

1 FUTTERMAN DUPREE DODD CROLEY MAIER LLP  
MARTIN H. DODD (104363)  
2 180 Sansome Street, 17<sup>th</sup> Floor  
San Francisco, California 94104  
3 Telephone: (415) 399-3840  
Facsimile: (415) 399-3838  
4 [mdodd@fddcm.com](mailto:mdodd@fddcm.com)

5 *Attorneys for Receiver*  
J. Clark Kelso  
6  
7

8 **UNITED STATES DISTRICT COURT**  
9 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**  
10 **AND FOR THE EASTERN DISTRICT OF CALIFORNIA**

11 MARCIANO PLATA, et al.,  
12 *Plaintiffs,*  
v.  
13 EDMUND G. BROWN, JR., et al.,  
14 *Defendants.*  
15

Case No. C01-1351 TEH

16 RALPH COLEMAN, et al.,  
17 *Plaintiffs,*  
v.  
18 EDMUND G. BROWN, JR., et al.,  
19 *Defendants.*  
20

Case No. CIV S-90-0520 KJM-DAD

21 JOHN ARMSTRONG, et al.,  
22 *Plaintiffs,*  
v.  
23 EDMUND G. BROWN, JR., et al.,  
24 *Defendants.*  
25

Case No. C94-2307 CW

26 **NOTICE OF FILING OF RECEIVER'S**  
27 **TWENTY-EIGHTH TRI-ANNUAL REPORT**  
28

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

3 Dated: February 2, 2015

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-eighth Tri-Annual Report of the Federal  
Receiver's Turnaround Plan of Action  
For September 1–December 31, 2014**

**February 2, 2015**

# California Correctional Health Care Receivership

## **Vision:**

As soon as practicable, provide constitutionally adequate medical care to patients 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 patients 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 and Reporting Requirements

In our third Tri-Annual report for 2014, the accomplishments for the period of September 1, 2014, through December 31, 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 Tri-Annual reporting period include the following:

- New Quality Management (QM) efforts includes the publication of an enhanced Dashboard; the release of the first-ever Patient Safety Report; the establishment of a polypharmacy and End-Stage Liver Disease (ESLD) initiatives designed to improve patient outcomes; and the establishment of a "best practices" compendium available to all institutions designed to improve clinical and operational activities.
- The Population Management Care Coordination (PMCC) Committee is in the final stages of preparation for deploying the interfacility transfer processes statewide.
- Working with California Department of Corrections and Rehabilitation (CDCR), a new statewide Durable Medical Equipment (DME) policy was created, one of the most comprehensive initiatives undertaken by California Correctional Health Care Services (CCHCS), to create standardization within the prison system, improve patient care, and diminish inconsistencies that will result in better treatment outcomes.
- The improvement continues related to custody and health care operations at the California Health Care Facility (CHCF). The Governor's proposed 2015–16 budget includes proposed funding that will allow the facility to operate at full capacity. The need for additional funding was validated by Health Management Associates, who conducted an on-site review of patient acuity, staffing levels, and physical plant/operational conditions present at CHCF.
- The Health Care Facility Improvement Program (HCFIP) continues to progress. During this Tri-Annual reporting period, the last seven (7) projects are in the preliminary design phase and 24 projects have proceeded into and/or have completed the working drawings phase. The revised schedules for completion continue to reflect the construction for the first prison being completed in 2015 and construction of the remaining projects being completed in 2016 and 2017.
- On January 12, 2015, CCHCS completed systemwide skin testing for coccidioidomycosis, as recommended by the federal Centers for Disease Control and Prevention. Persons testing negative will be prohibited from being housed at Avenal State Prison (ASP) and Pleasant Valley State Prison (PVSP).

- CCHCS continues its efforts to implement an Electronic Health Records System (EHR). This system will be pivotal for improving those elements of the RTPA that have yet to be completed.
- Office of the Inspector General (OIG) finalized their medical inspection monitoring tool and methodology, and Cycle 4 of monitoring commenced during the week of January 26, 2015.
- The prison population has decreased during this reporting period to 134,443. The in-state prison population stood at 115,089, which represents 139.2 percent of capacity. The next court-ordered benchmark for prison capacity is 141.5 percent by February 28, 2015.

This is the twenty-eighth report filed by the Receivership, and the twenty-second 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 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. (Reference Judge Thelton Henderson's March 27, 2014, Order at

<http://www.cphcs.ca.gov/docs/court/plata/2014-03-27-Doc-2776-Order-Re-Receiver's-Triannual-Reports.pdf>)

To assist the reader, this Report provides three (3) 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. Completed action items have been removed from the Table of Contents and the body of the Tri-Annual Report, and are included as [Appendix 1](#). A chart has been created to specifically illustrate the major technology projects and the deployment of those projects. This document is included as [Appendix 2](#).
- *Website References*: Website references are provided whenever possible.

In support of the coordination efforts by the three (3) federal courts responsible for the major health care class actions pending against CDCR, the Receiver files the Tri-Annual report in three (3) 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 2: Status and Progress Toward the Receiver's Turnaround Plan Initiatives

**NOTE: Completed action items have been removed from the Table of Contents and the body of the Tri-Annual Report, and are included as [Appendix 1](#).**

### 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 Tri-Annual reporting period is as follows:

During this Tri-Annual reporting period, CCHCS focused on continuing to build the organization's quality measurement, evaluation, and patient safety programs as follows:

- Upgrading the monthly Health Care Services Dashboard.
- Conducting a special study on health information management (HIM).
- Partnering with University of California, Davis (UC Davis) to validate and expand the use of performance metrics widely recognized in the broader health care industry.
- Completing the first annual Patient Safety Report, which identifies patient and system factors that place the population at highest risk for harm.
- Moving forward with two (2) statewide patient safety initiatives.

#### **Dashboard 4.1**

In December 2014, CCHCS released "Dashboard 4.1," a new version of the Health Care Services Dashboard with expanded functionality. Among other changes, Dashboard 4.1:

- Introduces the Trended View, which shows up to 12 months of performance data on all Dashboard metrics, allowing institutions to see patterns in performance over time. Refer to Figure 1.
- Gives numerator and denominator information for each performance measure at the individual record level, so institutions can see exactly how each Dashboard score is calculated. Refer to Figure 2.
- Links viewers to the monthly Candy Cane analysis, which offers a relative ranking of institutions based on aggregate and individual category scores.
- Introduces new measures, such as a metric assessing adherence with new ESLD guidelines and two (2) HIM measures.
- Changes the methodology for several measures to reflect updated guidelines, policy, or practice.

A memorandum entitled "New and Improved Health Care Services Dashboard 4.1," which includes greater detail is attached as [Appendix 3](#).

Figure 1. Screenshot, Dashboard 4.1 Trended View (12 Months of Data)

