

APPENDIX 8



Performance Improvement Plan 2013-2015

Improvement Strategies

PERFORMANCE IMPROVEMENT PLAN 2013-2015: OVERVIEW

Each year, California Correctional Health Care Services (CCHCS) reviews health care processes and services considered to be high risk, high cost, high volume, or problem-prone, and selects priority areas to be targeted in improvement initiatives organization-wide. CCHCS incorporates these priority areas into an annual Performance Improvement Plan, which also describes:

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

Statewide performance improvement initiatives slated for implementation in 2013-2015 support or serve one of four functions:

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

STRATEGIC ALIGNMENT

Improvement efforts are most effective when all levels of an organization are informed of improvement priorities and rally around a core set of improvement goals. Under this strategy, statewide improvement priorities and objectives are communicated to all staff within the organization. Locally, institutions take into consideration statewide performance objectives as they create 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 (CDCR) Strategic Plan. As the prison health care system transitions from federal court receivership to state control, CCHCS will coordinate more and more closely with CDCR, and the major service areas in the health care system – medical, mental health, dental, and allied health – will become more and more integrated. In support of this transition, the CDCR will issue a Strategic Plan in 2013 that includes goals for the full health care services delivery system, prompting a unified effort between CDCR and CCHCS staff in working towards delivering a value-driven, integrated healthcare system. Health care performance will be measured using a Performance Index similar to what is being used for other programs under CDCR.

Statewide Performance Improvement Plan. Updated at least every two years, the Statewide Performance Improvement Plan (PIP) presents a group of high-priority program areas that will be the focus of statewide improvement initiatives and will help steer local improvement efforts. The 2013-2015 PIP incorporates goals from the CDCR Strategic Plan, subdivided into performance objectives at a level of detail that

promotes 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 (PIWP). Under current statewide policy, each institution is required to establish an annual performance improvement work plan. The Quality Management Section and various clinical services staff will work with institutions to assist them in establishing and implementing improvement plans. Upon developing a performance improvement work plan for the year, institution leadership is responsible for communicating priorities to staff at all levels of the health care system and helping staff understand their role in achieving improvement objectives. Institution leadership will also guide the process of strategic alignment, by which managers and supervisors determine how program operations and day-to-day supervision will support performance objectives, and how care teams and other staff incorporate improvement activities for priority areas into their day-to-day work.

Quality Management Program Governance. At headquarters and at each institution, CCHCS staff maintains a network of committees that oversee and coordinate 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 2013-2015, CCHCS 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 improvement priorities.

INTEGRATED HEALTH CARE DELIVERY SYSTEM

CCHCS delivers a continuum of health care services to inmates across multiple levels of care in both outpatient and inpatient settings. The more complex patients may receive services from many different professional disciplines. In order to improve care, and avoid unnecessary morbidity, mortality and costs, CCHCS will need to fully implement sustainable processes and systems that provide continuous and coordinated care, as well as ensure communication and collaboration among all professional disciplines and with the patient.

In 2009, CCHCS adopted the Primary Care Model as the predominant strategy for achieving 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 on Accreditation of Healthcare Organizations (JCAHO), this model of primary care emphasizes:

- Risk stratification of individual patients and patient populations;
- A comprehensive patient focus;
- Interdisciplinary team-based care;
- Evidence-based practices;
- Active patient involvement and self-management; and
- Decision support and information systems to assist in managing individual patients and patient populations, and facilitating continuous improvements in patient outcomes, clinical practice and processes of care.

Care Teams. Care teams will develop or refine processes for planned, proactive care of patients within an assigned patient panel, as well as processes to enhance communication, coordination and collaboration among care teams as patients move in and out of different levels and settings of care. Additional activities in this area may include changes in existing statewide processes, policies, and procedures to facilitate system integration and standardization.

Complex Patients. A subset of clinically complex patients is particularly vulnerable to poor health outcomes and account for the majority of inpatient bed, specialty care, and pharmaceutical usage. Because clinically complex patients frequently move from one level of care to another or require specialty and inpatient care, these patients are at 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 2013-2015 performance improvement strategies, CCHCS will assist care teams in identifying the clinically complex patients that have been assigned to them through monthly patient lists, creating decision tools to support monitoring and management, assisting with redesign of core processes, and developing tools to assess how well tracking and follow-up systems are working.

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

PROCESS IMPROVEMENT TOOLS AND TRAINING

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. CCHCS 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 sustainable into the future.

Quality Improvement Toolkits and Best Practices. CCHCS 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 set up forums for sharing information about improvement initiatives and results.

