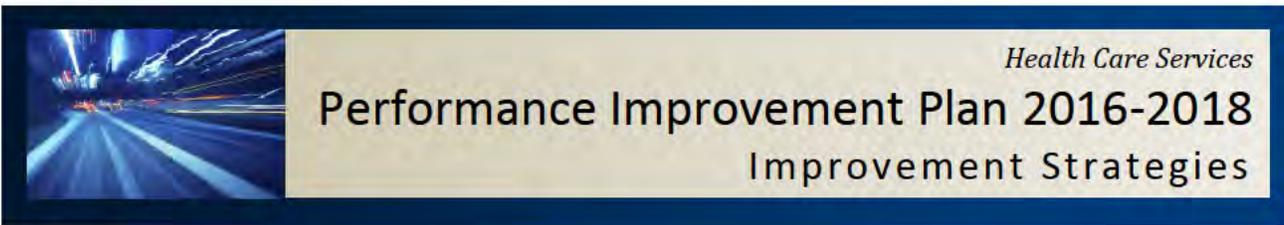


APPENDIX 1



Performance Improvement Plan 2016-2018: Overview

Each year, Health Care Services (HCS) reviews health care processes and services considered to be high risk, high cost, high volume, or problem-prone, and selects priority areas to be targeted in organization-wide improvement initiatives. HCS incorporates these priorities into a biennial Performance Improvement Plan that describes:

- Specific performance objectives within each priority area, with associated timeframes; and
- Major strategies that will be used to accomplish performance improvement goals and objectives.

Statewide performance improvement initiatives slated for implementation in 2016-2018 support or serve one of four functions:

- Align institution level improvement projects and program activities with statewide priorities;
- Integrate health care processes across disciplines and programs;
- Provide resources and tools to support process improvement; and
- Monitor and evaluate delivery and management system performance.

Strategic Alignment

Improvement efforts are most effective when all levels of an organization are informed of the priorities and rally around the same core set of improvement goals. Under this strategy, statewide improvement priorities and objectives are communicated to all staff within the organization. Locally, institutions take into consideration statewide performance objectives as they develop a customized improvement plan that addresses the institution's particular mission, resources, and needs of the patient population and staff. Health care executives are responsible for communicating priorities to staff at all levels of the organization, and ensuring that program planning, day-to-day operations, and supervision align with these priorities.

California Department of Corrections and Rehabilitation Strategic Plan

As the prison health care system transitions from federal court receivership to state control, HCS will coordinate closely with the California Department of Corrections and Rehabilitation (CDCR), and the major service areas in the health care delivery system – medical, mental health, dental, and allied health – will become more and more integrated. In support of this transition, the CDCR issued a Strategic Plan that includes goals for the full health care services delivery system, prompting a unified effort between CDCR and HCS staff in working towards delivering a value-driven, integrated health care system. Health care performance will be measured using a Performance Index similar to what is being used for other programs under the CDCR.

Statewide Performance Improvement Plan

Updated at least every two years, the Statewide Performance Improvement Plan (PIP) presents a group of high-priority areas linked to implementation of the Complete Care Model, and will help steer local improvement efforts. The 2016-2018 PIP incorporates goals from the CDCR Strategic Plan, subdivided into performance objectives with enough detail to promote behavior change. The PIP's specific performance objectives are monitored for the duration of the Plan in the monthly Health Care Services Dashboard.

Institution Performance Improvement Work Plans

Under current statewide policy, each institution is required to establish an annual Performance Improvement Work Plan (PIWP). The Quality Management Section, Regional Executives and Quality Management Support Units will assist institutions in implementing improvement plans to establish foundational elements of the Complete Care Model locally. Institution leadership is responsible for communicating priorities to all health care staff and helping them understand their role in achieving improvement objectives. Institution leadership will also guide the process of strategic alignment, by which managers and supervisors determine how program operations and day-to-day supervision will support performance objectives; and how Care Teams and other staff will incorporate improvement activities for the priority areas into their day-to-day work.