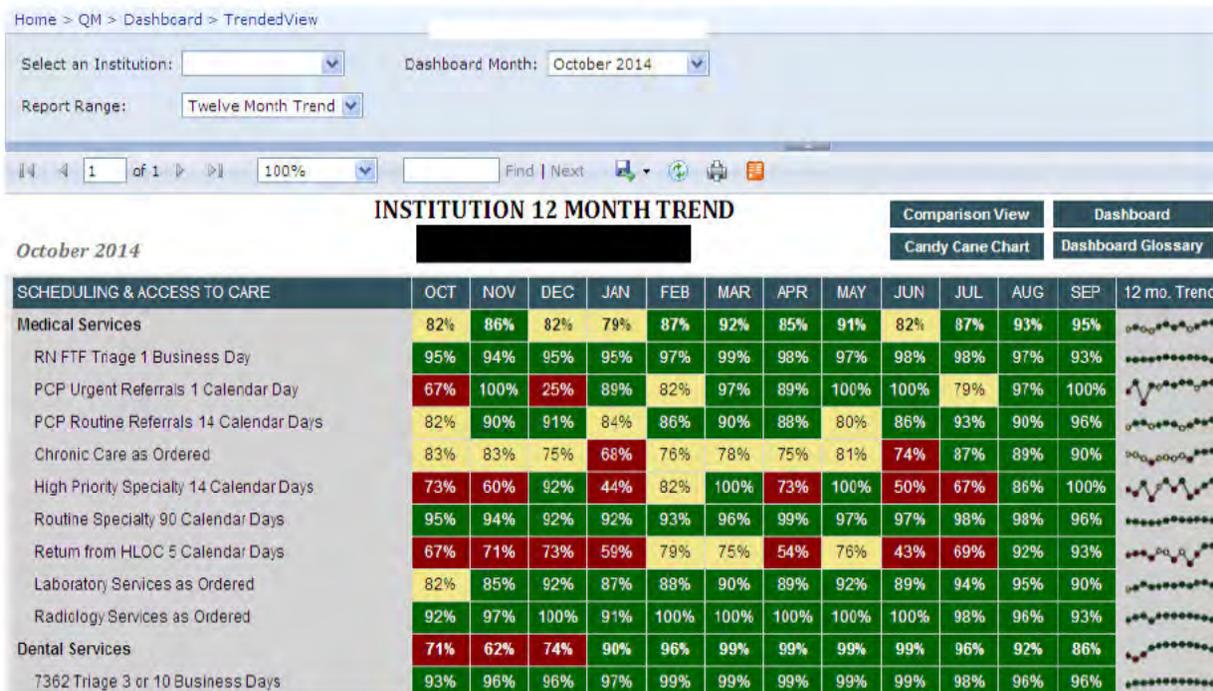
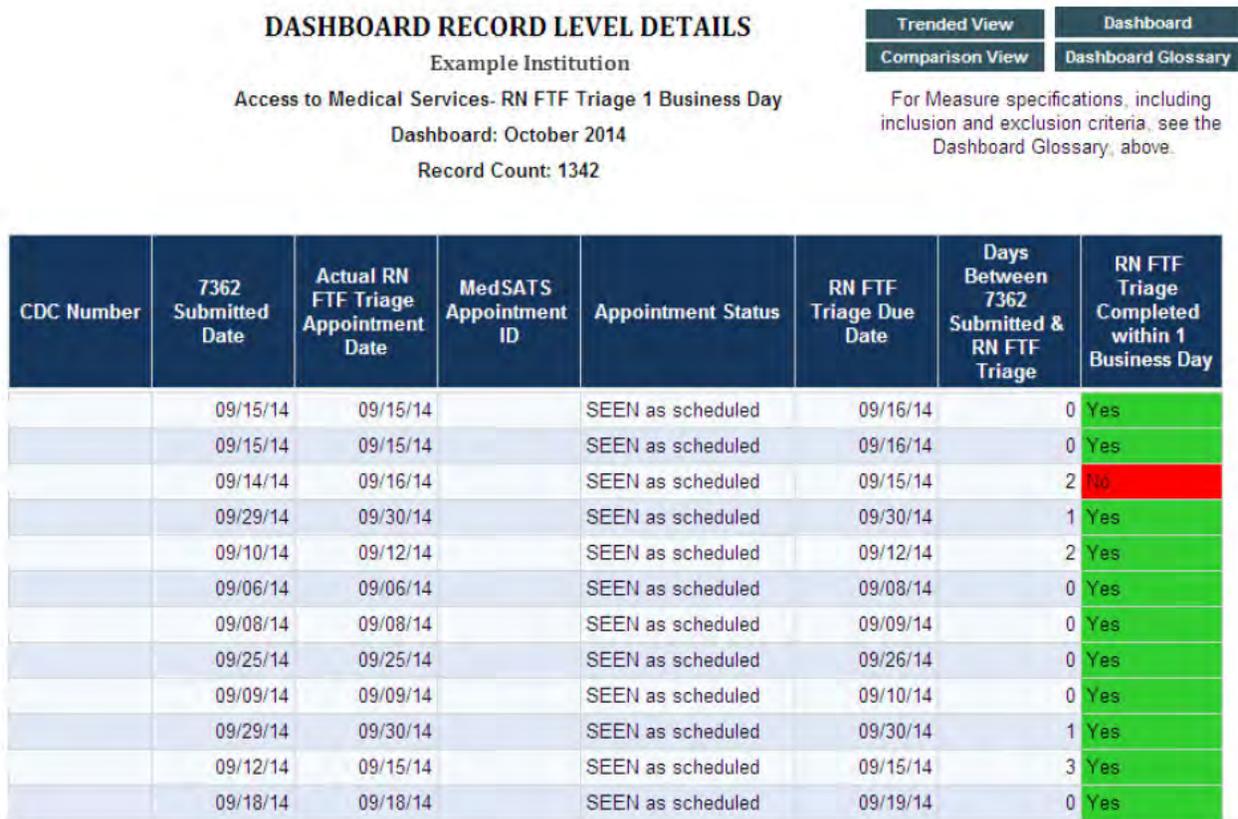


Figure 2. Screenshot, Dashboard 4.1 Record-Level Detail



### Executive Report – Health Information Management

It has been the practice of the Headquarters Quality Management Committee (QMC) to periodically release special reports on areas from the statewide Performance Improvement Plan that require additional scrutiny or focus – sometimes because performance remains below statewide targets, and often because system fixes require collaboration across multiple programs or disciplines.

The HIM measures meet both of these criteria. In September 2014, CCHCS issued the QMC Executive Report – Timely Availability of Health Information examining performance at statewide, regional, and institution levels on five (5) Dashboard performance measures, in many areas comparing performance from 2013 against the same time period in 2014. The QMC Executive Report explains the steps necessary to process clinical documentation from the time of the patient encounter to scanning in the health record, analyzes where documents are delayed in the process, and debunks several myths about why institutions may be scoring poorly in different HIM metrics. At the end of the QMC Executive Report, readers find a number of best practices for improving performance from Centinela State Prison (CEN), an institution that was able to exceed the statewide average by more than 20 percentage points on several measures.

The QMC Executive Report – Timely Availability of Health Information can be found in [Appendix 4](#).

### Partnership with University of California, Davis – Data Validation

Since the earliest iterations of the monthly Dashboard were released more than five (5) years ago, CCHCS has been applying performance measure methodologies used in the broader health care industry, such as those employed by the Agency for Healthcare Research and Quality (AHRQ) and the Healthcare Effectiveness Data and Information Set (HEDIS). By using methodologies common to most other health care organizations, CCHCS can compare performance against what consumers find at other large health plans (i.e., Kaiser, Medi-Cal, and the Veterans Healthcare Administration). This kind of comparison is especially helpful in defining benchmarks for performance measures. However, comparisons are only valuable when the methodologies match and when CCHCS can reach “apples to apples” results. This can be tricky when dealing with incomplete data sets. For years, for example, CCHCS has had to substitute diagnostic or pharmacy data for disease diagnoses, because providers do not enter diagnostic codes into clinical documentation the way a non-correctional provider might for billing purposes. During this Tri-Annual reporting period, CCHCS is finalizing an interagency agreement with UC Davis to review CCHCS’ performance measure methodologies and bring them into alignment with what is required for HEDIS or AHRQ. UC Davis will verify that CCHCS is correctly applying nationally-recognized data methodologies and producing credible performance reports. In addition, UC Davis will help CCHCS to expand the existing repertoire of performance measures to a larger set of measures used by most health care organizations in the United States.

### 2014 Patient Safety Report

CCHCS is required, pursuant to our own internal policy, to conduct system surveillance and issue a Patient Safety Report annually (or more frequently, as necessary) as a vehicle to provide important patient safety information to all health care staff. Typical system surveillance questions listed in Figure 3 are used to identify factors that place patient at higher relative risk for morbidity and mortality.

*Figure 3. Typical System Surveillance Questions*

<b>Patient Factors</b>	Which patient factors (characteristics and conditions) are associated with the highest risks for adverse events and are disproportionately associated with hospitalizations or deaths?
<b>System Factors</b>	What system factors (lapses) related to breakdowns in health care processes are most commonly associated with patient harm?
<b>Interventions</b>	Based on patient and system factors, what subpopulations and process vulnerabilities should be targeted for interventions so improvement efforts have maximum impact on reducing morbidity and mortality and avoiding associated costs?

At the end of 2014, CCHCS answered these typical system surveillance questions in the first Patient Safety Report which covered calendar year 2013 and part of 2014. This report reaffirms what is often seen in performance improvement work: a small subset of factors disproportionately drive risk for the patient population. If CCHCS can effectively address the identified factors, CCHCS can go a long way to improve patient outcomes and reduce costs.