Risk Mitigation Tools. As part of the implementation of the statewide Patient Safety Program in 2013, CCHCS will implement 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. CCHCS will develop a taxonomy to organize and analyze health incident reports, and provide headquarters, regional, and institution staff reports highlighting operational areas that may present risk to patients, visitors, or staff, with an emphasis on identifying and reporting potential risks before an adverse event occurs. This initiative includes the tools used to shore up system gaps when a problem is identified, such as failure mode and effects analysis.

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

development program, creating role-specific training modules that empowers all health care staff to participate in improvement initiatives, regardless of reporting level or respective duties.

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 additional information to help institutions, care teams, and individuals to actively change performance levels. In 2013-2015, CCHCS will use advances in information systems and available technology to expand the existing collection of performance reports and offer CCHCS additional actionable data.

Health Care Services Dashboard. CCHCS will continue to produce a Health Care Services Dashboard, a report that consolidates more than 80 performance measures into one document, trended over time. Dashboard information in 2013-2015 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 among institution staff, and focus technical assistance toward those areas of the institution that are the most challenging.

Patient Safety Surveillance Data. In 2013-2015, CCHCS will design a 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 for the Patient Safety Committee and other CCHCS staff. In addition, CCHCS will continue to prepare special studies analyzing patterns and trends in inmate morbidity and mortality, such as ambulatory care-sensitive conditions that attribute to potentially avoidable hospitalizations derived from claims data.

Performance Improvement Plan 2013-2015

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 2013-2015 were selected because they pose quality and safety concerns, and are high risk, high volume, high cost, and/or otherwise high impact areas. Many of the priority areas are integral to a well-functioning primary care model, and are organized in this document according to major components of the model. CCHCS Primary Care Model components addressed in these improvement areas relate to a number of core business processes 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 teams use patient registries and other tools to manage subpopulations such as high risk and chronic care patients and to case manage the highest risk 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 specialty 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 hospital, 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 the local Quality Management Committee.
- 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 appropriate technology.



Performance Improvement Plan 2013-2015

Specific Objectives

Consistent Care Teams

Continuity of Care

By December 31, 2013, 85% or more of:

- High and medium risk patients will have at least 85% of their encounters with less than three different primary care providers within the past six months.
- EOP patients will have at least 85% of their encounters with one Mental Health Primary Clinician within the past six months.
- EOP patients will have at least 85% of their encounters with one primary psychiatrist within the past six months.

Care Management – High Risk Patients will be Appropriately Case Managed

- By December 31, 2013, 90% or more of high risk patients will reside at the appropriate institution.
- By December 31, 2015, 90% or more of high risk patients will have a written interdisciplinary care plan.
- By December 31, 2014, 5% or less of all hospitalizations results in a readmission within 30 days.
- By December 31, 2014, 5% or less of patients who return from Mental Health Crisis Bed or Department of State Hospitals will be readmitted within 30 days.
- By December 31, 2014, the rate of avoidable hospitalizations will be less than 10 per 1,000 inmates per year.

Population Management

Asthma Care

- By December 31, 2013, 90% or more of patients with persistent asthma will have a controller medication prescribed within the last twelve months.
- By June 30, 2014, no more than 25% of patients with asthma will require 2 or more SABA inhalers in a 6 month period (or no more than 4 SABA inhalers per year).

Anticoagulation

- By December 31, 2013, 90% or more of all patients on Warfarin will have most recent INR result within 30 calendar days at therapeutic levels.

Diabetes Care

- By December 31, 2013, 90% or more of diabetic patients will be in good control based on the following indicators: hemoglobin A1C, cholesterol, and blood pressure levels in good control, and screened or treated for nephropathy.

Colon and Breast Cancer Screening

- By December 31, 2013, 90% or more of inmates 51 years to 75 years will be offered colon cancer screening as recommended by the US Preventative Task Force.
- By December 31, 2013, 90% or more of female inmates 52 years and older will be offered a mammogram as recommended by the US Preventative Task Force.

Specialty Services

- By December 31, 2013, 90% or more of approved specialty referrals that have evidence-based criteria available to guide referral decisions are consistent with the criteria.

Cirrhosis and Hepatitis C Virus (HCV)

- By June 30, 2013, 95% or more of patients with Hepatitis C Virus started on combination therapy including a protease inhibitor will receive treatment consistent with CCHCS HCV Care Guide.
- By June 30, 2013, 95% or more of patients with Hepatitis C Virus started on combination therapy excluding a protease inhibitor will receive treatment consistent with CCHCS HCV Care Guide.
- By June 30, 2014, 95% or more of patients with Hepatitis C Virus who receive combination therapy will complete or discontinue therapy consistent with clinical guidelines.