Quality Management Program Governance

At headquarters and at each institution, HCS staff maintains a network of committees that provide oversight and management of improvement activities. Over time, some committees have become mired in litigation compliance and mandates that may no longer be necessary, thus losing capacity for important improvement activities. In 2016-2018, HCS will work to align the activities of these committees with specific functions in statewide policy, providing decision support, training, and standardized assessment tools to remind committees of their original function and help them eliminate work that is no longer required or is not tied to quality, performance or patient safety improvement.

Complete Care Model

In 2015, HCS adopted the Complete Care Model as the foundation for health care services delivery to achieve continuous, integrated, and coordinated care, especially for patients with chronic and complex physical and behavioral health conditions who disproportionately drive risk and resources. Endorsed by the National Committee for Quality Assurance (NCQA), the government-based Agency for Healthcare Research and Quality (AHRQ), and the Joint Commission (JC), this model of primary care emphasizes:

Domain	Description
Continuous Care	<ul style="list-style-type: none"> Patients have a consistent relationship with multi-disciplinary staff, facilitating staff's ability to integrate knowledge and effectively provide care with a whole-patient perspective.
Comprehensive Care	<ul style="list-style-type: none"> The care team assesses and re-assesses patient health needs and collaborates with other disciplines to provide the patient with appropriate

	<p>providers and services.</p> <ul style="list-style-type: none"> • Programs are put into place to stratify patients, provide care management services, and identify and manage subpopulations of patients.
Coordinated Care	<ul style="list-style-type: none"> • The Care Team serves as the hub for organizing, coordinating and scheduling health care services, follow-ups and associated delivery of care; continuity of care; and the proper management of information related to these services.
Patient-Centered Care	<ul style="list-style-type: none"> • Staff encourage patients to be involved in their own care and includes patient preferences and needs into treatment plans.
Preventive Care	<ul style="list-style-type: none"> • Staff provide preventive care to the patient population based on age, gender, and other clinical recommendations from the United States Preventive Services Task Force where health care staff can focus on disease prevention and health maintenance.
Accessible Care	<ul style="list-style-type: none"> • Patients receive timely access to all necessary services and communication with patients is delivered effectively and adapted to the patient's need.
Use of Health Information	<ul style="list-style-type: none"> • Health care records are timely, accurate, complete, and readily located in the health record prior to patient encounters. • Communication and connectivity is established between providers caring for the same patient via electronic or other information pathways. • Clinical decision support is used to remind staff of and assist staff in applying current guidelines or standards in the course of patient care. • Reports are provided to support management of individual patients and patient subpopulations, and health care staff regularly use these reports for purposes of care management, population management, and other patient care activities.
Continuous Improvement	<ul style="list-style-type: none"> • Leaders at all levels of the organization establish a culture of teamwork and continuous learning and innovation by incorporating activities that evaluate and improve health care processes in the daily work of staff.

The different domains of the Complete Care Model will be organized into procedures including, but not limited to:

Care Teams and Panel Management

A major improvement strategy in 2016-2018 is building the local Care Team infrastructure and refining processes for planned, proactive care of patients within an assigned patient panel, as well as processes to enhance communication, coordination and collaboration with team members and other health care staff involved in the delivery of care as patients move in and out of different levels and settings of care.

Population and Care Management

To meet the needs of a diverse patient population, HCS provides systematic assessment, risk stratification, monitoring, and care management of identified groups of patients. Population health management forums will be implemented as an integral Care Team process where time is dedicated to monitoring and managing subsets of patients with chronic conditions or those identified as having complex health needs.