Among other topics, the report combines data from the death review analyses, multiple clinical databases, and health care incident reporting to specify the following:

- Four (4) patient characteristics that increase an inmate's likelihood to die as much as 51 times that of the average inmate.
- Five (5) causes of death that resulted in death of more than 80 percent of inmates in 2013.
- Three (3) disease categories that caused half of all potentially avoidable hospitalizations.
- Five (5) disease categories that caused more than three-fourths of 30-day hospital readmissions.
- Five (5) areas of the primary care delivery system that were most often broken and harmed patients in 2013.

Most of these high risk areas overlap. For example, cardiovascular disease is the third-leading cause of death for patient and associated with 16 percent of 30-day hospital readmissions. Medication events drive 15 percent of potentially avoidable hospitalizations; medication delivery or prescribing errors were identified in 9 percent of patient deaths in 2013, and medication errors accounted for more than half of the health incidents reported in 2014.

The intent of the Patient Safety Report is to make health care staff aware of the areas of highest risk to patients so they can intervene early and often to save lives. In many of the high-risk areas highlighted in the report, however, CCHCS is already in the process of developing or implementing improvement initiatives, and links to these initiatives are provided. The 2014 Patient Safety Report is included as [Appendix 5](#).

#### Patient Safety Initiative – Polypharmacy

As of the beginning of September 2014, five (5) percent of the total patient population in CDCR, or more than 6,600 patients, had current prescriptions for 10 or more medications, and roughly 230 of these patients were taking 20 or more medications. Many of these patients are considered clinically complex, and all are at risk for medication adherence problems and drug-drug interactions. A number of recent adverse events have been linked to polypharmacy, including falls for patients taking medications with side effects of dizziness or blurred vision and accidental toxicity due to drug-drug interactions.

During the previous Tri-Annual reporting period, the Patient Safety and Pharmacy and Therapeutics Committees convened a workgroup to design an improvement initiative that would mitigate risk to patients on 10 or more medications. The workgroup developed a process for medication regimen reviews by primary care teams, psychiatrists, and pharmacy staff to identify and address drug-drug interactions and other risks to patients, as well as several tools to assist health care staff in managing polypharmacy patients. Among the patient management tools is a new Polypharmacy Registry, which lists the patients at each institution who have been prescribed 10 or more medications, the number of prescribers associated with each patient, and whether the current medication regimen contains drug interaction alerts or contraindications current guidelines. Refer to Figure 4.

Figure 4. Screenshot, Polypharmacy Registry

Identification & Housing				Prescribing					Alerts				Review					
CDCR#	Last Name	Age	Care Team	Risk Level	MH LOC	Total Active Meds	Total Active Rx's	Prescribers Past 6 mo	MH Meds	NF	Drug Drug Alert	≥3 Anti-Chol Meds	≥2 QT Prolong Meds	≥ 65 y.o. Beers Meds	Duplicate Drug Class	Date of PolyRx Review		
<i>Patient information redacted</i>				HIGH 1	ICF	22	24	10	6	1			4			2		
				HIGH 1	CCCMS	16	17	6	4	3	Level 2				3		2	
				HIGH 2		13	13	2		1							2	
				MED	ICF	10	11	6	8		Level 2*			6			2	
				HIGH 1		25	26	3			Level 2					4	1	
				HIGH 1	CCCMS	22	23	16	1	3					2		1	
				MED	CCCMS	20	21	11	1	4							1	
				HIGH 2	ICF	18	20	7	1	1	Level 2*	4	3				1	

By clicking on the numbers in the “Total Active Meds” or “Total Active RX” columns, the viewer can access Polypharmacy Patient Detail and show a customized report for each patient with key clinical information, such as allergies, current prescriptions, and recent laboratory tests and results. Refer to Figure 5.

Figure 5. Screenshot, Polypharmacy Patient Detail

Last Name	CDCR #	Inst	Care Team	Clinical Risk	Arrival Date	Age	Mental Health											
<i>Patient Information Redacted</i>																		
Medication Alert Details																		
Allergies																		
Penicillins																		
Tetracyclines																		
Anticholinergic Burden Medications																		
Medication	Alert																	
AMANTADINE HCL	Cumulative effect of Anticholinergic medications are particularly significant in the older patient. If patient is on 3 or more medications consider if all remain necessary, if any can be stopped, or doses decreased.																	
HYDROXYZINE PAMOATE																		
OLANZAPINE																		
Medications known to cause QT Prolongation																		
Medication	Last EKG	Alert																
METHADONE HCL	09/06/13	It is recommended that surveillance EKGs be done before and after initiation of QT-prolonging drugs. DCHS recommendations for monitoring patients taking psychotropic																
OLANZAPINE																		
Medications that cause Drug Drug Interactions																		
Medication 1	Medication 2	Severity	Description			Explanation												
PHENOBARBITAL	WARFARIN SODIUM	2	ANTICOAGULANTS/BARBITURATES			Decreased warfarin serum concentration. Warfarin dosage adjustment is required when initiating and discontinuing												
Current Prescriptions																		
Provider	Medication Name	Initial Start	Current Start	Label Line			NF											
	WARFARIN SODIUM 3 MG TABLET	10/25/13	05/05/14	Take 1 tablet by mouth every evening (WITH WARFARIN 5.5MG TOTAL) **DOT**			No											
Labs Completed in the Last 12 months																		
Date	Alb	ALT	AST	Carb	Chol	Creat	Dep	Hem	A1C	INR	LDL:HDL	Lith	Pheny	Ptt Cl	K	Na	TSH	WBC
									14.9	4.8				156			1.21	5.9

The registry's "Drug Drug Alert" field tells the viewer if there is a drug-drug interaction alert triggered for the patient, and what level of alert applies. When the viewer clicks on the alert level, he or she is linked to a screen that explains exactly which medication caused the alert and why the alert applies. Refer to Figure 6.

Figure 6. Screenshot, Drug-Drug Alert Profile (Patient Information Redacted)

## Drug Drug Interaction Alert

CDC Number

Drug Drug Interactions				
Medication 1	Medication 2	Severity	Description	Explanation
LISINAPRIL	LITHIUM CARBONATE	2	ACE INHIBITORS; ARBS/LITHIUM	

**Alert**

**Level 1:** This category is often labeled "Contraindicated". Prescribers should review the medications involved and the described potential interaction and consider discontinuing one of the medications or changing to a safer alternative if clinically appropriate.

**Level 2:** This category is often labeled "Severe". Prescribers should consider whether the medication(s) still have an indication and whether there is a safer alternative for either or both.

For either alert if the prescriber does not believe the medication combination can be changed, then documentation regarding the risk/benefit should be included in the medical record.

The Polypharmacy Workgroup produced a specially-designed progress note that care teams, psychiatrists, and pharmacists can use to document medication regimen review findings. The progress note was distributed statewide in January 2015. When the form is completed and scanned into the electronic Unit Health Record, the date of the medication review is automatically populated into the Polypharmacy Registry, facilitating patient tracking.

In addition, the Polypharmacy Workgroup developed a series of training presentations to orient health care staff statewide to polypharmacy as a patient safety issue, guidelines for treating patient on 10 or more medications, the medication review process, and the new tools available to support patient management. Initial training occurred in November 2014, with follow-up training in December 2014 and February 2015. Participants are eligible to receive Continuing Education credit upon completion of the training program.

In April 2015, CCHCS will begin tracking the percentage of patient on 10 or more medications who receive an annual medication regimen review on the monthly Dashboard.

All materials associated with the Polypharmacy Initiative can be located via a link on the QM Portal. Refer to Figure 7.

Figure 7. Screenshot of the New Polypharmacy Resources Page on the QM Portal

**POLYPHARMACY RESOURCES**

**PLAN**  
Polypharmacy Review LCP

**IMPROVE**

**EVALUATE**  
Polypharmacy Process Overview/Dashboard Performance

**QUESTIONS**

**Tools**

- Link to Polypharmacy Registry
- Polypharmacy Registry User Guide
- Polypharmacy Review Process - Clinical
- Polypharmacy Review Form - In Development

**Training**

- Polypharmacy CE Series, Part I Presentation
- Polypharmacy CE Series, Part II Presentation

**Decision Support**

- Alerts Detail: Drug-Drug Interaction
- Alerts Detail: Anticholinergic Burden
- Alerts Detail: QT Prolongation
- Alerts Detail: Beers Criteria for Patients 65+ years old
- BEERS Pocket Card
- Alerts Detail: Duplicate Drug Class
- Medication Appropriateness Index (MAI)
- Prescribing Cascades

### Patient Safety Initiative – End-Stage Liver Disease

For more than five (5) years, ESLD has ranked as one of the top causes of death for CDCR inmates, second only to cancer. Liver disease is also a major contributor to 30-day hospital readmissions. During this Tri-Annual reporting period, CCHCS developed an initiative to improve the management of this at-risk patient population. Specifically, at the end of 2014, CCHCS created new guidelines for the management of patients with ESLD, and followed-up with a patient registry that helps institutions monitor for complications associated with advanced liver disease, along with relevant tests and treatments. Refer to Figure 8 for a screenshot of the ESLD Registry. The CCHCS Care Guide on ESLD is included as [Appendix 6](#).