Mental Health Disorders

- By June 30, 2014, 90% or more of patients prescribed Second Generation Antipsychotics (SGA) and/or Mood Stabilizers (MS) will have appropriate laboratory monitoring.

Scheduling and Access to Care

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

By December 31, 2013:

- 85% or more of patients who require care receive timely access to providers, laboratory, and radiology services (see Attachment I for a detailed list of services).
- 85% or more of patients who require care receive timely access to dental services (see Attachment I for a detailed list of services).
- 85% or more of patients who require care receive timely access to mental health services (see Attachment I for a detailed list of services).
- 90% or more of EOP patients are offered 10 or more hours of group therapy weekly.

Appointments Completed as Scheduled

By December 31, 2013:

- Less than 1% of health care appointments are cancelled due to controllable reasons (i.e. uncontrollable reasons include: custody reasons, provider unavailable, eUHR unavailable).
- 85% or more of health care appointments are seen as scheduled.

Effective Communication

- By December 31, 2013, 85% or more of patients requiring effective communication are accommodated.

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

Access to Medications

By December 31, 2013, 85% or more of:

- Chronic care patients will receive all essential medications within the past 3 months including psychotropic medications.
- Patients will receive medications within 1 calendar day of return from a higher level of care including community hospitalizations and emergency department encounters and emergency department and hospitalizations at Department of State Hospitals.
- Patients will receive medications within 1 calendar day of transfer to an institution or new arrival.

Safe, High Value Medication Regimens

- By December 31, 2013, 25% or less of antidepressant medications provided by psychiatrists will be non-preferred or non-formulary including 2nd tier antidepressants.
- By December 31, 2013, 5% or less of Second Generation Antipsychotics (SGA) medications provided by

psychiatrists will be non-preferred or non-formulary.

- By June 30, 2014, 95% or more of patients prescribed one or more select medications associated with QT prolongation will have an EKG performed at least annually.
- By December 31, 2014, 3% or less of medications provided by health care providers will be non-preferred or non-formulary.
- By December 31, 2015, 95% or more of patients prescribed 10 or more medications will have their medication regimens reviewed and modified as appropriate by their interdisciplinary care team.

Availability of Timely and Accurate Health Information

- By December 31, 2013, 95% or more of documents will be scanned accurately and timely into the chart within 3 calendar days from the date of the patient encounter.
- By June 30, 2014, 85% or more of Specialty consultation notes will be available in the chart within 3 calendar days of the consultation.
- By June 30, 2014, 85% or more Laboratory and Radiology services will be available in the chart within 3 calendar days after the service is performed.
- By June 30, 2014, 85% or more of Hospital Discharge Records will be available in the chart within 3 calendar days after the patient is discharged.

Resource Management

- By December 31, 2013, 98% or more of claims will be processed within 30 calendar days.
- By December 31, 2013, 50% or more of appropriate off-site specialty consultations will be provided via teleservices.
- By December 31, 2015, 90% or more of all healthcare staff will complete required training and demonstrate competence in the CCHCS Primary Care Model.

Continuous Evaluation and Improvement

- By December 31, 2013, 50% or more of institutions will have implemented a Quality Management and Patient Safety Program.
- By December 31, 2014, 100% of institutions will have implemented a Quality Management and Patient Safety Program.
- By December 31, 2015, each institution will demonstrate at least a 20% increase in the health care index over the previous twelve month period, if not previously reported at goal.

Detailed Measures for Access to Care – Medical, Dental, and Mental Health Services

Access to Medical Services (Including Teleservices)

- 85% or more of patients who require care receive timely access to providers, laboratory, and radiology services as noted below:
 - Face-to-face triage with an RN occurs within 1 business day.
 - Appointments with the primary care provider from RN referrals related to a 7362 occur within timeframes.
 - Chronic care appointments with the primary care provider occur per orders or at least within 180 calendar days.
 - High priority appointments with a specialist occur within 14 calendar days of the referral.
 - Routine appointments with a specialist occur within 90 calendar days of the referral.
 - Follow-up appointments with a primary care provider after discharge from a community hospital or Emergency Department occur within 5 calendar days.
 - Laboratory services occur within specific timeframes as ordered.
 - Radiology services occur within specific timeframes as ordered.