This subset of clinically complex patients is particularly vulnerable to poor health outcomes and account for the majority of inpatient bed, specialty care, and pharmaceutical usage. Because clinically complex patients frequently move from one level of care to another or require specialty and inpatient care, these patients are at a higher risk for lapses in care that occur during “handoffs” when a patient transitions from one care setting to another. As part of the 2016-2018 performance improvement strategies, HCS will assist Care Teams in identifying clinically complex patients, creating decision support tools to monitor and manage these patients, assisting with redesign of core processes, and developing tools to assess how well care coordination processes are working.

Process Improvement Training and Tools

Within the broader health care industry and quality improvement field of expertise, there are nationally-recognized methods to improve systems and processes and achieve sustainable change. HCS will provide health care staff with quality improvement tools and staff development programs that teach process improvement skills and techniques, helping improvement teams and individual Care Teams develop new health care processes and redesign existing processes in a way that is efficient, effective and sustainable into the future.

Training and Professional Development

HCS will partner with experts to offer Lean Six Sigma training to increase process improvement expertise, especially at the institution level where direct patient care processes are utilized. Lean Six Sigma is a nationally recognized, data-driven improvement methodology that improves business and health care processes by identifying and removing causes of process deviation and sources of waste within those processes. Staff selected to participate in Lean training will become local champions who will contribute a culture of continuous learning and improvement through Lean initiatives and ongoing mentoring and coaching of health care staff participating in improvement projects.

Quality Improvement Tool Kits and Best Practices

HCS will establish tools and step-by-step instructions for institution staff to use during process improvement, including basic flow diagramming, cause and effect diagramming, rapid cycle improvement, and root cause analysis, as well as coordinate regular forums for sharing information about improvement initiatives and results, and best practices.

Risk Mitigation Tools

As part of the statewide Patient Safety Program, HCS implemented a statewide Health Care Incident Reporting System, a repository for information about gaps in the health care system from a variety of sources, including staff, patients, and stakeholder groups. HCS developed a taxonomy to organize and analyze health care incident reports, and provide headquarters, regional, and institution staff with a Patient Safety Dashboard highlighting operational areas that may present risk to patients, visitors, or staff. This strategy includes the tools used to shore up system gaps when a problem is identified, such as failure mode and effects analysis, and root cause analysis when a sentinel/adverse event is identified.

Performance Monitoring and Evaluation

Performance data becomes a powerful catalyst for behavior change when it is reported at a level of detail that inspires accountability and provides not solely a score, but enough information to help institutions, care teams, and individuals actively change performance levels. In 2016-2018, HCS will use advances in information systems and available technology to expand performance reporting capabilities.

Health Care Services Dashboard

HCS will continue to produce a Health Care Services Dashboard, a report that consolidates performance measures from statewide priority areas into one document, trended over time. Dashboard information in 2016-2018 will be available not just at statewide and institution levels, but at the level of individual providers, care teams, and patients, helping health care staff to closely monitor progress towards the achievement of performance improvement objectives, identify best practices, and target technical assistance to areas of the institution that are the most challenging.

Patient Safety Surveillance Data

In 2016-2018, HCS will continue to refine the Patient Safety Surveillance System that aggregates data from a wide variety of sources – patient registries, appeals, death reviews and professional practice reviews, the Health Incident Reporting System, habeas corpus cases and other litigation, and stakeholder reports, among other sources – using a common taxonomy to analyze information and provide actionable reports at the statewide and institution levels. In addition, HCS will continue to prepare special studies analyzing patterns and trends in inmate morbidity and mortality, such as ambulatory care-sensitive conditions attributed to potentially avoidable hospitalizations.