Figure 8. Screenshot, ESLD Registry

Identification & Care Team				Screening		ESLD Condition Management											Other Meds	Laboratory					
CDCR#	Last name	Care Team	Age	Ultrasound Date	EGD Date	Ascites Dx	Spiro	Furos	Eso Var Dx	beta-br	SBP Dx	Abx	Enceph Dx	Lact	Rifx	HCC Dx	Snfib	NSAID	PLT	CR			
<i>Patient identifiers redacted</i>				06/25/14	01/09/14		✓	✓	Yes	✓					✓					236	1.17		
										✓											58	0.83	
				09/03/14	10/14/13						✓					Yes	✓					37	1.56
				N/A HCC Dx												Yes	Exp		Yes			272	0.93
				10/01/14	10/21/14				✓	✓											✓	69	1.24
																						228	0.77
				10/15/14					✓	✓			✓				✓					52	0.73
									Yes										112	0.78			
																			312	0.94			

In February 2015, a two-part Continuing Education training will be made available to health care staff statewide. The first part of the training concentrates on case studies and the application of the new ESLD guidelines, delivered via webinar. The second portion is a self-guided study of the ESLD Registry and a specific care team's patient panel, and can be accessed any time through an Intranet link.

CCHCS began monitoring adherence to the ESLD guidelines in the monthly Dashboard in December 2014. The current measure is a roll-up of four (4) submeasures, calculating the percentage of ESLD patients who:

- Received an esophagogastroduodenoscopy within 36 months.
- Received a hepatocellular cancer screening ultrasound within 12 months.
- Did not receive a nonsteroidal anti-inflammatory drug for 30 days or more within the previous 60 days.
- Received appropriate medication per ESLD related diagnosis.

The current Performance Improvement Plan aims for 90 percent or more of patients with ESLD to receive care consistent with the CCHCS Care Guide on ESLD by December 31, 2015.

## **Objective 4.2. Establish a Quality Improvement Program**

***Action 4.2.1.(merged Action 4.2.1 and 4.2.3): By January 2010, train and deploy existing staff--who work directly with institutional leadership--to serve as quality advisors and develop model quality improvement programs at selected institutions; identify clinical champions at the institutional level to implement continuous quality improvement locally; and develop a team to implement a statewide/systems-focused quality monitoring/measurement and improvement system under the guidance of an interdisciplinary Quality Management Committee.***

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

During this Tri-Annual reporting period, CCHCS moved forward with a number of projects to build quality improvement capacity at the local level, including:

- A new and improved process for developing Performance Improvement Work Plans (PIWPs).
- Collection and posting of best practices.
- Testing tools and strategies for the second phase of the Scheduling Process Improvement (SPI) Initiative.
- Developing the methodology for the QM/Patient Safety Maturity Matrix in preparation for testing in the field.

### **Regional Quality Management and Patient Safety Updates**

In late October and early November 2014, CCHCS Quality Management Section (QM Section) staff traveled to each of the four (4) regions and met with both clinical and Quality Management Support Unit (QMSU) leadership to discuss recent and upcoming developments in the QM and Patient Safety Programs. The presentations were arranged in partnership with the Regional Health Care Executives (RHEs), who hosted, attended, and helped facilitate the presentations.

### **Performance Improvement Work Plans**

Current QM policy requires institutions to establish an annual PIWP that lists priority improvement areas and, for each priority area, specific performance objectives and improvement strategies. Generally, PIWPs are due early in the calendar year.

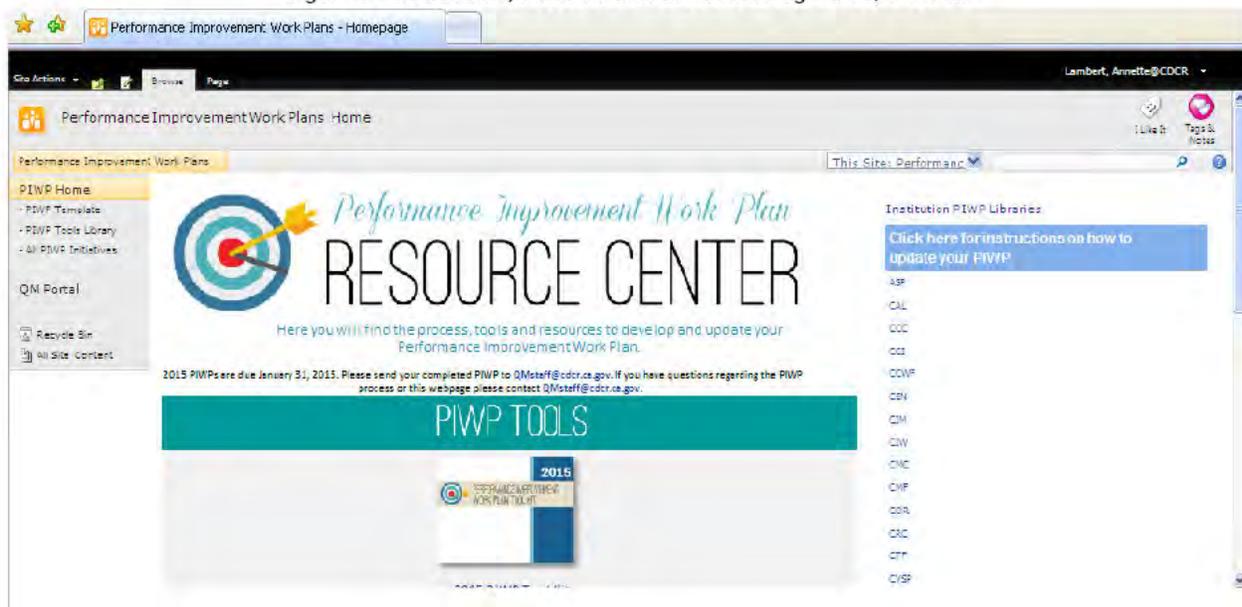
This year, institutions submit their draft PIWPs to their Regional Team for review and approval by the end of January 2015. Regional Teams will work with institutions to address any identified gaps in the PIWP so that plans can be finalized and posted by the end of February 2015.

To assist institutions in creating effective improvement plans for 2015, CCHCS made the following changes to the PIWP process:

- Provided institutions with a Priority Improvement Opportunities Report, which identifies areas where the institution both performed below statewide targets and ranked in the lowest third of all institutions.

- Updated the PIWP Tool Kit and associated tools.
- Created a PIWP Resource Center site on the QM Portal with links to training materials, the PIWP Tool Kit, a database of institution initiatives, and other resources. Refer to Figure 9.

