpatient mental health care for inmates housed in CDCR facilities. CDCR can more efficiently and effectively manage on its own the inpatient mental health care system within its own facilities.
- This report includes a new section as required in Judge Thelton Henderson's March 27, 2014, Order Re: Receiver's Tri-Annual Report to report on topics of importance, including, but not limited to, progress at CHCF, recruitment/retention efforts, as well as the Receiver's views on the sustainability of reform efforts. This section can be found beginning on page 47.

#### Format of the Report

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

*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 that are not completed.

*Appendices:* In addition to providing metrics, this report also references documents in the Appendices of this report.

*Website References:* Website references are provided whenever possible.

Information Technology Project Matrix

A chart has been created to specifically illustrate the major technology projects and the deployment of those projects. This document is included as [Appendix 1](#).

## Section 2: The Receiver's Reporting Requirements

This is the twenty-sixth report filed by the Receivership, and the twentieth 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>)

Judge Thelton Henderson's March 27, 2014, Order Re: Receiver's Tri-Annual Report (refer to [Appendix 2](#)) directs the Receiver to discuss in each Tri-Annual report his views on the sustainability of the reforms he has achieved and plans to achieve. Each report is to include updates on the development of an independent system for evaluating the quality of care, as well as a discussion on the degree, if any, to which custodial interference with the delivery of care remains a problem.

In support of the coordination efforts by the three federal courts responsible for the major health care class actions pending against CDCR, the Receiver files the Tri-Annual report in three different federal court class action cases: *Armstrong*, *Coleman*, 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\\_othr\\_per\\_reps.aspx](http://www.cphcs.ca.gov/receiver_othr_per_reps.aspx))

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

## Section 3: Status and Progress Toward 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. Volume 4, Chapter 2.1, Reception Health Care Policy and Volume 4, Chapter 2.2, Reception Health Care Procedure were both revised and updated in October 2012.

Based on the *Plata* Court Experts review of the San Quentin State Prison (SQ) reception center processes in March 2013, a review of the objective of optimizing further reception center processes, in light of redistribution of reception center missions, is underway.

***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 December 2013 through March 2014.

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

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

This action is complete. The Health Care Scheduling and Patient-Inmate Tracking System project was closed on April 16, 2014. The medical, dental, and mental health scheduling systems have been in production at 34 institutions since July 2013, and all aspects of technical support have been transitioned to information technology (IT) maintenance and operation.

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

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

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:

An interdisciplinary team is reviewing and revising the Primary Care Model. Based on the review, the team has re-organized the relevant policies and procedures to include:

- Overview of the Health Care Model: Defines and establishes relationship, integration, and responsibilities for Primary Care, Diagnostic and Therapeutic Services, Urgent Care, Tertiary Care, Dental Care, and Mental Health Care.
- Primary Care Team: Defines membership in primary care team, responsibilities, continuity of team, primary care team huddles, care conferences, and primary care panel assignments.
- Disease Management (Chronic Care): Defines program for management of enduring medical conditions, including establishment of clinical guidelines, surveillance and screening, tracking of conditions, adjustment of therapy, patient-inmate self-management, tracking of patient-inmate outcomes and populations, continuity of care, and case conferences.
- Preventive Primary Care Services: Requires established guidelines for preventive services, infectious disease surveillance, immunizations, screening, patient-inmate education and support in health maintenance. Includes annual primary care nursing visit focused on screening and patient-inmate education, as well as season-focused immunization program for influenza.
- Episodic Primary Care Services: Establishes system to respond to symptoms of a new condition and to exacerbations of pre-existing conditions. Includes method for patient-inmates and others to initiate health care visits.

The revisions provide for involvement of dental and mental health services through population management and care coordination, and the revision to the Primary Care Model is also taking into consideration and preparing CCHCS for implementation of the EHRS.

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

This action is ongoing. Progress during this reporting period is outlined above in Action 2.1.1.

### **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 January through April 2014. These reports are included as [Appendix 4](#).

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

This action is completed. However, pursuant to Judge Thelton Henderson's March 27, 2014, Order Re: Receiver's Tri-Annual Report, an update on this action item is provided in Section 7(B) of this report. Judge Thelton Henderson's March 27, 2014, Order Re: Receiver's Tri-Annual Report is included as [Appendix 2](#).

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

This action is completed. However, pursuant to Judge Thelton Henderson's March 27, 2014, Order Re: Receiver's Tri-Annual Report, an update on this action item is provided in Section 7(B) of this report. Judge Thelton Henderson's March 27, 2014, Order Re: Receiver's Tri-Annual Report is included as [Appendix 2](#).

#### **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 a Quality Assurance and Continuous Improvement Program**

### **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:

#### **Revisions to the Health Care Services Dashboard**

In 2013, CCHCS updated the statewide Performance Improvement Plan (PIP), retaining some performance measures from the previous plan and adding a set of new measures. The Dashboard was taken offline temporarily to be reconfigured in accordance with the new plan, and during that period CCHCS developed and tested the methodology for new measures, redesigned the Dashboard database infrastructure, and increased web-based functionality.

At the end of February 2014, CCHCS released a new and improved version of the Health Care Services Dashboard (Dashboard 4.0). Among other changes, Dashboard 4.0:

- Includes 183 measures in 13 domains. Many measures are “roll ups” of multiple sub-measures whereby the viewer sees a composite score, and can choose to drill down into deeper levels of data.
- Taps into new data sources for performance measurement, including centralized medical, dental, and mental health scheduling systems; the Patient Health Information Portal; and Medication Administration Process Improvement Program (MAPIP) audit results.
- Is Web-based and interactive. A new database structure allows viewers to design their own Dashboard reports according to their own particular needs or interests.

To accompany the Dashboard 4.0 release, CCHCS created resources to help orient users to new and updated features, including Frequently Asked Questions and a glossary with specifications for all Dashboard measures. These resources are hosted on a website linked to the Quality Management (QM) Portal. Refer to Figure 1, Dashboard 4.0 Resource from QM Portal.

Figure 1. Dashboard 4.0 Resource from QM Portal

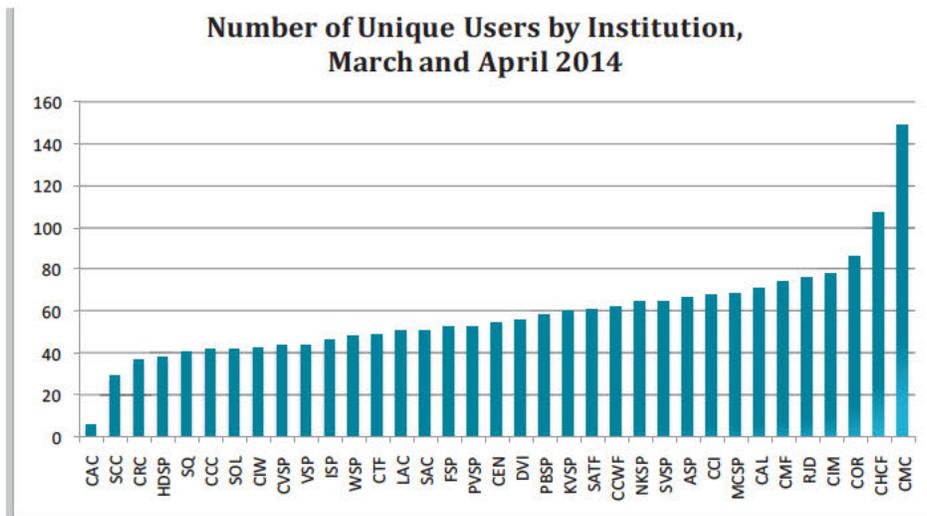


The new Dashboard format allows CCHCS to track which users are accessing the Dashboard and how often reports are run, among other data points. More than 2,000 unique CCHCS users accessed Dashboard 4.0 in March and April of 2014 and generated a total of 10,750 reports. Nursing staff represented the largest volume of Dashboard users at more than 800 unique users during the reporting period. The highest usage rate was among medical providers and pharmacy staff, at 30 percent and 20 percent respectively, accessing the Dashboard. Refer to Figure 2, Dashboard 4.0 Usage by Classification Category, March and April 2014. Among institutions, CMC, CHCF, and Corcoran State Prison (COR) had the highest usage, with 80 unique users or more during the two-month period. Refer to Figure 3, Dashboard 4.0 Usage by Number of Unique Users by Institution, March and April 2014. The full release memorandum for Dashboard 4.0, which describes in detail many of the Dashboard’s new features, is included as [Appendix 5](#).

Figure 2. Dashboard 4.0 Usage by Classification Category, March and April 2014

Classification Category	Total Unique Users	Civil Service FTE	Percentage
Medical	137	426	32%
Nursing	848	4772	18%
Pharmacy	92	463	20%
Dental Clinical	113	809	14%
Mental Health Clinical	225	1392	16%
Clinical Support	37	336	11%
Administrative Support	511	3319	15%
User Not Yet Classified	87	N/A	N/A
<b>Total</b>	<b>2,050</b>	<b>11,517</b>	<b>18%</b>

Figure 3. Dashboard 4.0 Usage by Number of Unique Users by Institution, March and April 2014



At the end of April 2014, QM section staff held a series of webinars targeting staff in specific roles or disciplines to orient them to performance measures and Dashboard functions that may be of particular use in their day-to-day work. Refer to Figure 4, Advertising Flyer: Dashboard 4.0 Training Details.

Figure 4. Advertising Flyer: Dashboard 4.0 Training Details

DASHBOARD 4.0		
Open Forum/Demonstration/Question & Answer		
WHO	WHEN	DOMAIN
<b>Executive Leadership</b> CEO, CSE, PIC, Chief P&S, CNE, Chief Dentist, Chief Psychiatrist, Chief Psychologist, CHSA	<b>Tuesday, April 8<sup>th</sup></b> 11:30 AM – 12:30 PM	<ul style="list-style-type: none"> <li>Care Management</li> <li>Population Health Management</li> <li>Scheduling and Access to Care</li> <li>Resource Management</li> <li>Staffing in FTE</li> <li>Medication Management</li> <li>Major Costs</li> <li>Workload per Day</li> <li>Appeal Processing</li> </ul>
<b>Medical/Nursing Staff</b> Clinical Staff, Pharmacy Staff, Nursing Staff, Clerical/Administrative Support Staff, Health Records Staff	<b>Wednesday, April 9<sup>th</sup></b> 11:30 AM – 12:30 PM	<ul style="list-style-type: none"> <li>Continuity of Clinicians and Services</li> <li>Care Management</li> <li>Population Health Management</li> <li>Scheduling and Access to Care</li> <li>Medication Management</li> <li>Workload Per Day</li> <li>Other Trends</li> <li>Resource Management</li> </ul>
<b>Mental Health/Dental Staff</b> Mental Health and Dental Clinical Staff, Clerical/Administrative Support Staff	<b>Thursday, April 10<sup>th</sup></b> 11:30 AM – 1 00 PM	<ul style="list-style-type: none"> <li>Continuity of Clinicians and Services</li> <li>Care Management</li> <li>Population Health Management</li> <li>Scheduling and Access to Care</li> <li>Medication Management</li> <li>Workload Per Day</li> </ul>

Patient-Inmate Registries

In April 2014, CCHCS released two new patient-inmate registries focused on patient-inmates populations at increased risk for adverse outcomes, one for patient-inmates with Gender Identity Disorder (GID)/Transgender, and another for patient-inmates with Human Immunodeficiency Virus (HIV). All patient-inmate registries are intended to support providers in applying evidence-based CCHCS guidelines published in the form of Care Guides.

GID Registry

The new GID Registry provides clinical information about the approximate 320 transgender patient-inmates including hormone therapy medications, diagnostic test results, and preventative screenings, and can be screened by male-to-female and female-to-male groups.