Performance Improvement Plan 2016-2018

Priority Improvement Areas

Goal

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

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

Proposed Priority Improvement Areas

Priority improvement areas for 2016-2018 were selected because they pose quality and safety concerns, and are high risk, high volume, high cost, and/or otherwise high impact areas. Complete Care Model elements addressed in these improvement areas relate to foundational delivery system components that must be in place and are described below:

- **Consistent Care Teams** – Patients are assigned a consistent interdisciplinary care team whose members work together to provide and coordinate care for patients in their panel.
- **Population and Care Management** – Care is evidence-based and care teams use patient registries and other tools to manage subpopulations such as high risk and chronic care patients and to case manage the most complex patients.
- **Scheduling and Access to Care** – The scheduling process is optimized (consolidating appointments, open slots, etc.) to improve timely efficient access to the assigned care team or and other health services.
- **Medication Management** – Processes are in place to ensure appropriate, timely, safe and cost-effective medications.
- **Health Information Management** – Care teams have timely access to information to manage patients including diagnostic information and information from community hospitals, Department of State Hospitals (DSH) and specialty providers.
- **Continuous Evaluation and Improvement** – There is an ongoing effort to identify improvement opportunities and use standardized tools and techniques to understand and address potential quality, performance and patient safety issues. Institutions develop improvement plans and monitor performance and progress through a local system of quality improvement committees.
- **Resource Management** – Institutions will be staffed with appropriate numbers of qualified staff to provide and manage patient care. Staff will receive timely orientation, training and performance feedback. Staff will work within adequate physical space and be provided with appropriate technology and supplies to support the delivery of health care.
- **Complete Care Model Infrastructure** – Key infrastructure elements of the Complete Care Model are in place to ensure effectiveness and efficiencies within the delivery and management systems.



Performance Improvement Plan 2016-2018

Specific Objectives

Consistent Care Teams

Continuity of Care

By December 31, 2016:

- High and medium risk patients will have 85% or more of their encounters with no more than two unique primary care providers within the past six months.
- Enhanced Outpatient Program (EOP) patients will have 85% or more of their encounters with the same Mental Health Primary Clinician within the past six months.
- Enhanced Outpatient Program (EOP) patients will have 85% or more of their encounters with the same primary psychiatrist within the past six months.

Care Management – High Risk Patients will be Appropriately Case Managed

- ★ By December 31, 2016, 90% or more of high risk patients will reside at the appropriate institution.
- ★ By December 31, 2016, 90% or more of patients discharged from a Psychiatric Inpatient Program, Department of State Hospital or Mental Health Crisis Bed will receive follow-up with appropriate documentation every day for 5 days after their return.
- ★ By December 31, 2016, 5% or less of patients who return from Psychiatric Inpatient Program, Department of State Hospital or Mental Health Crisis Bed will be readmitted within 30 days.
- ★ By December 31, 2016, 5% or less of all hospitalizations results in a readmission within 30 days.
- ★ By December 31, 2016, the rate of avoidable hospitalizations will be less than 10 per 1,000 inmates per year.
- ★ By December 31, 2016 90% or more of Enhanced Outpatient Program patients and patients requiring Mental Health Crisis Bed admissions will have Treatment Plans consistent with documentation requirements.
- ★ By December 31, 2016, 90% or more of inmate patients discharged/released from a Mental Health Crisis Bed for suicide precaution/watch will have documentation by the Primary Clinician in the receiving program indicating reason for admission and review of and implementation of discharge plan during the first encounter post discharge.
- ★ By December 31, 2016, 90% or more of all Suicide Risk Evaluations will meet all audit criteria.
- ★ By December 31, 2018, 90% or more of high risk/complex patients will have a written Patient Service Plan consistent with documentation requirements and clinical goals.

Population Health Management

Asthma Care

- By December 31, 2016, 85% or more of asthma patients will be in good control based on the use of inhaled corticosteroids (ICS) and/or short acting beta agonists (SABA).

Anticoagulation

- By December 31, 2016, 90% or more of all patients on Warfarin will have their most recent INR result within the last 30 days at therapeutic levels.

Colon Cancer Screening

- By December 31, 2016, 90% or more of eligible patients will be offered colon cancer screening as recommended by the US Preventive Task Force.

Women's Care

- By December 31, 2016, 90% or more of eligible female patients will be offered a mammogram and cervical cancer screening as recommended by the US Preventive Task Force.