Figure 9. Screenshot, PIWP Resource Center Page on QM Portal



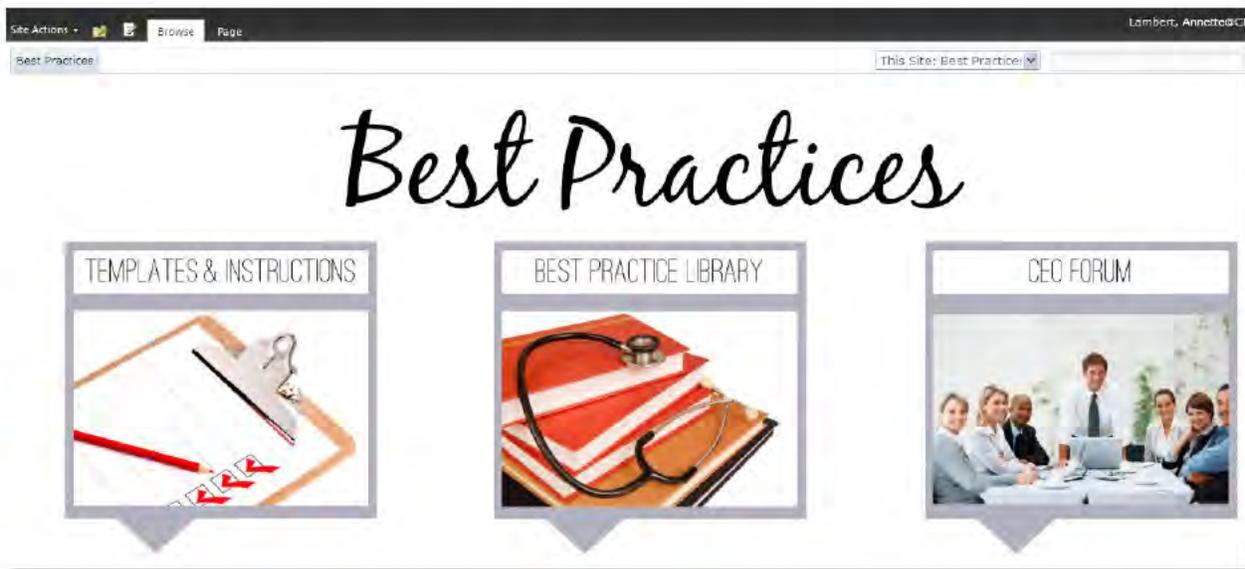
In addition, QM Section staff provided in-person training to all institution QMSU staff on the PIWP process in October and November 2014, in collaboration with the four (4) RHEs. PIWP training included information and exercises to help institution QMSU staff support leadership teams as they review program data, investigate possible improvement priorities, select improvement priorities, and write the PIWP. Institution QMSU staff were also trained to serve as subject matter experts in the PIWP process steps and Tool Kit.

The revised 2015 PIWP Tool Kit is included as [Appendix 7](#).

### Best Practices

In November and December 2014, the RHEs collaborated with QM Section staff to create a centralized repository for best practices. Spearheaded by the RHE for Region I, Eureka Daye, this project established tools and templates to collect information about institution best practices; a process for vetting best practices prior to dissemination; and a web page hosting best practices and links to organizations with health care best practice materials. Refer to Figure 10.

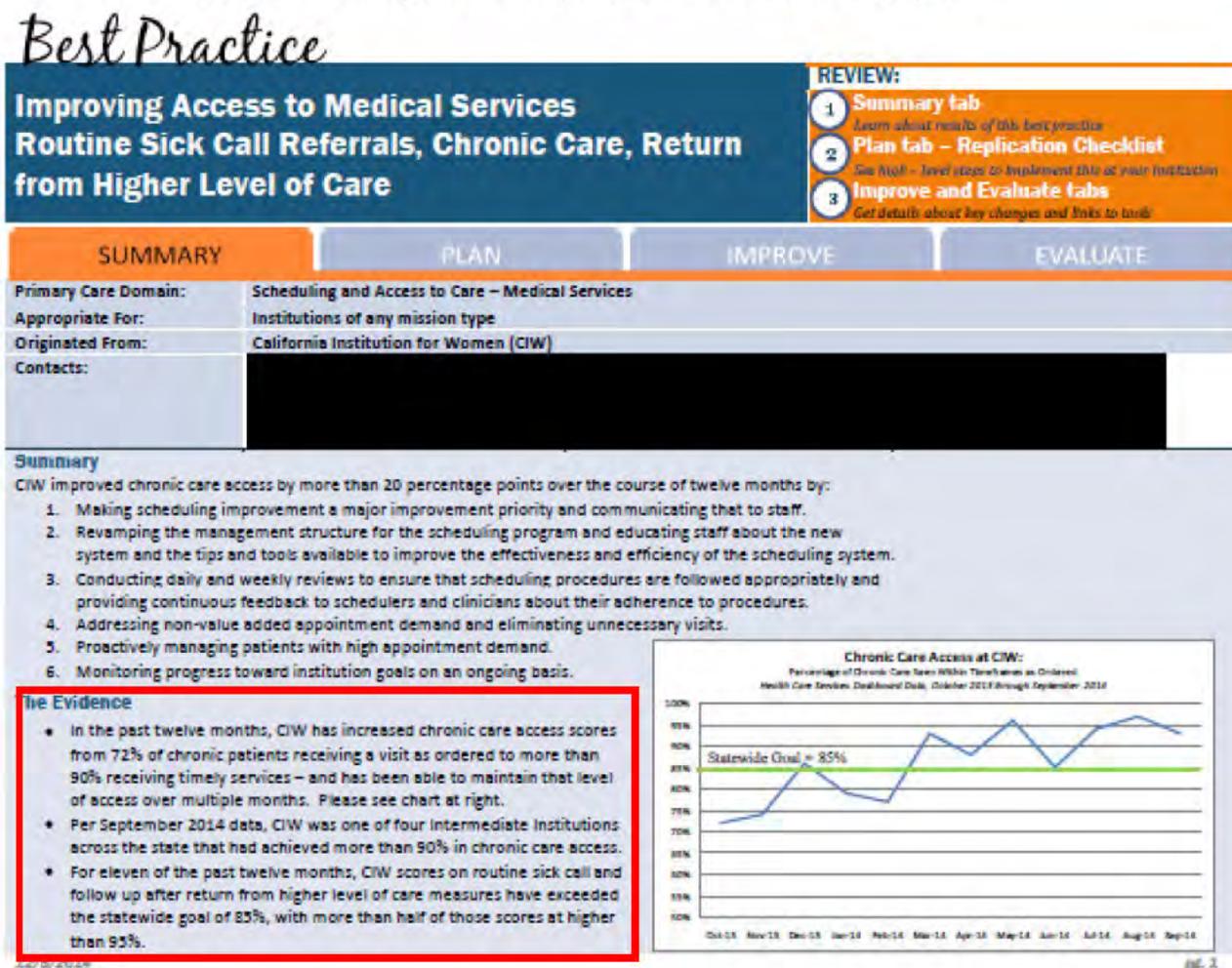
Figure 10. Screenshot, Best Practices Library on QM Portal



To jumpstart the Best Practices Library, RHEs identified at least one (1) institution in each region that had achieved and sustained high performance in areas where other institutions have recently struggled. These areas include medical scheduling; effective communication (EC); discharge planning; and timely availability of dental documentation, specialty reports, and discharge summaries. These institutions were contacted and information about their best practices recorded. Existing best practices developed by the Dental Program Support Unit in Region I were added to the library, as well as a Mental Health best practice relative to EC.

To ensure that best practices are evidence-based, the current best practice template prompts institutions to provide data to verify that the best practice resulted in positive change and that the change has been sustainable over time. Refer to Figure 11. Three (3) sample best practices (California Institution for Women [CIW] Scheduling, Richard J. Donovan Correctional Facility [RJD] EC, and California Rehabilitation Center [CRC] Dental Documentation) are provided in [Appendix 8](#). During the December 2014 Chief Executive Officer (CEO) meeting at headquarters, Eureka Daye facilitated a panel of institution executives as they presented the best practice packages that are now available.

Figure 11. Scheduling Best Practice from CIW, Evidence Section Highlighted



In December 2014, CCHCS created a program to train institution QMSU staff in identifying best practices using available data sets, applying best practices, and documenting best practices for submission to the Best Practices Library. Training will be presented in person at the regional offices beginning in February 2015.