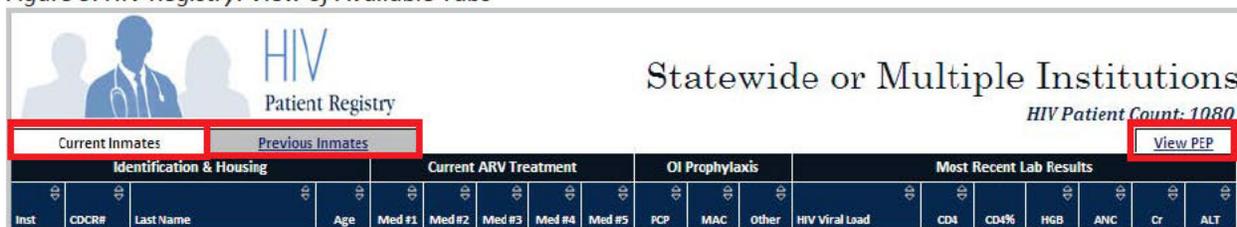
HIV Registry

More than 1,000 patient-inmates in the California prison system are chronically infected with HIV, which usually requires antiviral treatment with a combination of medications. The new HIV Registry is divided into the following three parts:

- **Current Inmates Tab:** Patient-inmates currently affected by HIV. Includes information about active antiretroviral drug regimens, active treatment for opportunistic infection prophylaxis, HIV viral load and other treatment monitoring laboratory tests, and most recent lab results.
- **Previous Inmates Tab:** Previously incarcerated patient-inmates affected by HIV. Includes last HIV viral load and other previous monitoring laboratory tests.
- **View PEP Tab:** Patient-inmates undergoing post-exposure prophylaxis. Includes antiretroviral drug regimens, HIV viral load and other treatment monitoring laboratory tests.

Refer to Figure 5, HIV Registry: View of Available Tabs.

Figure 5. HIV Registry: View of Available Tabs



An additional feature of the HIV Patient Registry is the ability to view a detailed Patient Treatment History report by clicking on the patient-inmate’s CDCR number. Refer to Figure 6, HIV: Example of a Patient-Specific Treatment History Report.

Figure 6. HIV Registry: Example of a Patient-Specific Treatment History Report



## HIV Treatment History

---

CD4R#:  
Lastname:  
Location:  
Age/Height:

EPRD:  
Mental Health:  
Tabc Score:

HIV Ab:  
HCV Ab:  
HBV SAg:

---

**Current Medications**

Abv. Agent	Medication Name	Provider	Start	End	Label Text
SULFAMETHOXAZ	SULFAMETHOXAZOLE-TMP DS TABL				Take 1 tablet by mouth daily
EPV EFVIRENZ	ATRIPLA TABLET				Take one tablet by mouth every evening
FTC EMTRICITABINE	ATRIPLA TABLET				Take one tablet by mouth every evening
TDF TENOFOVIR	ATRIPLA TABLET				Take one tablet by mouth every evening

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**Treatment & Laboratory History**

Date	Type	Active Medication(s)	CD4	CD4%	Viral Load	WBC/ANC	HGB/HCT	PLT	AST/ALT	BUN/Cr	GLU	ALB/Bili	Chol/Trig	HDL/LDL	RPR	GC/CT	UA/MA
Labs	EPV,FTC,TDF		236	13	<20 DETECTE	6.3/4202	11.9/35.5	262	25/20	16/1.10	105	4.3/0.2	197/130	31/140			
Labs	EPV,FTC,TDF		221	11	<20 NOT DET	6.1/3935	11.6/36.3	287	27/23	15/1.09	78	4.2/0.2	207/97	33/155			
Meds	EPV,FTC,TDF																
Meds	No Meds																
Labs	EPV,FTC,TDF				<20 DETECTE		13.4/41.5										
Labs	EPV,FTC,TDF		193	9	45	5.2/2704	11.4/35.0	270	22/18	13/1.14	95	4.3/0.3	185/129	33/126			
Labs	EPV,FTC,TDF		143	10	<20 NOT DET	4.3/2623	11.6/35.5	242	48/33	17/1.22	95	4.4/0.2	179/78	32/131			

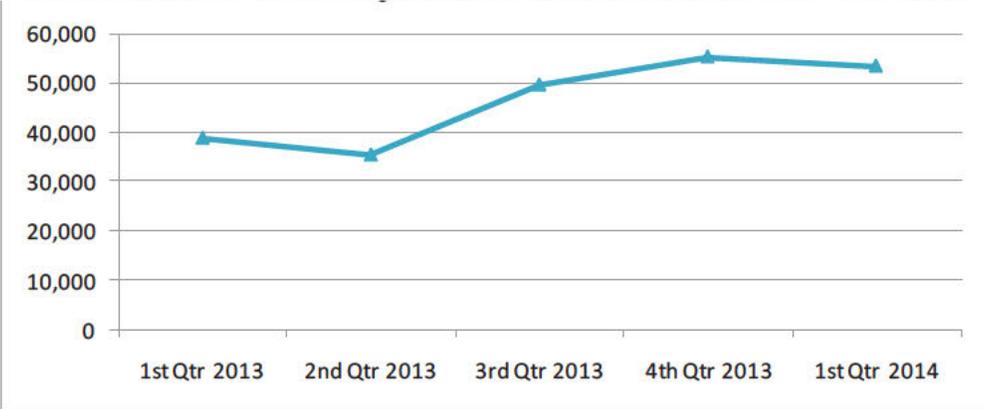
Both the GID and HIV Registries can be accessed via the QM Portal on CCHCS' Lifeline intranet. For further detail and screen shots of these registries, refer to the release memorandum in [Appendix 6](#).

### Registry Use

CCHCS has made it a priority to promote the use of its 26 registries and sub-registries, which make critical clinical information, such as a patient-inmate's health risk status, easily accessible to care teams working to manage an assigned patient-inmate panel. The flags imbedded in the patient-inmate registries prompt care teams to follow CCHCS guidelines, which both improves patient-inmate outcomes and helps to reduce costs. Widespread and consistent registry use is required for full implementation of the Population and Care Management elements of the CCHCS Primary Care Model, and necessary for compliance with certain Inmate Medical Services Program Policies and Procedures (IMSP&P).

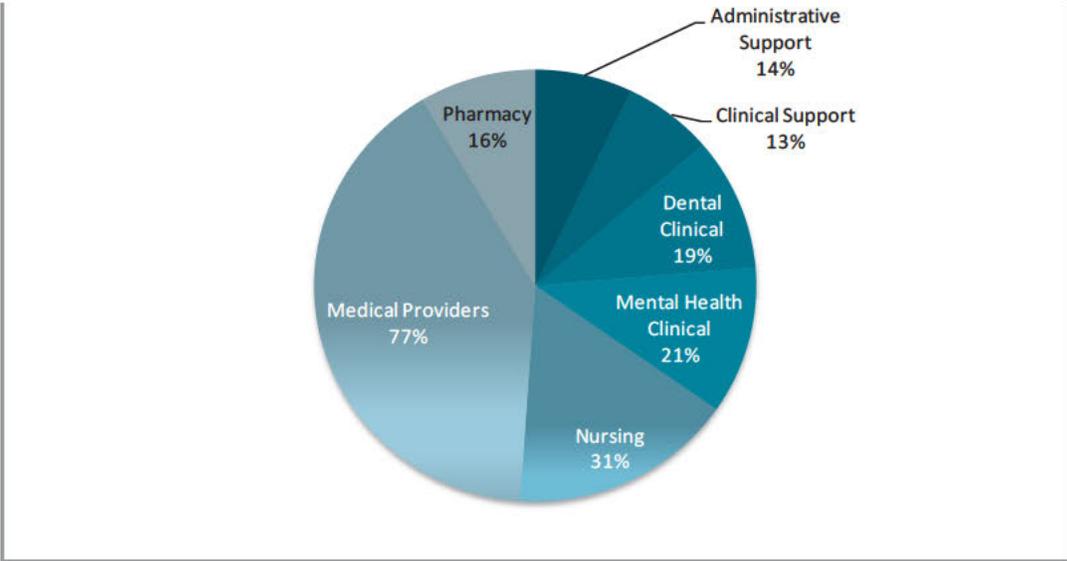
Statewide, registry usage has steadily increased since the May 2012 release of on-demand patient-inmate registries. During the first quarter of 2014, 2,829 unique users accessed the Master Registry, up 545 users from the same time period last year. The number of total registry reports run has also increased over time. (Every time a user pulls up a registry or changes the registry view per specific parameters, this counts as a report.) Refer to Figure 7, Number of Master Registry Reports Run per Quarter, First Quarter 2013 through First Quarter 2014. CCHCS staff have run more than 1 million registry reports since 2012.

Figure 7. Number of Master Registry Reports Run per Quarter, First Quarter 2013 – First Quarter 2014



Registry usage by discipline was highest among primary care physicians and nursing staff during the first quarter of 2014. Nursing staff usage has steadily increased over the past year, from nearly 22 percent of nurses accessing the registries a year ago to 31 percent as of April 2014. Refer to Figure 8, Registry Usage by Discipline: Percent of Positions Accessing Registry, First Quarter 2014.

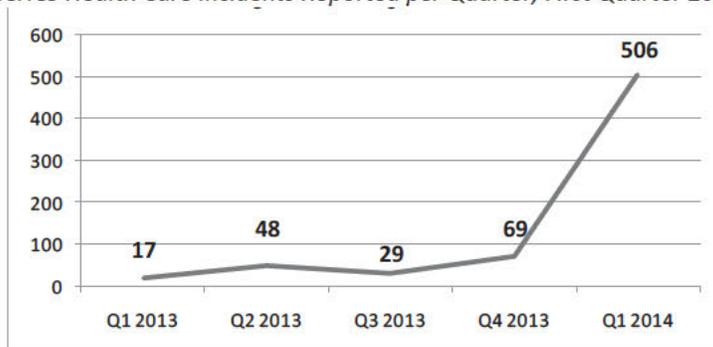
Figure 8. Registry Usage by Discipline: Percent of Positions Accessing Registry, First Quarter 2014



Patient Safety Program – Health Care Incident and Medication Error Reporting. During this reporting period, CCHCS staff continued to report actual and potential adverse events through the Health Care Incident Reporting System, and a multi-disciplinary group at headquarters met daily to triage the health incidents, directing institutions to take appropriate follow-up action, as per policy.

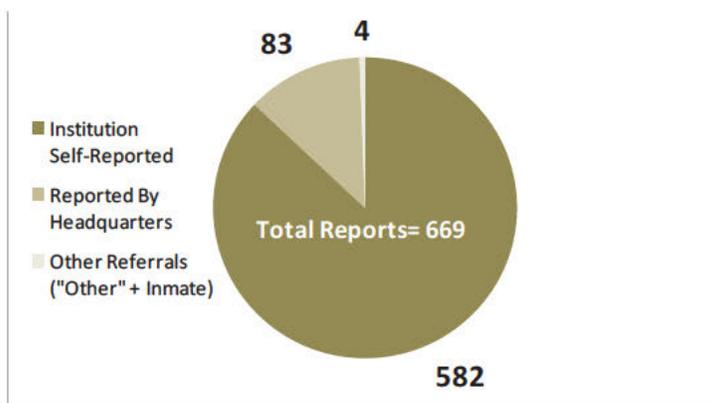
During the reporting period, the total number of incident reports nearly tripled the 162 reports submitted during the entire calendar year of 2013, due to the full integration of medication error reports into the new reporting system. Refer to Figure 9, Number of CCHCS Health Care Incidents Reported per Quarter, First Quarter 2013 through First Quarter 2014.

Figure 9. Number of CCHCS Health Care Incidents Reported per Quarter, First Quarter 2013 – First Quarter 2014



Most health incident reports are submitted directly by institution health care staff. During the first quarter of 2014, 12 percent of reports came from headquarters staff, and less than 1 percent derived from other sources, such as inmates or inmate advocates. Refer to Figure 10, CCHCS Health Care Incidents Reported by Source, First Quarter 2014.