Specialty Services

- By December 31, 2016, 90% or more of approved specialty referrals that have evidence-based criteria available to guide referral decisions are consistent with the criteria.

Advanced Liver Disease

- By December 31, 2016, 90% or more of patients with advanced liver disease are appropriately managed consistent with the HCS End Stage Liver Disease Care Guide.

Diagnostic Monitoring

- ★ By December 31, 2016, 90% or more of patients prescribed select high risk medications will have appropriate diagnostic monitoring.

Polypharmacy

- By December 31, 2016, 95% or more of patients prescribed 10 or more medications will have their medication regimens reviewed consistent with requirements.

Diabetes Care

- By December 31, 2018, 90% or more of diabetic patients will be in good control.

Scheduling and Access to Care

Access to Clinicians and Laboratory, and Radiology Services (Including Teleservices)

By December 31, 2017:

- ★ 85% or more of patients who require care receive timely access to clinicians and diagnostic services.
- 85% or more of patients who require care receive timely access to dental services.
- 85% or more of patients who require care receive timely access to mental health services.

Appointments Completed as Scheduled

By December 31, 2016:

- Less than 1% of health care appointments are cancelled due to custody reasons.
- 85% or more of health care appointments occur as scheduled.

Effective Communication

- By December 31, 2017, 85% or more of encounters which required reasonable accommodations to achieve effective communication had accommodations appropriately documented.

Medication Management – Patients will Receive Timely, Safe and High-Value Medications

Medication Administration (MAPIP)

By December 31, 2017, 90% or more of:

- ★ Patients who arrived at a reception center or transfer across health care settings will continue to receive their medications in a timely manner.
- ★ Chronic care patients will receive all essential medications including psychotropic medications in a timely manner.
- ★ Patients not compliant with medication orders will be appropriately referred to a clinician.

Safe, High-Value Medication Regimens

- ★ By December 31, 2016, 3% or less of medications prescribed by Psychiatrists will be non-formulary.
- ★ By December 31, 2016, 3% or less of medications prescribed by medical providers will be non-formulary.

Availability of Timely and Accurate Health Information

- By December 31, 2016, 85% or more of records generated within the electronic health record by CDCR clinicians are documented in the chart within 1 calendar day from the date of the patient encounter.
- By December 31, 2016, 85% or more of paper based records/forms generated by clinicians are available in the chart within 3 calendar days from the date of the patient encounter.
- By December 31, 2016, 85% or more of specialty reports are available in the chart within 5 calendar days from the date of the patient encounter.
- By December 31, 2016, 85% or more of hospital records are available in the chart within 3 calendar days from the date the patient is discharged.

Resource Management

- By December 31, 2016, 65% or more of appropriate specialty consultations will be provided via on-site specialty or video conferencing.
- By June 30, 2017, 95% of medical equipment will be available within 5 calendar days from ordering.
- By December 31, 2018, 95% of routine medical supplies ordered will be provided to the patient within one calendar day.
- By December 31, 2018, 85% of healthcare environment, cleanliness and maintenance audit criteria are met.
- By June 30, 2018, 10% or less of healthcare positions will be vacant.
- By June 30, 2018, 5% or less of functional vacancies will remain in all healthcare classifications.

Other

- By December 31, 2016, 85% or more of inmate health care appeals are processed timely.
- By December 31, 2016, 95% or more of possible non-compliant incidents related to effective communication are processed timely.

Complete Care Model Infrastructure

- By December 31, 2016, 90% or more of all health care staff will complete required training in the Complete Care Model.
- By December 31, 2017, each institution will have implemented the Complete Care Model infrastructure by achieving 90% or better on both Delivery System and Management System components in all assessment categories.
- By December 31, 2018, institutions will achieve an average of 75% or more, or at least a 20% increase from baseline Patient Safety Culture Survey results for the measure: Non-Punitive Response to Errors.