### Statewide Improvement Initiative – Scheduling Process Improvement Phase II

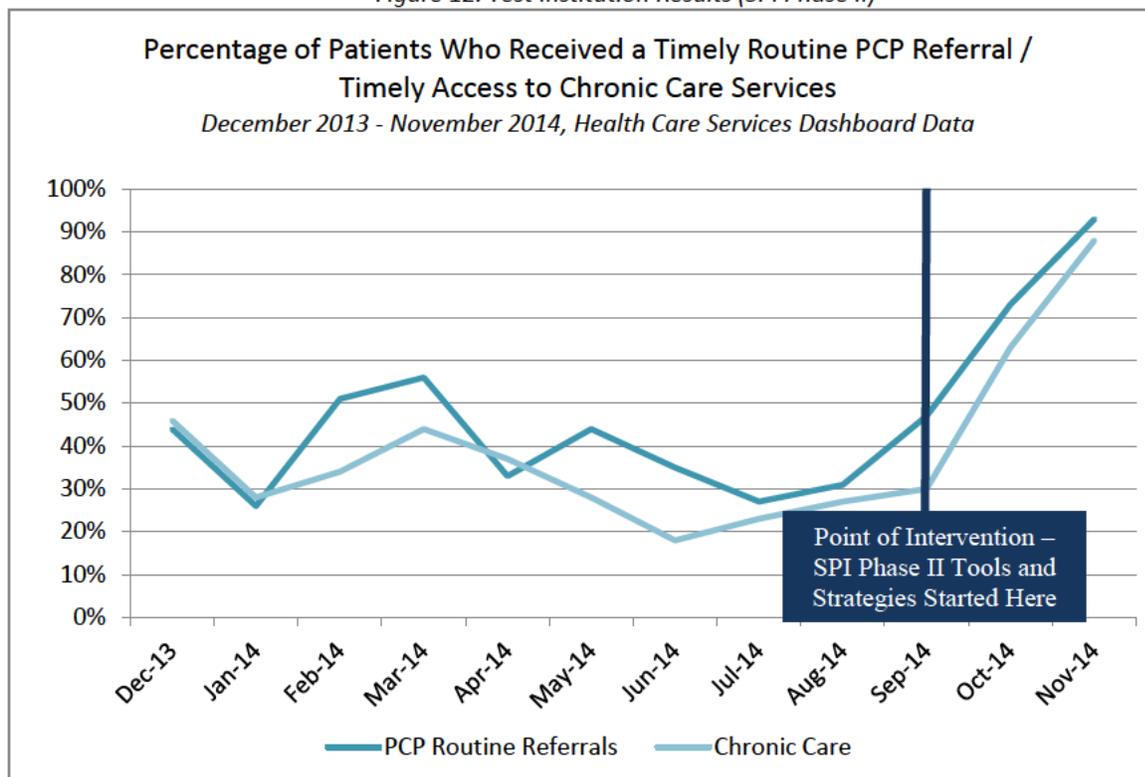
Last year, CCHCS introduced a statewide SPI Initiative which provided a structured process and a set of tools to improve access to care and scheduling efficiency locally. Phase I of the initiative included information and activities to improve the reliability of scheduling data, use of performance data to target specific scheduling processes, and the application of quality improvement techniques to improve scheduling efficiency and access to care.

As part of the initiative, the Statewide QMC mandated SPI as a PIWP project in 2014. Some of the institutions that used the SPI resources were able to make substantial and sustainable improvements to local scheduling processes, but many others continued to struggle with medical access.

Throughout the latter half of 2014, institutions and regional staff contacted the QM Section seeking technical assistance in improving access to medical services, particularly in the areas of routine episodic care, chronic care, and follow up upon return from a higher level of care. In response, the QM Section collected information about the scheduling operations at institutions that had consistently high performance in medical access measures (refer to the above “Best Practices” section). The QM Section revamped SPI resources using this information and staff experiences providing technical assistance in the field.

In September 2014, QM Section staff tested the application of both the new SPI tools and new strategies for managing the scheduling system at one (1) institution in the Central Valley. Once institution staff had fully implemented the tools and management strategies, the institution saw immediate and dramatic improvements in access to care. Overall medical access at the test institution improved 24 percentage points in a two-month period, from 70 percent to 94 percent. In September 2014, before the application of SPI Phase II strategies and tools, just 30 percent of patients received chronic care services as ordered; by two (2) months after the SPI interventions, the test institution had achieved a 58-point increase to 88 percent of patients having timely access to chronic care. Refer to Figure 12.

Figure 12. Test Institution Results (SPI Phase II)



In February and March 2015, CCHCS will make the SPI tools and strategies available to all institutions on the QM Portal. Up to 16 institutions statewide (four [4] institutions in each region) will receive more targeted technical assistance, including the following:

- A customized report for each institution to assist institution staff in identifying and analyzing scheduling system problems.
- Training on SPI Phase II tools and strategies via webinar.
- An eight-hour hands-on technical assistance session at Headquarters for scheduling system managers.
- Ongoing assistance from QM staff through weekly teleconferences.

#### Quality Management/Patient Safety Maturity Matrix

During this Tri-Annual reporting period, CCHCS continued work on a standardized evaluation methodology and tool to assess the extent to which institutions have implemented the QM and Patient Safety Programs locally. CCHCS plans to test the methodology and associated tool at one (1) or more institutions in Region III in March 2015.

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

### 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 this Tri-Annual reporting period is as follows:

#### Imaging/Radiology Services

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

- Since CCHCS completed implementation of the Radiology Information System and Picture Archiving and Communication System (RIS/PACS) statewide in July 2013, enhancements have been continuously added to the system including those that will shorten page-loading time and assist medical providers in quickly locating patients.
- Training in use and access of RIS/PACS has been provided to all affected staff. New training material is provided to RIS/PACS users, as updates are made.
- Mobile imaging services are available at all institutions, and electronic transmission capabilities are at all institutions with the exception of the California Medical Facility (CMF) and Deuel Vocational Institution (DVI). CMF is scheduled to have a new mobile pad and data connectivity installed in the first quarter of 2015. (Additional work is needed to ensure reliable connectivity at a few other sites and to upgrade to October 2012 network and power box standards).
- The contracted statewide radiology group also provides Radiology Supervisor and Operator (RS&O) oversight to all institutions for radiation safety, as well as quarterly mammography program review at the women's institutions. These services ensure complete coverage of all institutions, standardization of practices, and improvement in quality control activities. The annual RS&O inspections were completed statewide in November 2014. Quarterly mammography inspections are current.
- The six-hour timeframe for report turnaround times is being maintained due to statewide use of the RIS/PACS, which is a great improvement on the previous turnaround time of three (3) to five (5) days.
- During the last quarter of 2014, exam protocols and preps have been added into the RIS to help ensure that correct protocols are used by radiologic technologists in performing patient examinations.

### Laboratory Services

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

- As of December 2014, all remaining in-house laboratories (except those contained in two [2] General Acute Care Hospitals) in CCHCS were closed. Clinical laboratory testing for all CCHCS institutions is performed by a contract laboratory service provider. Currently, Quest Diagnostics performs or contracts with other laboratories to perform all laboratory testing for CCHCS patients under their agreement with HealthNet, CCHCS' contracted medical service provider. CCHCS provides clinical laboratory services to all patients. Institution laboratory personnel draw or collect and process blood and other clinical samples (e.g., urine, sputum, wound specimens) to send to the statewide contracted external clinical laboratory. Laboratory personnel also process laboratory result reports.
- Certain Clinical Laboratory Improvement Amendment certificate waived point of care (POC) laboratory tests are performed on CCHCS patients at all institutions by licensed nursing personnel or by providers. These tests currently include fingerstick blood glucose testing for diabetes management, urine dipsticks to screen for urinary tract problems, urine pregnancy tests, and diagnostic fecal occult blood tests.
- Guidance for performance of proficiency testing for POC laboratory tests are being developed to ensure appropriate monitoring and use of POC laboratory tests. (Proficiency testing evaluates equipment, assists with troubleshooting, assesses staff competency and provides information to assist with staff training).
- Standardized laboratory policies and procedures are being developed for statewide implementation.
- Laboratory services staff have improved communication between Headquarters and field personnel:
  - With ongoing monthly statewide laboratory conference calls. This provides an opportunity to share information with the field staff and to hear about laboratory operation issues at the institutions.
  - Established a centralized electronic mailbox for field staff to inquire lab questions, share information, and/or obtain assistance from Headquarters staff concerning unresolved issues.
- CCHCS uses Quest's electronic result reporting system, Care360, which provides electronic results for all tests performed at Quest laboratories. Results for laboratory tests performed in non-Quest facilities (which are contracted by Quest) are faxed and/or called to the institutions and are not available to view in Quest Care360.
- Laboratory Services is supporting the development of the laboratory portion of the EHRS which will be implemented at CCHCS in 2015.
- Guidelines to assist providers in delivering appropriate and cost-effective patient care for particular conditions based on CCHCS Care Guides and other clinical recommendations are being developed by physicians at Headquarters as 'order sets' to be used when EHRS is implemented in 2015.