Figure 10. CCHCS Health Care Incidents Reported by Source, First Quarter 2014



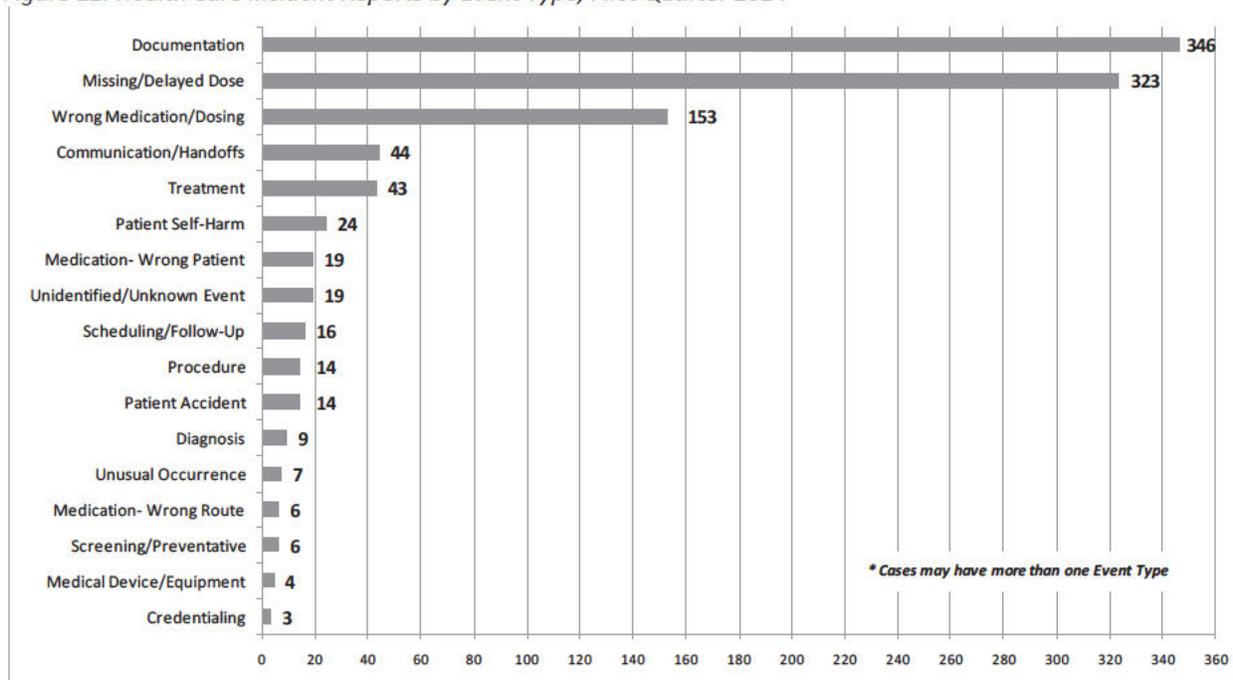
During this reporting period, the Adverse and Sentinel Event Committee (ASEC), which provides oversight to both the Health Care Incident Reporting System and the statewide root cause analyses process (RCAs), continued to apply a new taxonomy to group health care incidents by event type, a required first step in the trending of process problems. The taxonomy is inserted into the incident reporting form and revisited during the triage. Refer to Figure 11, Excerpt from Incident Reporting Form – Taxonomy (Event Categories).

Figure 11. Excerpt from Incident Reporting Form – Taxonomy (Event Categories)

Please select at least one event category to describe this event:				
Coordination/Continuity of Care >	<input type="checkbox"/> 1.1 Communication/ Handoffs <ul style="list-style-type: none"> <li>Health Care Worker to Patient</li> <li>Health Care Worker to Health Care Worker                             <ul style="list-style-type: none"> <li>Within CDCR</li> <li>With External Provider</li> </ul> </li> </ul>	<input type="checkbox"/> 1.2 Documentation <ul style="list-style-type: none"> <li>Missing</li> <li>Delay in Availability</li> <li>Wrong Document/Chart</li> <li>Illegible/Incomplete</li> </ul>	<input type="checkbox"/> 1.3 Scheduling/ Follow-up <ul style="list-style-type: none"> <li>PCP Appointments</li> <li>Specialist Referrals</li> <li>Inadequate Follow-up</li> <li>Labs/Imaging</li> </ul>	
Clinical Management >	<input type="checkbox"/> 2.1 Diagnosis <ul style="list-style-type: none"> <li>Error in Diagnosis</li> <li>No Diagnosis</li> <li>Delay in Diagnosis</li> </ul>	<input type="checkbox"/> 2.2 Treatment <ul style="list-style-type: none"> <li>Failure to Identify or React to Test Results</li> <li>Failure to Follow Clinical Guidelines</li> <li>Failure to Recognize, Evaluate or Manage Symptoms</li> <li>Failure to Monitor</li> <li>Delayed</li> </ul>	<input type="checkbox"/> 2.3 Procedure <ul style="list-style-type: none"> <li>Not Performed</li> <li>Delayed</li> <li>Incomplete</li> <li>Wrong Patient</li> <li>Wrong Process</li> <li>Wrong Body Part/Side</li> </ul> Type of procedure:	<input type="checkbox"/> 2.4 Screening/ Preventative <ul style="list-style-type: none"> <li>Not Performed When Indicated</li> <li>Delayed</li> <li>Incomplete</li> <li>Wrong Patient</li> <li>Wrong Process</li> </ul> Type of screening:
Medication >	<input type="checkbox"/> 3.1 Missing/Delayed Dose(s) <ul style="list-style-type: none"> <li>Prescribing</li> <li>Dispensing (Pharmacy)</li> <li>Administering (Single Dose)</li> </ul> Please list medication:	<input type="checkbox"/> 3.2 Wrong Patient <ul style="list-style-type: none"> <li>Prescribing</li> <li>Dispensing (Pharmacy)</li> <li>Administering (Single Dose)</li> </ul> Please list medication:	<input type="checkbox"/> 3.3 Wrong Route <ul style="list-style-type: none"> <li>Prescribing</li> <li>Dispensing (Pharmacy)</li> <li>Administering (Single Dose)</li> </ul> Please list medication:	<input type="checkbox"/> 3.4 Wrong Medication/Dosing <ul style="list-style-type: none"> <li>Prescribing</li> <li>Dispensing (Pharmacy)</li> <li>Administering (Single Dose)</li> </ul> Please list medication:
Miscellaneous >	<input type="checkbox"/> 4.1 Medical Device/ Equipment Malfunction Please list device:	<input type="checkbox"/> 4.2 Patient Accident <ul style="list-style-type: none"> <li>Patient Delay/Refusal</li> <li>Patient Fall</li> </ul>	<input type="checkbox"/> 4.3 Patient Self-Harm <ul style="list-style-type: none"> <li>Suicide Attempt</li> <li>Completed Suicide</li> <li>Other non-lethal self-harm</li> </ul>	<input type="checkbox"/> 4.4 Credentialing
	<input type="checkbox"/> 4.5 Unusual Occurrences <ul style="list-style-type: none"> <li>Physical/Sexual Assault</li> <li>Electric Shock</li> <li>Wrong Gas/Toxic Substance</li> <li>Burn/Fire/Explosion</li> <li>Poison</li> </ul>	<input type="checkbox"/> 4.6 Undefined / Unknown Event <i>*An undefined event or series of events that led to patient harm or death.</i> Please describe (Optional):		
Near-Miss >	<input type="checkbox"/> 5.1 An event or situation that could have resulted in an adverse/sentinel event but did not, either by chance or through timely intervention.			

During the first quarter of 2014, documentation errors, which might include missing documentation, wrong chart/documentation, illegible or incomplete documentation, or delayed documentation, were a factor in more than half of the events reported. Another major factor in health incidents was missing or delayed doses of medication, impacting 48 percent of cases reported during the reporting period. (Note: one health care incident may qualify as more than one type of event, depending on the factors involved.) Refer to Figure 12, Health Care Incident Reports by Event Type, First Quarter 2014. A more detailed analysis of all incident reports and RCAs results will be issued in 2014 as the first Patient Safety Program Annual Report, required by current policy.

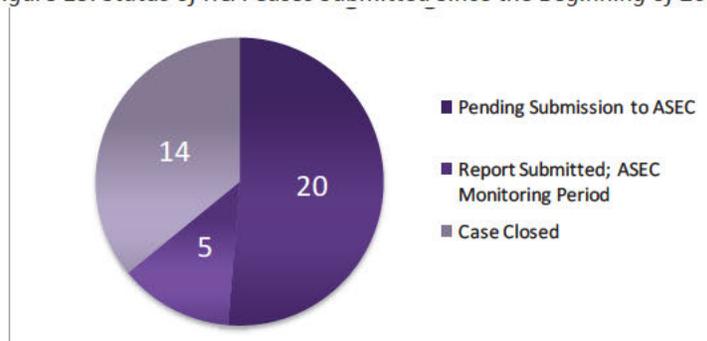
Figure 12. Health Care Incident Reports by Event Type, First Quarter 2014\*



**Root Cause Analysis.** The Patient Safety Program Policy and Procedure introduced new requirements that institutions conduct RCAs for a subset of health care incidents defined as adverse/sentinel events. RCA is a well-tested approach to effectively and efficiently identify and fix fundamental system processes. To support institutions in completing thorough and credible RCAs as required by policy, CCHCS established a standardized RCA procedure and tools, referred to as the RCA Tool Kit; provided statewide training; and made QM Section staff available to assist institutions with RCA facilitation upon request. (A recording of the RCA webinar and the RCA Tool Kit is posted for easy access by all staff on the [Patient Safety](#) page on Lifeline.

Since the beginning of 2013, a total of 39 RCAs had been assigned to institutions or as statewide aggregate RCAs. Once assigned, institutions have 45 days to complete the RCA process and submit a report with findings and an improvement plan. The ASEC gives input to the RCA report and may request clarification or additional work on the analyses. Each RCA report includes performance metrics to ensure that identified root causes have been effectively addressed by the proposed improvement activities and the risk of the adverse event recurring is significantly reduced. After report approval, the institution submits performance measure data to the ASEC, which monitors progress for four months. If the ASEC deems that sufficient progress has been made, the RCA is closed. Refer to Figure 13, Status of RCA Cases Submitted Since the Beginning of 2013, which provides the status of the 39 RCA cases assigned to date.

Figure 13. Status of RCA Cases Submitted Since the Beginning of 2013



During this reporting period, CCHCS completed an Aggregate RCA to address the process for transferring high risk patient-inmates. By late 2013, the ASEC had received multiple reports of near misses and adverse events with a common theme: patient-inmates with complex health conditions were placed at risk of harm during movement from one institution to another. The ASEC assigns Aggregate RCAs when the committee receives multiple health care incidents and adverse events from different institutions linked to the same health care process, circumstances which suggest a systemic failure, rather than an isolated problem at an individual facility.

In an aggregate RCA, multiple incidents involving the same health care process are analyzed simultaneously. The RCA Team includes representatives from several institutions and multiple disciplines, as well as participants from the headquarters program with statewide oversight responsibilities. Fact-finding is conducted at both the institution and headquarters level, and the entire team convenes for the brainstorming session used to identify contributing factors and root causes. In lieu of the action plan submitted for an RCA assigned to an individual institution, the Aggregate RCA team offers a series of statewide projects or activities to improve the statewide process under consideration and performance metrics to assess progress.

The scope of the High Risk Transfer Aggregate RCA encompassed preparation for transfer, actual transportation of patient-inmates, and coordination and continuity of care prior to and upon arrival at the receiving institution. ASEC identified three cases in particular for the Aggregate RCA Team to analyze, but by the time the RCA process had been completed in March 2014, an additional 10 transfer-related events had been incorporated as well. These additional 10 cases did not receive the same focused review by the RCA Team, but the issues highlighted in these cases were considered in the development of the Plan of Action.

During the previous reporting period, CCHCS convened an Aggregate RCA Team of institution staff with direct knowledge of and involvement in transfer processes at four institutions with a high volume of high risk patient-inmates – California Institution for Men (CIM), California Men’s Colony (CMC), California Medical Facility (CMF), and CHCF. The RCA Team included headquarters staff from health care and custody programs that support and oversee health care transfers and QM staff facilitating and supporting the RCA process.

During this reporting period, the Aggregate RCA Team completed fact-finding efforts to understand in detail what occurred in the three transfer cases highlighted in the RCA, as well as how communication and care coordination typically occurs during transfers. The RCA Team met at headquarters in January 2014 to identify the factors that cause breakdowns in the transfer process and specific root causes for the three focus events. In addition, the Aggregate RCA Team arrived at a number of improvement projects to address these root causes and mitigate risks to patient-inmates. A subsequent session was scheduled for March 2014 with custody staff to discuss the custody processes that may have impacted these cases, and possible improvements to health care-custody communication processes. The final RCA report was submitted to the ASEC at the beginning of May 2014 and is pending review and approval.