Access to Dental Services

- 85% or more of patients who require care receive timely access to dental services as noted below:
 - Dental treatments as a result of 7362 triage occur within 3 days or 10 days depending on the urgency of symptoms described.
 - Dental treatments occur within timeframes based on acuity of diagnosed condition.
 - Reception Center Screenings occur within 60 days of patient arrival to the institution.
 - Patient requested comprehensive examinations occur within 90 days.
 - Transfer-Ins (DPC 1 or 2 classification codes) occur within specific timeframes per policy.
 - Patients over 50 years old or diagnosed with Diabetes, HIV, seizure disorder, or pregnancy will be notified no later than sixty (60) calendar days before the anniversary month of their eligibility to receive a periodic comprehensive dental examination.

Access to Mental Health Services (Including Teleservices)

- 85% or more of patients who require care receive timely access to mental health services as noted below:
 - **Routine, urgent and emergent treatment referrals are seen within required timelines:**
 - Emergency within 4 hours
 - Medication Refusal within 7 days
 - Routine within 5 work days
 - Urgent within 24 hours
 - **Primary clinician contacts occur within required timelines:**
 - ASU, CCCMS from GP (#1/Ongoing) 1 week/1 week
 - ASU, CCCMS (#1/Ongoing) 1 week/1 week
 - ASU, CCCMS from ASU EOP(#1/Ongoing) ongoing, else 1 week/1 week
 - ASU, EOP (#1/Ongoing) 5 days/1 week
 - ML CCCMS from DMH (#1/Ongoing) within 10 work days/90 days
 - ML CCCMS from GP (#1/Ongoing) within 10 work days/90 days
 - ML CCMS (#1/Ongoing) within 10 work days/90 days
 - ML CndEx (#1/Ongoing) within 14 days/1 week
 - ML EECF (#1/Ongoing) within 14 days/1 week
 - ML EOP from DMH (#1/Ongoing) within 14 days/ 1 week
 - ML EOP (#1/Ongoing) within 14 days/1 week
 - EOPMod (#1/Ongoing) ongoing else 14 days/1 week

- PSU (#1/Ongoing) within 5 days else 1 week
 - Reception Center CCCMS from GP (#1/Ongoing) 30 days/90 days
 - Reception Center CCMS (#1/Ongoing) 30 days/90 days
 - Reception Center EOP (#1/Ongoing) 1week/1 week
 - SHU CCCMS from GP (#1/Ongoing) 30 days/30 days
 - SHU CCCMS (#1/Ongoing) 30days/30 days
 - SHU EOP (#1/Ongoing) 5 days/1 week
 - **Psychiatry contacts occur within required timelines:**
 - ASU, CCCMS on meds from GP (#1/Ongoing) ongoing, else 90 days/90 days
 - ASU, CCMS on meds (#1/Ongoing) ongoing, else 90 days/90 days
 - ASU,EOP (#1/Ongoing) 30 days/30 days
 - EOP, EOP on meds (#1/Ongoing) Ongoing else 30 days/30 days
 - MHCB-MHCB (#1/Ongoing) 4 days/4 days
 - ML CCCMS on meds from DMH (#1/Ongoing) Ongoing else 10 work days/90 days
 - ML CCCMS on meds from GP (#1/Ongoing) Ongoing else 90 days/90 days
 - CCCMS on meds (#1/Ongoing) Ongoing else 90 days/90 days
 - CndEx on meds (#1/Ongoing) Ongoing else 30 days/30 days
 - EECp on meds (#1/Ongoing) Ongoing else 30 days/30 days
 - ML EOP from DMH on meds (#1/Ongoing) Ongoing else 30 days/30 days
 - ML EOP on Meds (#1/Ongoing) Ongoing else 30 days/30 days
 - PSU (#1/Ongoing) 30 days/30 days
 - SEO EOP on Meds (#1//Ongoing) Ongoing else 30 days/30 days
 - SHU CCCMS on meds from GP (#1) Ongoing else 90 days
 - Reception Center CCCMS on meds (#1/Ongoing) Ongoing else 90 days/30 days
 - Reception Center EOP (#1/Ongoing) 30 days/30 days
 - SEO EOP on meds (#1/Ongoing) Ongoing else 30 days/30 days
 - SHU CCCMS on meds from GP (#1) Ongoing else 90 days
 - SHU CCCMS on meds (#1/Ongoing) Ongoing else 90 days/90 days
 - SHU EOP (#1/Ongoing) 30 days/30 days
 - Patients requiring effective communication are accommodated.
 - Follow-up appointment with a mental health provider after discharge from a Department of State Hospitals or Mental Health Crisis Bed will occur every day for 5 days.
-