## **Goal 6: Provide for Necessary Clinical, Administrative and Housing Facilities**

**Objective 6.1. Upgrade administrative and clinical facilities at each of CDCR's thirty-three prison locations to provide patients with appropriate access to care**

***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 is ongoing. As reported in the previous Tri-Annual Report, construction of the CHCF and DeWitt Nelson Correctional Annex in Stockton is complete. A failure in the hydronic loop (the second to have occurred since activation) in December 2014 resulted in a temporary loss of heating and hot water in some buildings and required temporary measures, including movement of some patients, while the leak was repaired. CDCR has initiated an independent assessment to determine if further corrective work is required while the facility is still covered under the contractor's warranty. Patient intake continues under a careful and measured approach.

Regarding upgrades through the HCFIP projects, the last seven (7) projects are in the preliminary design phase and 24 projects have proceeded into and/or have completed the working drawings phase. Of those 24 projects, 11 projects have been approved by the Office of the State Fire Marshal (SFM) and submitted to Department of Finance (DOF) for approval. To date, DOF has approved seven (7) of the 11 projects. The DOF approvals have been timely following SFM approvals. Two (2) of the seven (7) approved projects, which are to be constructed by general contractors, have been advertised for bid. In addition, significant procurement and mobilization activities are occurring by Inmate Ward Labor. Some HCFIP schedule extensions occurred due to elongated SFM reviews and CDCR/CCHCS efforts to ensure integration of operational continuity plans and swing space. Most of the projects scheduled to begin in late 2014 have been delayed to early 2015. In addition, schedules for several projects have been adjusted due to the replacement of the initial design firms due to their poor performance. The revised schedules continue to reflect construction at ASP being completed in 2015 and construction of the remaining projects being completed in 2016 and 2017.

While CDCR continues to face schedule and budget challenges in the completion of the HCFIP projects and significant challenges in maintaining operational continuity in the facilities during construction, CDCR sustains the commitment, focus, and ability to manage construction and activation of these complex projects.

## **Section 3: Additional Successes Achieved by the Receiver**

### **A. Electronic Health Records System**

As reported in the previous Tri-Annual Report, Cerner Corporation has been selected to provide a commercial “off-the-shelf” EHR for CCHCS. This system will provide CCHCS and CDCR demonstrable and sustained benefits to patient safety, quality and efficiency of care, and staff efficiencies and satisfaction. The EHR project is part of a larger organizational transformation project entitled ECHOS – Electronic Correctional Healthcare Operational System. The project is presently in the Build/Testing Phase.

During this Tri-Annual reporting period, the EHR project team finalized workflows for more than 192 health care delivery processes including 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 who facilitate the introduction of project specifics to their respective site/staff. Additionally, the training plan has been approved and materials are being developed to support the “Go Live” implementation of the system. Overall, the ECHOS project is 31 percent complete.

The EHR project team continues to support the integration of an electronic dental record solution into the EHR and is presently monitoring the completion of the requirements document by Cerner and Dentrix (Henry Schein).

Implementation of the EHR will begin in October 2015.

### **B. Population Management Care Coordination Committee**

In the summer of 2014, CCHCS established the PMCC Committee with two (2) main objectives: Create a nursing focused care coordination model and improve health care transfers.

#### Care Coordination Subgroup

Care coordination is the deliberate organization of patient care activities, defined by the goals listed below:

- Organize and schedule activities within a complex organization.
- Facilitate the appropriate delivery of health care services within and across systems.
- Maintain continuity of care.
- Manage by the exchange of information.
- Create and implement a collaborative and team approach.

In the summer of 2014, the Care Coordination subgroup of the PMCC Committee established the Patient Acuity Tool (adopted from North Carolina Assessment) for use in licensed inpatient units (CTCs) to ensure appropriate staffing based on patient acuity level. Policy and training for the use of this tool is in development with an implementation targeted for the spring of 2015.

The Care Coordination subgroup has also updated the Medication Management policy and procedures to be reflective of the Complete Care Model of health care delivery. The policy and procedures are currently in the executive approval process with a target date for training in late February 2015 or March 2015 and a statewide implementation in the summer of 2015.

Integral to Nursing Care Management, the Care Coordination subgroup is also:

- Establishing Patient Service Plans, a tool used for patient management. This tool is the basis for Population Risk Stratification, which will standardize terminology and guide resource utilization in the management of entire patient populations.
- Developing Nursing Care Management Reference Manual and Operational Guide. Training on Care Management of Complex Care Patients is planned for the summer of 2015.
- Developing Disease Management Protocols for Nursing Care Managers. Implementation of Care Management of Complex Care Patients is planned for the fall of 2015.
- Developing, modifying and updating Complete Care Model series of policies and procedures which will incorporate Access to Primary Care, Primary Care Model, Preventive Clinical Services, Outpatient Specialty Services, Physical Therapy, Reception Health Care Policy and Chronic Care Disease Management. Completion of policies is planned for the spring of 2015. Next steps will be training development and implementation planning that will occur in the summer of 2015.

#### Transfer Subgroup

In the fall of 2014, the Transfer subgroup of the PMCC Committee has bolstered the Medical Hold process, in which clinicians have the ability to hold patients at their institution until they are medically safe to be transferred to another institution. This ability prevents inappropriate transfers that could cause health care concerns for the patients. The ability to place a medical hold on a patient is now available electronically on the Medical Classification Chrono application. This application automatically transfers medical hold information to the Strategic Offender Management System simultaneously, and places a movement warning on the patient. The subgroup has completed statewide education to both clinical and custodial staff.

In the past six (6) months, the transfer subgroup has also updated the Health Care Transfer policy and procedure, with a training to be held in the summer of 2015. Several new transfer tools are included in the draft procedure and include an automated Transfer Information Sheet and an updated Transfer Form.

The Transfer subgroup is hopeful that these tools and processes are integrated into ECHOS.

### C. Coccidioidomycosis Testing

The consultation from the Centers for Disease Control and Prevention advised that using a strategy of excluding patients who are coccidioidomycosis skin test negative could reduce morbidity and mortality due to coccidioidomycosis in CCHCS' system by about 60 percent. To be able to follow this strategy, CCHCS purchased the antigen for coccidioidomycosis skin testing and developed a program for a one-time mass testing of patients in January 2015.

In December 2014, CCHCS educated all patients about the coccidioidomycosis skin test that would be offered to those who could be housed at ASP or PVSP. CCHCS produced a video and written educational materials, and the men's advisory councils and the inmate family councils facilitated the education. On January 12, 2015, movement between institutions was halted to permit offering of the coccidioidomycosis skin test to patients statewide. Only those patients with the potential to be housed at ASP or PVSP were offered the test; those who are condemned, medical high-risk or women were not offered the test because they cannot be housed at ASP or PVSP. Preliminary results of this testing are as follows:

- 94,574 inmates were offered testing in this testing period.
- 36,608 inmates consented to testing (38.7 percent) and had a skin test placed.
- 3,050 inmates (8.6 percent) had a positive test suggesting previous exposure to coccidioidomycosis.
- 1350 inmates at ASP are skin test negative.
- 815 inmates at PVSP are skin test negative.

A more detailed report is expected in February 2015.

To achieve the benefit of the testing program through excluding those at high risk of coccidioidomycosis infection, CCHCS drafted changes to the medical classification system so that patients who test negative with the coccidioidomycosis skin test will be absolutely excluded from ASP and PVSP. CCHCS expects that patients who test negative will be moved out of ASP and PVSP over the next few months, well before the time of year when coccidioidomycosis usually spreads from the environment to patients. To facilitate the identification of patients at risk of coccidioidomycosis, CCHCS is revising the QM coccidioidomycosis risk registry. We will use the mass coccidioidomycosis testing results to develop new policies for testing of patients who enter the CDCR system, who were not offered testing on January 12, 2015, but are eligible to reside in ASP or PVSP, or who become eligible to reside in ASP or PVSP (e.g., if their medical risk changes from high-risk to medium-risk).

#### **D. Office of Inspector General – Cycle 4**

CCHCS, OIG, the parties, and *Plata* Court Experts continued to meet throughout this Tri-Annual reporting period 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. At each meeting, the parties provided feedback concerning the sample sizes used for the compliance portion of the inspection tool, inclusion of the qualitative patient care case reviews, and reporting format. The OIG incorporated many suggestions and changes offered by the stakeholders and released a final Comprehensive Inspection Tool in January 2015. The Cycle 4 Inspections commenced during the week of January 26, 2015.