Patient Safety Culture Survey. A key element in increasing health incident reporting, effectively conducting RCAs, acting upon the RCA results – and other important, foundational aspects of the Patient Safety Program – is to establish a culture of safety and improvement at institutions statewide. In February 2014, the Patient Safety Committee surveyed health care staff statewide as an initial effort to educate staff about the factors that directly impact a patient safety culture – many of them related to the workplace environment and how staff communicate with one another. The Patient Safety Culture Survey had four main objectives:

- Raise awareness of the new Patient Safety Program.
- Perform a baseline assessment of the safety culture in our organization, including specific strengths and weaknesses.
- Identify institution-level and statewide trends or themes.
- Provide tools and resources to staff to support positive changes in our patient safety culture.

To prepare for the survey, institution Chief Executive Officers (CEOs) selected a survey coordinator at each institution. QM staff supporting this initiative oriented institution leadership teams and survey coordinators to the project in January 2014. Many institution executives and survey coordinators took the Patient Safety Culture Survey in advance of statewide implementation as part of preparing for local implementation. Each institution was provided with an implementation package that included marketing materials.

The survey took place during a three-week period from February 17 through March 7, 2014. To complete the survey, staff accessed a slightly modified version of a culture survey created by the federal Agency for Healthcare Research and Quality, an electronic process requiring about 10-15 minutes to complete. The goal was to achieve a 50 percent participation rate statewide by the end of the three-week survey period. QM Section staff provided executives at headquarters and in the field with weekly reports on survey participation to assist them in achieving the statewide goal.

By the close of the survey, more than 5,400 CCHCS staff had responded to the survey, a response rate of 53 percent. At three institutions, High Desert State Prison (HDSP), Avenal State Prison (ASP), and North Kern State Prison (NKSP), more than 70 percent of staff took the survey. Among major disciplines statewide, mental health and dental staff had the highest response rates at about 60 percent. Refer to the Patient Safety Culture Survey Participation Report included in [Appendix 7](#).

In March and April 2014, QM staff began to analyze survey data in preparation for release of reports that will be customized for each institution, as well as headquarters and regional level reports. In addition, staff began to research evidence-based practices, tools, and other resources to support managers, supervisors, and quality improvement teams in effectively addressing survey findings and promoting a culture of safety and improvement. The Patient Safety Committee intends to repeat the survey to assess changes over time.

***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. However, discussions are continuing with OIG and the Plata Court Experts to discuss possible refinements to the OIG's inspection program.

**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:

**Statewide Performance Improvement Plan**

Three years ago, CCHCS established its first statewide PIP, which outlines the organization's major improvement priorities, lists statewide performance objectives, and describes major improvement strategies. The PIP is updated periodically as performance objectives are met and new priorities emerge, and is posted on the Lifeline Intranet.

After vetting with CCHCS staff at different levels of the organization, the headquarters Quality Management Committee (QMC) finalized the PIP for 2013–15 during the last reporting period. While the statewide PIP retains many measures from the 2011–12 version of the PIP, it also includes many new metrics. During this reporting period, QM staff continued to work on the methodology, data collection, and validation for new PIP measures, which are displayed monthly in the Health Care Services Dashboard. By April 2014, 85 percent of the PIP metrics have been incorporated into the Dashboard, with anticipated completion for the remaining measures by close of the next reporting period.

#### Institution Performance Improvement Work Plans

Per current policy, institution leadership teams are required to update their local Performance Improvement Work Plan (PIWP) every 12 to 15 months. This annual requirement presents an opportunity for institutions to celebrate the progress they have made to date, identify improvement initiatives from the prior year's plan that still need work, and consider new priorities for the coming year. By the close of the PIWP process, institutions establish clear improvement priorities and a unified purpose for institution health care staff, which is essential to successful improvement work. The deadline for submission of institution PIWPs was February 28, 2014. All the institutional PIWPs were received during the reporting period.

Institutions are required to update their PIWP monthly to reflect current status of improvement projects. Updated PIWPs are uploaded on each institution's homepage on the QM Portal. As of the end of April 2014, 76 percent of institutions had updated their PIWP at least once in the two months since initial submission of the PIWP.

#### Institution Quality Management Support Units

In September 2013, a more formal process began at several institutions to reorganize existing resources into Quality Management Support Units (QMSUs) to better focus on QM and patient safety activities in a more integrative, efficient and effective approach across program areas. Units of staff with systems improvement expertise dedicated full-time to activities such as performance evaluation and process redesign are commonplace in the broader health care industry. Typically, the role of these units within the organization is to support and integrate activities related to the following:

- Prioritizing areas for improvement, including health care system surveillance.
- Analyzing quality problems.
- Planning and designing improvement initiatives.
- Testing improvements, and as appropriate, implementing them institution-wide.
- Evaluating performance.
- Active management of the QM System and individual improvement projects through an improvement committee structure.

As these institutions have established their Units, the demand for specialized training has grown. QMSU staff not only seek staff development in classic improvement techniques, such as performance measurement, problem analysis, process redesign, and rapid-cycle improvement, but other more broadly-applied skill sets, such as project management, meeting/group facilitation, committee coordination, and strategic planning. In response, the QM Section is in the midst of developing a standardized curriculum for QMSU staff.

The QM Section already provides QMSU staff with a two-day orientation to the Quality Management and Patient Safety Programs, called the QM Academy. To accommodate the influx of new QMSU members at the end of 2013, the QM Section has been offering the QM Academy more frequently. During this reporting period, the QM Section held QM Academies in January and March, providing training to 78 QMSU staff representing 13 institutions. Additional sessions will be held periodically in the future as the need arises.

In addition, the QM Section continued to develop advance topic training for QMSU staff. Building upon the broad orientation provided during the two-day QM Patient Safety Academy, the advanced modules focus intensively on certain QM skills and techniques, with the intent to promote skills development in areas critical to performance improvement. To develop advance topic training, the QM Section will draw upon training resources from nationally-recognized quality improvement organizations, such as the federal AHRQ, National Committee on Quality Assurance, and Institute for Healthcare Improvement, among others. During the next reporting period, the QM Section will develop a database to establish a census of all QMSU staff, track all QM-sponsored training completed by QMSU staff, and contact staff who have not yet received orientation and training.

#### Quality Management Maturity Matrix

Though the Quality Management Program Policy and Procedures have been in place for nearly two years, many headquarters and institution staff do not have a clear understanding of current standards and best practices in quality improvement and performance evaluation.

To help all CCHCS staff better understand what a well-functioning QM system looks like, CCHCS began development of a QM system assessment tool during this reporting period. Entitled the "QM Maturity Matrix," the self-assessment tool is intended to present a clear, concrete description of what key QM components look like at beginning, intermediate, and advanced levels of implementation. Institutions will be able to use the tool to identify where they are in adherence to statewide Quality Management and Patient Safety Program standards, and what they need to put into place to move forward with their local QM systems.

Full implementation of institution QM systems is critical to successful transition to State management of the prison health care system. In health care organizations, patient-inmate safety and QM systems are the primary mechanisms by which organizations prevent, detect, and resolve problems that impact quality of care and present risk to patient-inmates. It is through patient-inmate safety and QM functions that CCHCS demonstrates that it can independently identify threats to quality of care and implement effective solutions – a basic requirement for sustaining adequate care.

#### Statewide Improvement Initiatives – Input from *Plata* Court Experts

During 2013, the *Plata* Court Experts conducted site visits to ten institutions to evaluate the quality of care. Their comprehensive evaluations concluded that, while care was generally adequate at two of the ten institutions (subject to certain conditions), care was inadequate at the remainder. At a meeting with the *Plata* Court Experts in December 2013 to review the reports, it became clear from the reports and the discussion with the *Plata* Court Experts that, while there have been improvements in many areas of the medical care system, there remained a number of systemic problems that had not been fully corrected, including problems in the following areas: intersystem and intrasystem transfers (where frequent gaps in continuity of care persist); medication management; appropriate sanitation and cleanliness; and routine, on-site oversight and monitoring of institutions. In Judge Thelton Henderson's March 11, 2014, Court Order Re: Court Experts, the federal court directed the *Plata* Court Experts to shift their focus from individual institution evaluations toward more system-wide problems. "To that end," the Court stated, "the court experts are directed to assist headquarters, regional, and facility staff in correcting systemic issues that the experts have identified in their first ten reports."

As an initial step in this collaboration with the *Plata* Court Experts, the headquarters QMC completed an analysis of the ten reports with findings from the *Plata* Court Experts' visits to individual institutions and identified sweeping themes in these reports. In addition, the QMC gathered information about improvement activities intended to address the identified problem areas that are currently in process. During the next reporting period, QMC members intend to present this information to the *Plata* Court Experts and seek their feedback about additional improvement activities that might be required to correct systemic issues.

#### Statewide Improvement Initiative – Scheduling System

Starting in February 2013, CCHCS began rolling out an enterprise-wide Medical Scheduling and Tracking System (MedSATS) to improve the scheduling process, increase timely access to medical services, and establish a single centralized and standardized medical scheduling system for all institutions. In the last half of 2013, CCHCS launched a Scheduling Process Improvement Initiative to provide institution leadership with a structured process and new tools available through MedSATS implementation to improve access to care and scheduling efficiency locally. To apply the new structured process and tools, institution staff learn specific quality improvement techniques, building institution capacity to improve other critical health care processes in the future.

Though MedSATS presents a rich source of data to track and improve access to care, it is only as useful as the data is accurate. During this reporting period, CCHCS continued to support institutions as they fully implement the new scheduling system and draw data from the system to improve care.

Beginning in February 2014, QM staff worked closely with CHCF to put the scheduling system and new scheduling processes in place at that institution. CHCF's complex patient-inmate population also has complex scheduling needs; a single patient-inmate is subject to rounds every 72 hours in addition to regularly-scheduled chronic care encounters, episodic care appointments as needed, annual evaluations, frequent specialty appointments (such as dialysis), and follow-up appointments after return from higher level of care, urgent care, and other patient-inmate care events. The QM Section helped CHCF staff to:

- Learn the full scope of MedSATS appointment options and reporting tools.
- Define how encounters would be recorded, especially in care areas that present unique challenges, such as Receiving and Release, emergency medical services, high-acuity, and dialysis.
- Document scheduling processes in formal workflows and step-by-step desk procedures.
- Provide ongoing training to staff as they apply new procedures.
- Reduce the backlog of appointment data entry, such as identifying appointments that have been completed and need to be closed.

This support included multiple site visits and training for more than 100 Medical Assistants, nurses and nursing supervisors, and Office Technicians.

The QM Section provided similar support services to a number of other institutions on an ad hoc basis to provide MedSATS training and help resolve specific scheduling issues. During this reporting period, the QM Section fielded more than 500 e-mails from staff at 15 different institutions requesting MedSATS technical assistance, and many of these contacts resulted in follow-up by phone. For some institutions with a large volume of open appointments, QM staff matched encounter data against documentation in the scanned health record to identify appointments that should be closed, because there was documented evidence that an encounter had occurred.

The QM Section also began a second round of MedSATS validation during this reporting period. During the last reporting period, a team of analysts under the supervision of clinical staff matched MedSATS data points against corresponding information in the patient-inmate health record to ascertain data accuracy, emphasizing those data elements used to calculate access measures on the Dashboard. CCHCS provided each CEO with a report with validation findings, indicating not only areas where data integrity might be problematic, but areas where the institution may wish to focus access to care improvements. Institutions were provided with a number of tools to help them improve data accuracy and overall access to care.

In March 2014, CCHCS initiated a second validation project to determine whether institutions have been able to resolve problems with data accuracy and identify potential best practices in both MedSATS implementation and access to care. Validation results will be issued in summer 2014.

***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 over all 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 January through April 2014.

***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 units 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. Ongoing efforts are as follows:

CCHCS' Private Prison Compliance and Monitoring Unit (PPCMU) continues to conduct on-site compliance reviews of the existing four Out-of-State Correctional Facilities and the seven In-state Community Correctional Facilities contracted to provide housing to California patient-inmates, ensuring compliance with the Remedial Plan developed in July 2008 and to meet the Court mandate to provide a constitutional level of medical care. An accurate and objective review of each facility is critical to ensuring compliance with the RTPA. PPCMU staff conduct bi-annual audits of each of the contracted facilities under its purview and submit final audit reports to executive management.

In an effort to ensure Corrections Corporation of America's (CCA) compliance with the remedial plan developed in July 2008 and the Modified Community Correctional Facilities' (MCCF) compliance with the IMSP&P, the following was accomplished:

- CCA policy and procedure review and approval.
- California Out-of-State Correctional Facilities (COCF) compliance audits.
  - The results reflect an overall compliance rating surpassing the required 85.0 percent mark (refer to Figure 14, Compliance Rating).

*Figure 14. Compliance Rating*

Facility	Compliance Score
FCC	94.1%
LPCC	96.2%

- MCCF compliance audits and training.
- Unit health clinical performance appraisals of CCA primary care providers.
- Weekly physicians' collaborative conference call updates on COCF patient-inmates.
- Weekly MCCF collaborative conference call.
- Patient-inmate population realignment:
  - As a result of the CDCR Population Redistribution Project, the PPCMU and the CCA Regional Medical Director collaboratively updated over 4,000 Medical Classification Chronos (CDCR 128-C3) for patient-inmates housed in out-of-state facilities.

In-State Modified Community Correctional Facilities

As part of the efforts to meet the Court mandated population capacity of 137.5 percent, CDCR initiated an effort to redistribute the inmate population housed in and out of state. One component was to reactivate and relocate inmates to MCCFs within California. During this reporting period, Delano MCCF was activated on January 6, 2014, and Taft MCCF was activated on February 17, 2014.

CDCR has signed contracts to reactivate a female MCCF, McFarland Female MCCF, with activation forecasted for June or July 2014, with a bed capacity of 260.

Each MCCF is designated a 'hub' institution, one of CDCR's adult institutions. One of the hub institution's responsibilities is to facilitate health care services beyond which the MCCF is contractually bound to provide. These types of services are typically for urgent care situations, lab tests, or an evaluation for mental health, dental, specialty care referral, or medication. The assigned hub institutions and associated populations as of April 25, 2014, are listed in Figure 15, MCCFs by Hub Institution.

Figure 15. MCCFs by Hub Institution  
MCCFs by Hub Institution

	Capacity	Population
<b>California State Prison, Los Angeles County</b>		
• Desert View	700	694
<b>North Kern State Prison</b>		
• Central Valley	700	691
• Golden State	700	694
• Delano	578	549
<b>Wasco State Prison</b>		
• Shafter	640	633
• Taft	512	501
<b>Totals</b>	<b>3,830</b>	<b>3,762</b>

Contracted Bed Population

CCHCS utilizes the services of clinical and administrative staff to monitor and ensure the medical needs of the patient-inmate population are addressed in a timely manner within all contract beds. In a continuing effort by CDCR to reduce the overall patient-inmate population within the existing state institutions, there has been consistent movement into MCCFs, thereby increasing the total number of contract beds (both in and out of state is 12,414). As of April 25, 2014, the total number of patient-inmates housed in contracted beds. Refer to Figure 16, Total Contracted Beds.

*Figure 16. Total Contracted Beds*

<b>Contract Facilities Out of State</b>	<b>Location</b>	<b>Population</b>
Florence Correctional Center	Arizona	571
La Palma Correctional Center	Arizona	2,934
North Fork Correctional Facility	Oklahoma	2,468
Tallahatchie County Correctional Facility	Mississippi	2,679
	Subtotal	8,652
<b>Contract Facilities in State</b>	<b>Location</b>	<b>Population</b>
Central Valley MCCF	McFarland	691
Desert View MCCF	Adelanto	694
Golden State MCCF	Bakersfield	694
Shafter MCCF	Shafter	633
Delano MCCF	Delano	549
Taft MCCF	Taft	501
	Subtotal	3,762
	<b>Total</b>	<b>12,414</b>

## **Goal 5: Establish Medical Support / Allied Health Infrastructure**

### **Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program**

***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 January through April 2014.

***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 is completed.

### **Objective 5.3. Establish Effective Imaging/Radiology and Laboratory Services**

***Action 5.3.1. By August 2008, decide upon a 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 following strategy to improve radiology services statewide has been established:

- CCHCS has fully implemented the Radiology Information System and Picture Archiving and Communication System (RIS/PACS) statewide, along with the Nuance voice recognition software to improve report turn-around-times.
- Training in use and access of RIS/PACS has been provided to all affected staff.
- Mobile imaging services are available at all institutions, and electronic transmission capabilities are at all locations with the exception of the CMF and DVI. (Additional work is needed to ensure reliable connectivity at a few sites and to upgrade to October 2012 network and power box standards).
- All pre-RIS/PACS imaging records from all institutions have been sorted and filed at the imaging Record Center where they are uploaded as needed.

- A single statewide provider (a radiology group) has been contracted to provide radiology interpretation services, increasing consistency and standardization of protocols, cost savings, and more effective quality control.
- The provider of statewide radiology interpretation services also provides Radiology Supervisor and Operator (RS&O) oversight to all institutions, and quarterly mammography program review at the women's institutions. These services ensure coverage, standardization of practices, and improvement in quality control activities. Over 20 institutions have had their 2014 RS&O inspections with the remaining institutions to be scheduled this summer.
- The six hour timeframe for report turnaround times is being maintained, due to statewide use of the RIS/PACS.

#### Laboratory Services

The following strategies to improve laboratory services statewide have been established:

- The previously reported plan to implement a statewide Enterprise Laboratory Information System (LIS) has been revised. Laboratory results reporting will be incorporated into the EHRS currently under development. The system will also allow for logistic tracking of specimens and testing turnaround time, review of services, and other management reports. A full LIS will be an integral part of the EHRS.
- Evaluation of Point of Care (POC) testing practices in the institutions is in progress including, in particular, glucose and anticoagulation POC testing devices, as well as any other POC test devices in use. The goal is to standardize practices in the institutions and to enhance patient-inmate care and patient-inmate safety.
- Guidelines to assist clinicians in obtaining indicated lab studies for particular conditions based on CCHCS Care Guides and other recommendations are being created during development of 'order sets' for implementation of the EHRS.
- Since implementation of an electronic order system by our contract referral lab in February 2013, compliance with use of the electronic order form has increased to 96 percent statewide.

#### **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.

#### **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**

Construction of the DNCA, which is the second of the two major projects planned for the purpose of adding new medical and mental health beds to the CDCR system, is essentially complete. Construction of the CHCF was completed in August 2013. However, as previously reported and updated below, the Receiver halted further intake of medical patient-inmates on January 27, 2014, to the CHCF in order to improve the supply chain system and delivery of care. Also, because DNCA will rely upon many of the systems at CHCF, a new patient-inmate activation schedule for DNCA has been approved to ensure that CHCF is operating appropriately to support the operations at DNCA.

Regarding the HCFIP, which includes upgrades to add/renovate exam rooms and related health care treatment space, as well as improvements to medication distribution at existing prisons, 26 projects have now received project approval from the State Public Works Board (SPWB). Twenty-four projects have received interim loans from the Pooled Money Investment Board (PMIB). PMIB loans are not required for the statewide medication distribution projects, which are funded through State general funds. Following the March 2014 SPWB approval of the Kern Valley State Prison (KVSP) and Pleasant Valley State Prison (PVSP) HCFIP projects, the Department of Finance (DOF) determined that the total amount of the Senate Bill (SB) 1022 appropriation available for the HCFIP projects had been exhausted and additional funding needed to be authorized before the SPWB could establish the last five projects. Subsequently, additional funding was approved by both budget subcommittees of the Legislature in May and await final action by the Legislature and the Governor in the proposed 2014–15 Governor’s Budget. Thus, SPWB approval for the Centinela State Prison (CEN) and Calipatria State Prison (CAL) projects will be delayed from May 2014 until July 2014 at the earliest.

As it relates to HCFIP project construction schedules, CDCR has been meeting with site and headquarters health care management staff in order to develop site-specific operational continuity plans. Since much of the HCFIP construction involves renovations of existing health care buildings and spaces, CDCR and CCHCS are identifying site mitigation measures to minimize adverse impacts and address operational needs, swing spaces where necessary, and other measures to ensure health care services continue to be delivered to the patient-inmates during construction. These operational continuity plans may result in some changes and increases to the construction schedules.

**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**

Initial SPWB project approvals have been secured for all 10 of the intermediate level-of-care projects, the four reception center projects, and 11 of the 17 basic level-of-care projects, along with the statewide medication distribution projects. There are five projects remaining to be submitted for SPWB project approval and six projects to be submitted for PMIB interim funding approval. The HCFIP project at ASP will be a fiscal year 2014–15 minor capital outlay project. A decision by the Administration relative to continued use or closure of California Rehabilitation Center (CRC) has not been released and thus, the need or plan for clinical renovations at CRC is still pending. Construction is expected to begin in summer 2014 for the statewide medication distribution projects and for the first HCFIP projects, which will be the CMF and California State Prison, Solano (SOL).

On April 24, 2014, the California State Treasurer completed a bond sale. A portion (\$152,420,000) of the proceeds will be used to fully finance the HCFIP projects at California State Prison, Sacramento (SAC), Mule Creek State Prison (MCSP), and California State Prison, Lancaster (LAC). The remaining proceeds of the 2014C Bonds will be used to partially finance the HCFIP at CIM and Folsom State Prison (FSP).

***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:

There are five projects remaining to be submitted for SPWB project approval (CEN, CAL, Ironwood State Prison, Chuckawalla Valley State Prison (CVSP), and Pelican Bay State Prison) and six projects for PMIB interim funding approval (includes PVSP). The HCFIP project at ASP will be a fiscal year 2014–15 minor capital outlay project based on the cost and scope of work to be completed. Although CRC was previously slated for closure through provisions of SB 1022, most recently the statute to close CRC was suspended in SB 105 and a decision on the future use of CRC has not yet been provided. Thus, no evaluation, plans or schedule for clinical upgrades at CRC have been provided.

Following SPWB approval of the KVSP and PVSP projects at the April 2014 meeting, DOF has determined that the funding authorization available for the HCFIP projects in SB 1022 has been exhausted and that additional funding authority needs to be established before SPWB approval of the last five projects can occur, which as noted above, is awaiting final action by the Legislature and the Governor. This will delay the SPWB approvals of CAL and CEN from May 2014 until July 2014 at the earliest and present additional risk in completion of all of the last five HCFIP projects.

***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:

The preliminary design for each of the projects by an architectural and engineering (A&E) firm begins once SPWB project and PMIB loan approvals have been obtained. The contracts with A&E firms for site-specific preliminary plans have been executed for all of the authorized projects except for the last two projects that are being finalized. The completed preliminary plans must be approved by the SPWB and DOF before the A&E firm can proceed to preparation of the working drawings and bid these projects for construction. There are 12 projects in the preliminary planning phase; Central California Women's Facility, Valley State Prison (VSP), California Training Facility, Salinas Valley State Prison (SVSP), California Correctional Institution, Sierra Conservation Center, Substance Abuse Treatment Facility, COR, California Correctional Center, HDSP, PVSP, and KVSP.

Preliminary plans for FSP, CMC, and LAC received SPWB approval in February 2014 and preliminary plans for DVI, NKSP, and Wasco State Prison (WSP) were approved in April 2014. Construction drawings are currently being prepared for 14 projects; the SWMD modifications, CMF, SOL, CIW, CIM, Richard J. Donovan State Prison (RJD), SAC, MCSP, FSP, CMC, LAC, DVI, NKSP, WSP, and CVSP. The current schedule shows construction of the first two HCFIP projects (CMF and SOL) will start in mid-2014 and the last HCFIP project (CVSP), will be completed in late-2017.

**Objective 6.2. Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs**

Construction of CHCF was completed in August 2013 and the first patient-inmates were received on schedule in July 2013. However, defects occurred in the hydronic loop, which provides hot water and heating for the facility. Since the last reporting period, repairs were made by the design-builder and there have been no further system leaks. Nonetheless, CDCR has contracted with a scientific/engineering firm to perform a forensic analysis of the causes for the failures and intends to pursue the appropriate remedies.

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

This action item is complete.

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

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

Construction of CHCF and DNCA is essentially complete.

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

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

Construction of CHCF and DNCA is essentially complete. The contractors have reached all of their milestones and received the State Fire Marshal occupancy permit. Inmate workers started arriving as transfers from CHCF on April 1, 2014. Since DNCA will rely upon many of the systems at CHCF, CCHCS and CDCR leadership approved a revised, phased intake schedule for patient-inmates at DNCA to allow time to ensure that CHCF is operating appropriately in order to support the operations at DNCA.

**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. Electronic Health Records System**

As part of a multi-stage proposal process for an EHRs, an award was made to Cerner Corporation on June 25, 2013. CCHCS and CDCR are working with Cerner Corporation to plan, configure, and implement at all facilities, a commercial-off-the-shelf EHRs solution.

The implementation of an integrated EHRs will afford CCHCS and CDCR demonstrable and sustained benefits to patient-inmate safety, quality and efficiency of care, and staff efficiencies and satisfaction. It will help facilitate policy adherence, as well as monitoring and reporting our performance in a variety of arenas, including: scheduling and access to care, continuity of care, medication management, evidence-based health care practices, resource management, primary care model implementation, effective communication, patient-inmate education, and system management.

The project is marketed under the tagline "ECHOS" (Electronic Correctional Healthcare Operational System) and is presently in the Design/Configure phase. Solution teams, comprised of subject matter experts and analysts from program and regional and institutional staff, are presently focusing on configuring future State workflows for over 150 health care delivery processes. The future State workflows will be standardized enterprise-wide and include: medication administration, medical and mental health scheduling, computerized provider order entry and chronic care management. Project Communication and Organizational Change Management team members have initiated the Learning and Adoption phase that incorporates the indoctrination of system-wide Change Ambassadors, both at the local level and at headquarters operations, who will facilitate the introduction of project specifics to their respective staffs. Additionally, the training plan and materials are being developed to support the "Go Live" implementation of the system.

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

### **A. CCHCS Activities related to the Court's June 24, 2013, Order Granting Plaintiffs' Motion for Relief Re: Valley Fever at Pleasant Valley and Avenal State Prisons**

In February 2014, CCHCS and CDCR received the final report from National Institute for Occupational Safety and Health (NIOSH) with recommendations to reduce the risk of cocci for employees at ASP and PVSP. The recommendations included items that CDCR will need to implement to protect our employees. The recommendations are divided into engineering controls, administrative controls, and personal protective equipment.

CCHCS and CDCR continue to await the final report from the federal Centers for Disease Control on the predicted impact of the use of the cocci skin test to exclude susceptible patient-inmates from prisons with extremely high rates of cocci (i.e., ASP and PVSP) versus our current strategy of exclusion based on risk factors (i.e., Filipino or African American race or diabetes). There is ongoing surveillance for cocci; the number of cases at ASP and PVSP is lower this year compared with prior years primarily because of both a lower population in these prisons and environmental conditions (drought) that are not conducive to the growth of cocci. Between September 1, 2013, and April 15, 2014, there were 17 new cases of cocci at ASP, 8 new cases of cocci at PVSP, and 39 cases at other institutions.

We plan to continue surveillance for cocci statewide and encourage CDCR to implement the NIOSH recommendations.

### **B. Overcrowding Update**

As noted in the last report, California's prisons remain significantly overcrowded. As of the end of this reporting period, California's prison population stood at 134,888, which was an increase of 639 patient-inmates since the last reporting period. CCHCS awaits the publishing of CDCR's spring 2014 population projections to determine future trends for the inmate population. We will provide an update of that report, and its significance, in the next Tri-Annual report.

As mentioned in the previous Tri-Annual report, the Court had ordered both parties to engage in a meet and confer process to "explore how defendants can comply with [the] Court's June 20, 2013, Order, including means and dates by which such compliance can be expedited or accomplished and how [the] Court can ensure a durable solution to the prison crowding problem." (Three-Judge Court, Order to Meet and Confer, p. 2. September 24, 2013). When parties failed to reach an agreement, the Court subsequently ordered both parties to submit their proposed orders for compliance, which both parties did.

On February 10, 2014, the Court issued its order that granted the State's request for an extension until February 28, 2016, but required the State to meet the following interim benchmarks:

- 143 percent of design bed capacity by June 30, 2014;
- 141.5 percent of design bed capacity by February 28, 2015; and
- 137.5 percent of design bed capacity by February 28, 2016.

The order requires the State to immediately implement the following components:

- Cap out-of-state placements at 8,900;
- Increase credit-earning for non-violent second strike offenders and minimum custody patient-inmates;
- Implement new parole determination process for non-violent second strikers who have served half of their sentence;
- Parole certain inmates serving indeterminate terms who have been granted future parole dates by the Board of Parole Hearings;
- Expansion of existing medical parole process;
- Implementation of new parole process for patient-inmates 60 years of age or older who have served at least 25 years in state prison;
- Activation of new re-entry hubs at a total of 13 prisons to be operational by February 2015;
- Expansion of pilot re-entry programs with additional counties/local communities; and
- Expansion of alternative custody program for female inmates, and
- Appointment of a "compliance officer" empowered to order necessary releases (in a subsequent order, the Court appointed the Honorable Elwood Liu as the compliance officer).

The Court ordered CDCR to submit monthly status reports on its progress to implement the provisions listed above.

## **Section 6: Other Matters Deemed Appropriate for Judicial Review**

### **A. Coordination with Other Lawsuits**

During the reporting period, regular meetings between the three Courts, *Plata*, *Coleman*, and *Armstrong* (Coordination Group) class actions have continued. Coordination Group meetings were held on January 22 and February 25, 2014. Progress has continued during this reporting period and is captured in meeting minutes.

### **B. Master Contract Waiver Reporting**

On June 4, 2007, the Court approved the Receiver's Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders issued since that date. The approved project areas, the substitute bidding procedures and the Receiver's corresponding reporting obligations are summarized in the Receiver's Seventh Quarterly Report and are fully articulated in the Court's Orders, and therefore, the Receiver will not reiterate those details here.

As ordered by the Court, included as [Appendix 10](#) is a summary of the contracts the Receiver awarded during this reporting period, including a brief description of the contracts, the projects to which the contracts pertain, and the method the Receiver utilized to award the contracts (i.e., expedited formal bid, urgent informal bid, sole source).

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

During this reporting period, the Office of the Receiver, at the direction of the *Plata* Court, has entered into a consulting services agreement with Kemper Consulting Group, for Lee D. Kemper to provide oversight and executive direction for all activities pertaining to the oversight of the Prison Health Care Provider Network; to the re-procurement of the contract for Prison Health Care Provider Network services; to the existing contract for Prison Health Care Provider Network services; and to any other contracts with the contractor currently providing Prison Health Care Provider Network services.

## D. Overview of Transition Activities

### Post-Delegation Report for Health Care Access Units

#### Access Quality Report

The published Access Quality Report (AQR) remains unchanged from the time of the Health Care Access Unit (HCAU) Delegation of Authority. The Receivership continues to receive the required monthly data from institutions. As forecasted in the last reporting period, the new time and shift system ("TeleStaff") does not provide certain data points the institutions are required to report to complete the AQR. During the reporting period, all but three institutions have transitioned to the new system. TeleStaff continues to require adapted data retrieval methods for Transportation and Medical Guarding hourly overtime, permanent intermittent employee, and redirected staff hours. Since the majority of the institutions were unable to extract the data utilizing their available resources, Field Operations staff trained HCAU analysts at two-thirds of the institutions on these new methods.

Field Operations staff has refined the monthly AQR data validation process. The improved process consists of several phases, which take into account the results of the institution's operations monitoring audits (OMA), individual training and discussion with field analysts, and review and analysis of 12 months of published AQR data. As a result, the accuracy and validity of reported AQR data has improved considerably.

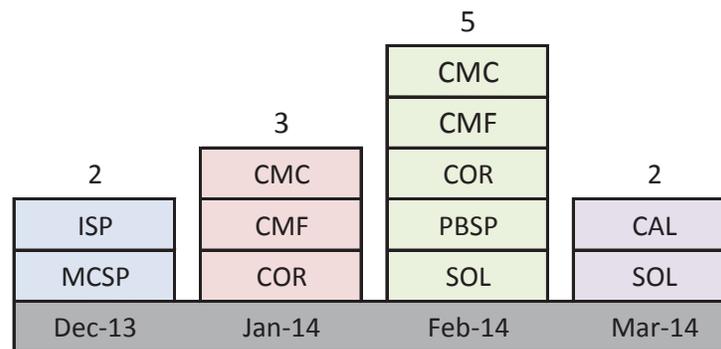
The AQR data from SQ was excluded from the December 2013 statewide rollup, as the data reported on the December AQR data was determined invalid due to the identification of serious flaws in data collection and reporting methods used by the institution. On February 19, 2014, Field Operations provided focused training addressing the issues identified in December 2013, and assisted the newly-assigned HCAU Analyst in establishing a thorough understanding of data collection processes and reporting rules. A "paper audit" was conducted in April 2014 to assess the validity of February 2014 data with the intent to resume publishing AQR data from SQ commencing March 2014.

AQR data from FSP has also demanded scrutiny due to the institution's approach regarding the AQR counting rules specifically regarding counting urgent and emergent treatment and triage area encounters and Transportation and Medical Guarding redirect hours. Throughout the document production process for FSP's recent Round II OMA, FSP staff demonstrated a high degree of difficulty producing valid/verifiable data, which resulted in an overall AQR validity rating of 42.5 percent, a decline of 17.8 percent from the Round I audit. Field Operations has extended numerous training offers to FSP in recent months regarding these reporting discrepancies. None have been accepted by FSP to date.

### Custody Access to Care Success Rate

Statewide AQRs were published for the months of December 2013, January 2014, February 2014, and March 2014 during the Tri-Annual reporting period. The average custody *Access to Care Success Rate* for this period was 99.58 percent. This represents a decrease of 0.01 percentage points as compared to the previous reporting period (inclusive of data from August through November 2013). Figure 17, *Institutions Failing to Attain the 99 Percent Standard for the Custody Access to Care Success Rate*, is a summary by month of the number of institutions failing to attain the 99 percent benchmark established in the delegation.

Figure 17. *Institutions Failing to Attain the 99 Percent Standard for the Custody Access to Care Success Rate*



For institutions failing to attain the benchmark, 12 Corrective Action Plans (CAP) were required during this reporting period. All plans were received.

### Operations Monitoring Audits

As outlined in the HCAU Delegation of Authority, Field Operations continues to conduct HCAU OMA at the adult institutions of the CDCR. During this reporting period, Field Operations staff conducted a total of 12 Round II audits, each of which occurs approximately 180 days following the Round I audit of the same institution.

From January 1 through April 30, 2014, Field Operations conducted Round II audits at 10 institutions, utilizing the same methodology relied upon for Round I audits (refer to Figure 18). Official findings were published for 10 Round II audits as well. Of the 10 published reports, the institutions averaged a score of 91.8 percent compliance; an average improvement of 4.35 percentage points. No institution audited during this timeframe scored below the benchmark of 85 percent overall. However, compliance scores for individual chapters within the audit indicate systemic non-compliance, averaging below 85 percent for all the institutions audited, in the following two areas:

- *HCAU Staffing* (80 percent), and
- *Access Quality Reports* (78 percent).

Specifically, these scores hinged upon the non-compliant institutions' failure to (a) notice the Office of the Receiver upon making changes to HCAU staffing, as required by the Delegation, and (b) adhere to the AQR Counting Rules and Instruction Guide in the accomplishment of reporting access to health care data for the monthly AQR.

**Figure 18. Audit Reports Published  
January - April, 2014**

Institution	Round II	Change from Round I
SVSP	85.3%	+6.2
KVSP	95.3%	-0.2
CMF	88.4%	-1.5
SAC	93.2%	+10.4
MCSP	90.2%	+1.3
SOL	93.7%	+0.2
DVI	89.3%	+3.0
FOL	92.6%	+9.5
HDSP	95.7%	+6.1
CRC	94.0%	+8.5

#### Failure to Resolve Round I Corrective Action Plan (CAP) Items

The following institutions' Round II OMA findings evidenced quantitative CAP items, identified during Round I audits, which had not been resolved or significantly improved by the time of the Round II audits. The institutions' continued non-compliance in these *fully correctable* areas, as shown in Figure 19, Institutions' Areas of Non-Compliance, demonstrates a lack of attention to these important issues.

Figure 19. Institutions' Areas of Non-Compliance

INSTITUTION(S) FAILING TO RESOLVE	CAP ITEM
SVSP	The Warden or appropriate designee is not in attendance at all QMC meetings.
SVSP	The local operational procedure (OP) for HCAU is out of date; and the organizational chart attached to that procedure is not approved/signed by the Warden and CEO.
SVSP	Nursing staff are not being notified by custody staff in a timely manner regarding inmate bed moves.
SVSP	Custody staff are not ensuring that patient-inmates being trans-packed for transfer are retaining their keep on person (KOP) medications, and taking them with them to Receiving and Release (R&R) on the date of transfer. KOP medications are frequently being packed with the personal property.
SVSP	Custody staff are not consistently carrying a personal cardiopulmonary resuscitation (CPR) mouth shield in their immediate possession at all times while on duty.
SVSP	Suicide cut-down kits do not contain all items required by the Mental Health Services Delivery System Program Guide.
SVSP, DVI	Suicide cut-down kits are not consistently or accurately inventoried, as required.
CMF, FOL	Custody staff are not consistently providing patient-inmate bed/cell move information to nursing staff prior to physically moving the patient-inmate.
CMF	Changes have been made to the institution Post Assignment Schedule (PAS) without notice having been provided to the Receiver as required by the Delegation of Authority.
SAC, SOL	Medical rounds and the collection of CDCR 7362, Health Care Services Request are not consistently being recorded in the Administrative Segregation Unit (ASU) Isolation Log Book.
SAC,	Nursing rounds and collection of the CDCR Form 7362 are not documented in general population housing units during periods of lockdown or modified program
SAC	Morning ASU mental health "check-in" meetings are not consistently recorded in the ASU logbook as required by policy.
SOL	Morning mental health "check-in" meetings are not being held each day between ASU custody staff and mental health staff.
SAC	Some custody staff are obtaining patient-inmates signatures on CDCR 7225s Refusal of Examination and/or Treatment in lieu of providers, with no face-to-face encounter occurring between the patient-inmate and the provider.
MCSP	The CDCR Form 7321A, Outpatient Medication Administration Record, and patient-inmates medication are not consistently being moved prior to or concurrent with the patient-inmate physically moving to the new housing unit.
MCSP, CRC	Custody staff are not consistently performing the function of moving the CDCR 7321A and the patient-inmate medication to the clinic serving the patient-inmate's new housing location.
MCSP, HDSP	Hora somni "hour of sleep" (HS) medication is not being delivered at a pill window, as required by statewide policy.
CMF, SOL, DVI	The institution does not accurately report the number of hours redirected into transportation and medical guarding.
CMF, MCSP, DVI, CRC	The institution is not accurately reporting the number of patient-inmates seen in the triage treatment area or transported via code II or code III ambulance, for inclusion in the AQR.
SOL	The institution does not accurately report the number of daily medical, mental health, dental and diagnostic/specialty services ducats from the clinic tracking sheets or appointment lists which have been reconciled against the master ducat list or daily movement sheet.
DVI, FOL	The institution is not accurately reporting the number of add-on appointments for all four health care disciplines, for inclusion in the AQR.
CRC	The institution does not accurately report the number of scheduled and unscheduled vehicle transports and the number of inmates transported.
DVI	HCAU officers do not consistently know where and how to access IMSP&Ps or institution OPs.
CRC	Once custody is notified that a patient-inmate at the mental health crisis bed (MHCB) level of care has been referred for MHCB placement, the patient-inmate is not being transferred within 24 hours.
SAC, CRC	A custody health care access manager is not consistently attending SPR-FIT meetings.

### Qualitative OMA Concerns

The second component to the audit process is a qualitative analysis, which seeks to identify processes, relationships, and other un-qualified factors which nonetheless have a tangible effect on health care access. The qualitative review process largely consists of interviews with staff at all levels, and auditor observation of operations having to do with health care access. During the qualitative review process of the Round II audits, the following qualitative findings were predominant:

- Transportation vehicles (onsite and offsite) are accruing high mileage, developing concerns over reliability. Institutions universally claim difficulty obtaining funding to maintain, upgrade or replace vehicles as necessary.
- The custody and health care management teams, at the 10 institutions audited, all appear to be working very well together, displaying cooperation and collaboration to overcome problems through communication and teamwork.

### HCAU Staff Utilization Review

In January 2014, Corrections Services conducted a staffing utilization review, which entailed reviewing all HCAU custody staff utilization for a one-week period. This was accomplished utilizing the Fair Labor Standards Act sign-in sheets for all HCAU posts. At a select number of institutions that have budgeted positions for medical guarding, this review indicated a significant number of those HCAU custody staff are being redirected out of hospital guarding posts and transportation posts into other institutional vacancies, based upon decreased hospital census within their geographical area, or lack of supporting workload for the transportation staff. The shift in workload has been identified at both basic care and intermediate acuity levels. Based upon developing trends this may indicate a staffing imbalance, which should be managed by CDCR under the current delegation.

### Medical Guarding / Activation of CHCF

Recent closure of intake at the CHCF, and the resultant pause in shifting of high-risk patient-inmates out of basic institutions, has resulted in a slight increase in the utilization of medical guarding unit/community hospital beds. From January 2014 to April 2014, the medical guarding unit/community hospital bed census has increased from 1,636 (an average of 409 per month) in the previous reporting period, to 1,705 (an average of 426 per month) during the current reporting period. It is forecasted that once the CHCF is re-opened to intake, the number of patient-inmates admitted to medical guarding unit/community hospital beds will decrease.

### Transportation Vehicles

CCHCS staff continue to work with CDCR staff on the monitoring and responsibility for managing medical transportation vehicles. Following a year of inactivity, CDCR appears to have made some noteworthy accomplishments during the reporting period:

CDCR's Office of Business Services (OBS) compiled a complete and thorough accounting of all state vehicles at every institution statewide. The list was inclusive of all Health Care Access vehicles. The comprehensive list detailed the age of the vehicle, mileage, condition and type of vehicle, along with other vehicle-specific identification markers. Taking into consideration all of the listed information, OBS was able to develop a prioritized vehicle replacement scoring system (High, Mid, Low). The list enabled OBS to identify 54 Health Care Access Vehicles that met the "high" criteria for replacement. All those vehicles within the "high" priority category have been identified for replacement utilizing current budget year funding.

In addition to the 54 vehicles OBS has agreed to purchase, OBS has also agreed to purchase Emergency Medical Response Vehicles (ERVs) that have been identified for replacement. After making contact with the original 12 requesting institutions and receiving their input, the number was narrowed down to nine. OBS committed to the date of June 30, 2014, for all nine ERV's to be physically onsite at the requesting institutions. Our next report will include an update of CDCR's progress on this issue.

The OBS did a remarkable job in developing vehicle replacement criteria that will be applicable to all state vehicles. The criteria are specific to the type of vehicle and its intended use. With the data received from each institution, Division of Adult Institutions will be able to compile a base from which it will be able to project replacement timeframes for each vehicle based upon monthly and yearly usage.

### **Post Delegation Report for Facility Planning and Activation Management (FPAM)**

#### CDCR Performance Under the October 26, 2012, Revocable Delegation of Authority For FPAM

Since the signing of this revocable delegation, FPAM has continued to perform with the same rigor, focus, and skills they demonstrated prior to the delegation. The coordination and collaboration of FPAM with the construction management team and the application of sound project management tools and skills continues to be effective. To facilitate success, CDCR created a team environment with active involvement from members of the program management firm (Vanir Construction Management, Inc.), the construction management firms, CCHCS, and Department of State Hospitals. The team continuously communicates and uses appropriate project management tools, such as dashboards, critical path schedules, regular team meetings and reports to maintain open lines of communication and to track and monitor the necessary activation activities.

#### Post Delegation Report for Construction Oversight

In order to streamline and coordinate health care construction, on September 21, 2009, the Receiver and the Secretary of CDCR issued a revocable delegation of their respective authorities related to the construction of the CHCF and the HCFIP. Facility Planning, Construction and Management (FPCM) became responsible for the study, planning, design, development, management, and construction of CHCF (and DNCA) and HCFIP. These projects comprise the elements of Goal 6; to expand administrative, clinical and housing facilities for patient-inmates with medical and/or mental health needs and to upgrade administrative and clinical facilities at CDCR's existing prisons.

#### CDCR Performance under the September 21, 2009, Revocable Delegation of Authority for Construction Oversight

CDCR continues to demonstrate the commitment, focus, and ability to effectively manage the health care construction projects. FPCM effectively managed design and construction of the CHCF and DNCA. Both of these projects were complex facilities with challenging schedules and budgets and FPCM demonstrated the capacity and leadership to effectively manage these critical projects.

While confidence in the HCFIP management continues for those projects that have been approved by SPWB and funded by PMIB and as preliminary plans for approved projects receive subsequent SPWB approval, funding for the last five projects awaits final action by the Legislature and Governor contained in the proposed 2014–15 Governor's Budget. This will delay SPWB approval of the CAL and CEN projects until next fiscal year. Also, as indicated, some impacts to construction schedules are anticipated as CDCR and CCHCS develop operational continuity plans to minimize impacts to the delivery of health care services to patient-inmates during the on-site construction periods.

#### Facility Construction

With the exception of SQ, which had physical plant upgrades constructed under the Receivership to address lack of treatment and clinic space, the *Plata* Court Experts found that all of the facilities they visited had serious physical plant issues. Their observations underscore the importance of completing the HCFIP program as quickly as possible.

## **Section 7: Required Reporting Pursuant to Judge Thelton Henderson's March 27, 2014, Court Order Regarding the Receiver's Tri-Annual Report**

On March 27, 2014, Judge Thelton Henderson issued an order pertaining to the content of subsequent Tri-Annual reports. In his order, the Judge asked the Receiver to report on the following: the level of care being delivered at the CHCF in Stockton; the increasing difficulties with recruiting and retaining medical staff statewide; the sustainability of reforms achieved, or being achieved to date; an independent system for evaluating quality of care; and discussion on the degree to which custodial interference with the delivery of care remains a problem and what actions are being taken to address the issue. These topics are discussed below:

### **A. California Health Care Facility – Level of Care Delivered**

As outlined in the last reporting period, serious support system and clinical system failures were observed at CHCF. With the changes in local leadership and focused support from both CDCR and the Receiver's staff, significant improvements have been made in the operation of the facility. The supply systems have been significantly improved with basic hygiene and patient-inmate care supplies readily available. The majority of specialty items are either available or quickly procured. The system is still heavily dependent on manual intervention and emergency orders as the automated supply/ordering systems are still not being used as designed. Food services are significantly improved with reorganization of the supervisory team and progress has been made on resolving the food tray sealing issues.

The clinical support systems continue to improve. Health record scanning backlogs have been resolved and the parallel clinical record has been shut down and absorbed into the existing eUHR. Specialty visit and off-site scheduling backlogs have largely been resolved. The CEO is currently conducting a phased reestablishment of the primary care delivery model and basic clinical/custody health care processes. This reestablishment, referred to as a "reboot," has been enthusiastically received by the staff and appears to successfully improve both the quality and efficiency of care. It is anticipated that completion of the reboot process throughout the facility will require another 8-12 weeks.

A permanent CEO with extensive rural hospital CEO experience has been hired and is on site. He will work with the current CEO in a comprehensive, open-ended transition period to ensure that the gains made at CHCF are solid and sustainable. He is in the process of interviewing to fill his senior medical and nursing leadership positions. Additional supervisory nursing personnel have been brought on and CCHCS is awaiting an outside staffing consultant report, due next month, to assist in determining any need for ongoing additional nursing staffing. The Governor's 2014–15 budget proposes additional custody staffing for the facility. If it is determined that additional health care staffing is needed, CCHCS will move quickly to establish those positions.

The suspension of medical clinical admissions continues. CCHCS is hopeful that this may be able to be modified in the near future once the clinical reboot concludes and the Receiver is satisfied that the clinical and infrastructure improvements are sustainable. CCHCS and CDCR have established a process to activate the DNCA in such a manner as to test the sustainability of the clinical care delivery over the coming months. It is anticipated that the clinical activation of the facility will be concluded in early 2015.

CCHCS is impressed by the pace of improvements and the focus by CDCR in acknowledging and partnering to resolve the deficiencies at CHCF. The gains made, however, are fragile and will require additional time to become established and sustainable.

## **B. Statewide Medical Staff Recruitment and Retention**

In the last year, CCHCS has noticed a slight increase in the statewide average percentage rate of filled positions for the nursing classification, with 84 percent of nursing positions filled in April 2013 and 90 percent of nursing positions filled in April 2014. CCHCS has noticed a slight decrease in the statewide average percentage rate of filled positions for the physician and surgeon (P&S) classification, with 91 percent of P&S positions filled in April 2013 and 86 percent of P&S positions filled in April 2014. With the implementation of the Affordable Care Act (federal) Covered California (State), CCHCS anticipated some challenges with recruiting and retaining staff in these classifications. In order to create a sustainable workforce, CCHCS must implement a recruitment and retention strategy that will continue to attract quality nurses and physicians to CDCR.

As of April 2014, over 90 percent of the nursing positions have been filled statewide. This percentage is an average of six State nursing classifications. More specifically, 12 percent of institutions (four institutions) have filled 100 percent of their registered nurse (RN) positions, and 74 percent of institutions (25 institutions) have filled 90 percent or higher of the RN positions. The goal of filling 90 percent or higher of the licensed vocational nurse (LVN) positions has been achieved at 62 percent of institutions (21 institutions). Thirty-two percent of institutions (11 institutions) have filled between 80 and 89 percent of their LVN positions.

During the reporting period, hiring-related initiatives for nursing classifications continued. A variety of online job postings were the focus of hiring activities during the reporting period. Nursing vacancies are posted on multiple websites, including school career websites, [www.ChangingPrisonHealthCare.org](http://www.ChangingPrisonHealthCare.org), [wwwIndeed.com](http://wwwIndeed.com), and [www.VetJobs.com](http://www.VetJobs.com). Each job posting typically represents multiple vacancies at an institution, and CCHCS staff monitors vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

In general, physician recruitment efforts continued to focus on “hard-to-fill” institutions during the reporting period. As of April 2014, 86 percent of physician positions are filled statewide. This percentage reflects the P&S classification only. More specifically, 29 percent of institutions (10 institutions) have filled 100 percent of their P&S positions. Fifty-three percent of institutions (18 institutions) have achieved the goal of filling 90 percent or higher of their P&S positions. 12 percent of institutions (four institutions) have filled between 80 and 89 percent of their P&S positions, 35 percent (12 institutions) have filled less than 80 percent of their P&S positions.

Workforce Development is continuing to look for innovative ways to improve this trend. Job postings for physicians continue to be placed online at the CCHCS’ recruitment website, other online job boards, and staff continues to recruit at medical conferences. CCHCS’ present and future recruitment efforts for nursing and primary care provider classifications will include the following:

Sourcing - Whenever possible we are working with on-line media outlets (i.e., Practicelink, LinkedIn, Healthcareers, etc.). These media sources provide direct access to their resume/member databases which will allow CCHCS to take a more proactive approach to recruitment by enabling CCHCS to select the candidates we are interested in and contacting the candidates directly rather than simply running an ad or job posting and waiting for candidates to respond to CCHCS.

Visa Sponsorship Program – The Visa Sponsorship Program provides opportunities for international candidates looking to gain experience in the United States. The Program has proved invaluable in our recruiting efforts for psychiatrists. The common feature of the various visa types that we sponsor, which includes TN, J-1 Waiver, H-1B and PERM, is that the employer is an integral part of the process. CCHCS is considered an exempt employer, which means we can sponsor more employees than the typical non-exempt employer.

Classification Salary Review - In an effort to ensure that CCHCS remains competitive in an ever-changing market, CCHCS intends to contract with a human resources company who can conduct salary surveys that take into consideration total compensation of health care professionals throughout the field on a nationwide level. The results of the survey will allow CCHCS to compare our current salary structure against that of our top competitors (both public and private) and make the necessary recommendations for salary increases as appropriate. These salary surveys will be requested on a regular basis to ensure that we remain competitive in the future.

Professional Conferences – CCHCS has identified professional health care conferences where CCHCS can have a presence either in-person with an exhibitor booth or remotely through sponsorships and other promotional opportunities. This strategy will allow CCHCS to increase our name recognition and brand awareness among both conference attendees and the health care community at large. Additionally, recruitment opportunities at these events are more personal, as CCHCS is able to speak directly to potential candidates in a way online postings or print ads cannot.

For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for January 2014, February 2014, March 2014, and April 2014. These reports are included as [Appendix 4](#). Included at the beginning of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: Physicians Filled Percentage and Turnover Rate, Physicians Filled Percentage, Physician Turnover Rate, Nursing Filled Percentage and Turnover Rate, Nursing Filled Percentage, and Nursing Turnover Rate.

### **C. Sustainability of Receiver's Reforms**

One of the most difficult issues at this point is assessing whether the reforms that have been achieved to date are sustainable over time. It is one thing to make changes during a period of recognized crisis; it is quite another for such reforms to take root and become sustainable as a matter of routine organizational performance.

In defining sustainability, it may be helpful to distinguish the elements of sustainability from the Receiver's reforms themselves. The Receiver's reforms are, essentially, the goals and action items identified in the RTPA. There may be elements of sustainability included in the RTPA. But elements of the Turnaround Plan are largely the "ends" of the Receivership, while the elements of sustainability are those qualities that will prevent the erosion of those ends.

The Receiver considers all of the goals in the RTPA necessary for sustainability, including:

- Goal 1: Ensuring timely access to health care services
- Goal 2: Establishing a prison medical program addressing the full continuum of health care services
- Goal 3: Recruiting, training and retaining a professional quality medical care workforce
- Goal 4: Implementing a quality assurance and continuous improvement program
- Goal 5: Establishing a medical support infrastructure (including pharmacy, medical records, radiology, laboratory, clinical information systems and telemedicine)
- Goal 6: Providing for necessary clinical, administrative and housing facilities

In addition to the goals and action items set forth in the RTPA, the Receiver views the following elements as necessary for sustaining the reforms he has achieved and plans to achieve:

- 1) Adoption of the primary care medical home model;
- 2) An independent system for evaluating the quality of health care;
- 3) A public dashboard, including regularly updated performance indicators;
- 4) Freedom from unnecessary custodial interference in the delivery of health care;
- 5) A transition from Court orders to statutes or regulations providing the authorities now required by the prison medical system;
- 6) A budget and personnel allocation sufficient for the necessary expenditures and staffing of the prison medical system, and a budget process preserving the health care budget allocation from diversion to other divisions of the Department;
- 7) A system for the development, review (including periodic review of existing policy), approval and distribution of central and local policies and procedures;
- 8) A system for equipment and fleet management, including inventory, routine maintenance and planned replacement;
- 9) A health care leadership structure with a direct reporting relationship to the Secretary;
- 10) A time-tested regional leadership structure; and
- 11) A culture in which patient-inmate care is a valued priority.

Current activity at CCHCS centers around developing, implementing and creating a process whereby these elements of sustainability are incorporated into the daily operations of the Office of the Receiver. As well, CCHCS will focus its efforts, as a requirement for successfully transitioning medical care back to State control, to ensure that CDCR adopts these tenets of sustainability.

#### **D. Development of Independent Systems for Evaluation of the Quality of Health Care**

Due to differences between the *Plata* Court Experts and the OIG findings in Round 3, the Round 4 inspections were halted pending an assessment of the Comprehensive Inspection Tool. During the reporting period, CCHCS, the parties, and the *Plata* Court Experts worked with the OIG to refine their Comprehensive Inspection Tool to include modified indicators and expanded inspection methodology intended to facilitate an accurate measurement of the health care quality provided by an institution. As of this reporting period, the parties and the *Plata* Court Experts have not agreed on the OIG's modifications to its methodology, and the OIG has not yet released a draft report from a pilot inspection at DVI. It is thus impossible to predict whether the parties and the *Plata* Court Experts will ultimately reach any agreements on the modified methodology, on how OIG reports its results, or on whether those results can be used reliably to assess constitutional adequacy. Absent such agreements, the utility of the OIG's inspection process may be seriously compromised. The OIG has announced its intention to resume inspections in July 2014. That date may prove to be premature given the uncertainties regarding the modified instrument and report methodology.

We will continue to collaborate with all stakeholders and provide additional reviews of the Comprehensive Inspection Tool as further modifications are released.

#### **E. Custody Interference with the Delivery of Health Care**

During the reporting period, two very high profile cases came to light. The September 7, 2013, death of an inmate housed in the Correctional Treatment Center at MCSP and the October 15, 2013, death of an inmate at PVSP both underscore the interdependence between clinical and custody staff who should be working collaboratively in the preservation of life. In each of these situations, it has been suggested that health care staff were precluded by custody staff from providing the care they were hired to provide.

Fortunately outcomes such as these are very rare and in most institutions, health care and custody staff work together as colleagues, each accepting the professional expertise and contributions the other brings to the table.

Shortly after the Health Care Custody Access Units were delegated back to the control of the Secretary in October 2012, CCHCS has completed two full audits (Round I and Round II) at each institution, measuring custody performance with access to care. In reviewing the HCAU Operations Monitoring Audit reports published during the reporting period, there were several institutions that failed specific chapters of the audit during Round I. During Round II, the monitoring reports for several institutions showed absolutely no improvement in the same areas they failed previously. For example, at several institutions, custody staff are not consistently providing patient-inmate bed/cell move information to pharmacy or nursing staff prior to physically moving the patient-inmate. In another institution, custody staff fail to ensure diabetic patient-inmates receive access to a meal within 30 minutes of their insulin treatment. At several other institutions, the audits revealed that no progress has been made by custody staff to ensure patient-inmates retain their keep-on-person medications and inhalers when they are being trans-packed in preparation for transfer to another institution. In most cases, the overall score the institution received may have shown improvement, but there appear to be residual areas and no improvement was seen in these areas after two audits. Although these issues are not as emotionally charged as those we have seen in the incidents at MCSP and PVSP, these policies are medically necessary and must be followed. While CCHCS appreciates the overall score may have gone up, these issues must be addressed immediately.

Conversely, the OMA have also yielded several examples where custody managers stood out as having the will, capacity and leadership to understand the importance of removing unnecessary barriers that hinder access to care.

For example, we found HDSP's medication management process related to the movement of medication when a patient-inmate changes location was observed to be a best practice. Specifically, prior to physically moving patient-inmates, custody prints out an inmate transfer report from SOMS and generates an inmate movement form. Custody and nursing identify whether a patient-inmate has any durable medical equipment (DME), safety vests (impairment), medications, and Medication Administration Records (MARs). Custody completes their portion and then presents the form to nursing staff. Nursing identifies whether the patient-inmate has medications and MARs, and if so, they prepare the medications and MARS for transfer in a locked pink bag. Custody and nursing staff from the sending facility sign the form and custody transfers the medications/MARs with the patient-inmate to the receiving yard where custody and nursing sign as the receiving staff to confirm they have received the above patient-inmate and medications/MARs, DME, etc. This process ensures accountability for custody and nursing and is functioning efficiently and effectively throughout the institution.

## **Section 8: An Accounting of Expenditures for the Reporting Period**

### **A. Expenses**

The total net operating and capital expenses of the Office of the Receiver for the four month period from January through April 2014 were \$651,996 and \$0 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 11](#).

### **B. Revenues**

For the months of January through April 2014, the Receiver requested transfers of \$450,000 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 2013/2014 to CPR from the State of California is \$1,325,000.

All funds were received in a timely manner.

## Section 9: Conclusion

While there have been significant improvements during the last four months, it is clear that much work remains to be done to resolve issues identified by the *Plata* Court Experts during their institution visits in 2013, including (a) implementation of new programs to improve cleanliness and hygiene at all facilities; (b) implementation of a population care management system which will, among other things, address difficulties in continuity of care when inmates move between yards and institutions; (c) implementation of an EHRS to improve scheduling and medication management, among other things; and (d) implementation of a new layer of regional oversight and assistance. In addition, a new system of independent evaluation must be developed that meets the expectations of the parties, the *Plata* Court Experts and the Court. Whether OIG's efforts to develop that new system are successful is uncertain at present and will undoubtedly require significant additional stakeholder discussions.

The Receiver has been impressed at CDCR's renewed spirit of cooperation and collaboration in achieving all of the goals listed above. That collaborative spirit makes our work so much easier to accomplish and helps ensure that we keep moving forward.