#### **E. In-State Contracting for Community Correctional Facility**

To ensure compliance with the RTPA dated June 2008 and to meet the court mandate to provide a constitutional level of health care to patients in contracted facilities, CCHCS' Private Prison Compliance Monitoring Unit continues to conduct on-site compliance reviews of the four (4) California Out-of-State Facilities (COCFs), six (6) in-state male Modified Community Correctional Facilities (MCCFs) and two (2) in-state Female Rehabilitative Facilities contracted to provide housing to California patients. The expectation is for each contracted facility to demonstrate the ability and to deliver a level of care that is consistent and comparable to the health care provided to all patients housed within the CDCR system. Twice a year, PPCMU conducts an on-site audit of each of the contracted facilities which results in a written detailed report wherein all of the audit team members' findings are clearly articulated.

As reported in the previous Tri-Annual Report, work on the revised audit instrument used to gauge performance of all contract beds has continued. The audit instrument has been based on the most current audit instrument proposed by the OIG, which includes reviews of patient care using extensive case record review methodology. The instrument was tested in a recent audit of a contract facility, resulting in minor revisions and adjustments to the scoring methodology.

##### Out-of-State Correctional Facilities

Corrections Corporation of America (CCA) serves as the sole vendor for the four (4) COCFs. On-site audits have continued at each of the COCFs during this Tri-Annual reporting period. Each facility has demonstrated the ability to provide adequate care based on the requirements outlined in the contractual agreement established with the CDCR's Contract Beds Unit (CBU). The North Fork facility in Oklahoma experienced difficulty meeting the standard of care, but through CCHCS' ongoing monitoring of CCA providers and communication with CCA executives, this facility has shown continued improvement in the level, quality, and access to care for California patients.

CCHCS staff, however, identified significant flaws in the invoicing and reimbursement process for off-site medical expenses accrued by CCA. The current manual process creates a high possibility of duplicate charges, hidden costs, and operator errors, creating great concern in the fiscal reliability of the medical invoicing process. Additional challenges of identifying provider rates, adjudicating duplicate charges, ensuring reimbursement rates are within established guidelines, and the ability to direct pay medical providers will continue as long as the existing process is employed. The existing process is problematic, time consuming, and less than accurate.

In an effort to mitigate this issue, CCHCS staff have identified a more effective “industry standard” method of reimbursement for off-site medical invoicing. The findings and recommendations were presented to CBU staff during this Tri-Annual reporting period. Subsequently, a conference was held with CCA, CBU, and CCHCS, wherein the findings, concerns, and recommendations were presented to CCA. CCA was receptive to the findings and expressed their commitment to work with CCHCS’ Invoicing Branch to provide required automated electronic invoicing data. Should this recommendation be fully implemented, electronic invoice data will streamline and improve invoice accuracy, transparency, and reliability and may even reduce costs. Hopefully, there will be progress which can be included in the next Tri-Annual report on CBU’s ability to renegotiate these requirements with CCA.

#### In-State MCCFs

The MCCFs continue to struggle to meet and maintain a level of care that is consistent and comparable to the health care provided to all patients housed within the CDCR system. Each of the MCCF’s health care operations and procedures are measured and documented bi-annually. Several barriers to health care still exist within the MCCFs due to the current staffing model, the inability to recruit and retain qualified physicians for a half time position, and the lack of training for all health care staff in regard to CCHCS processes, policies, and procedures. Therefore, to ensure adequate delivery of health care in the MCCFs is accomplished, the Receiver has charged CCHCS staff with developing an alternative health care delivery model for these facilities to address the seemingly intractable barriers currently present. Some preliminary work to identify alternatives that acknowledge the unique relationship between the contract facility and their respective hub facility has been initiated. A collaborative workgroup to include CBU staff, Division of Adult Institutions executive staff, and CCHCS staff is anticipated to be formed in January 2015 to address this on a broader scale.

#### **F. Durable Medical Equipment**

One of the most comprehensive initiatives undertaken by CCHCS is the new DME policy. Work on this policy has taken nearly three (3) years to complete and was completed during this reporting period. The policies and procedures were developed as a collaborative effort with CCHCS clinical, Utilization Management, administrative, and CDCR custody staff. Plaintiff’s attorneys have also contributed to the final policy. The new DME policy was developed to standardize all aspects of prescribing, ordering, distributing, and managing DME to ensure the DME needs of the patient are met while maintaining institution safety and security by working

with and advising custody staff. Standardization will improve patient care by diminishing inconsistencies and improving treatment outcomes.

DME is equipment prescribed by a licensed practitioner to meet medical equipment needs of the patient that can withstand repeated use, is used to serve a medical purpose, is not normally useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly and is appropriate for use in or out of the institutional housing. The list of the approved DME that can be prescribed by a licensed practitioner, also known as the DME formulary, is managed and maintained by the Headquarters' DME Committee. This committee, which meets monthly, consists of medical doctors who ensure that all items on the medical formulary are medically necessary.

The policy distinguishes DME from "medical supplies," which are prescribed based on medical necessity and are provided to patients without charge or co-payment. This means that items such as hearing aid batteries, dressings, colostomy supplies, and diabetic testing materials are available to those who need them without any charge.

The new policy further defines "hygiene supplies," which are items used for personal care. Hygiene supplies are generally used for non-medical purposes, are not medical supplies, and are available without a prescription. These items will now be requested from custody staff. Custody staff will not rely upon documentation contained on CDCR forms from health care staff for issuance of personal hygiene supplies.

The DME policy also specifies that certain miscellaneous supplies or property, such as blankets, foam mattresses, second state-issued mattresses, egg crate mattresses, pillows, shoes, and hats are not prescribed by health care staff. Custody staff will not rely upon documentation contained on CDCR forms from health care staff for issuance of miscellaneous supplies or property.

The policy establishes measurable timeframes for providing prescribed DME and supplies. Based on medical necessity, the provider determines the following, appropriate priority and timeframe:

- Same day
- Expedited - Within 5 calendar days
- High Priority - Within 14 calendar days
- Routine - Within 90 calendar days

For patients returning to institutions from hospitals, medically-necessary DME shall be available upon arrival at the institution.

DME is paid for by the patient or by the institution if the patient is indigent. DME becomes the patient's property. Patients may be loaned DME when the need is time-limited, during repair to DME, and while the permanent DME is not yet available. The policy contains detailed processes regarding change in security setting, misuse of DME, and diversion. These are mandatory requirements intended to ensure compliance with court orders, provide for security needs, and protect patients' health.

Statewide training for CCHCS staff began in November 2014, with multiple training sessions conducted in each region for CCHCS institution staff. In collaboration with representatives from CDCR's Class Action Management Unit (CAMU), another round of regional training was also provided to institution custody managers. There were questions brought up by the participants that were forwarded to health care experts for their input. The questions and answers will be formulated into a Frequently Asked Question format and distributed to the field once all questions have been answered and vetted.

The training has focused on improvements to the new electronic Disability Placement Program Verification and Comprehensive Accommodation Chrono (CDCR 1845 and 7410) process; changes to the current policy and the requirement to review the local operating procedures to ensure processes are developed and memorialized. All training sessions included an emphasis for custody and health care staff to work together to ensure there are no gaps or miscommunication in the overall process. The new policy will be implemented on February 2, 2015.

It should be noted that the CDCR's Director of Adult Institutions (DAI) has shown tremendous support to this initiative and issued his expectations for all Wardens in a memorandum to the field entitled "Durable Medical Equipment Policy" dated December 30, 2014.

## **Section 4: 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**

Refer to Section 3C – Coccidioidomycosis Testing for updates.

### **B. Overcrowding Update**

At the end of this Tri-Annual reporting period, the total prison population stood at 134,443, which is a decrease of 1,346 from the previous Tri-Annual reporting period. The decrease is likely attributable to the CDCR's continued implementation of population reduction measures, coupled with the passage and implementation of Proposition 47. As of December 31, 2014, the prison's in-state prison population (excluding camps and MCCF's) was 115,089, which represented an overcrowding capacity of 139.2 percent. Should this population level hold or continue its downward trend, CDCR will meet the courts next goal of 141.5 percent of capacity by February 28, 2015.

## Section 5: Overview of Transition Activities

Currently, three (3) areas of operation have been transitioned from the Receiver back to CDCR. These include Access to Care, Construction and Activation. Refer to Goal 6, Action Item 6.1.2 (page 21) for information related to Construction and Activation activities. Access to Care activities are described below.

### A. Access to Care

#### Access Quality Report

As explained in the previous Tri-Annual Report, Field Operations staff revised the Access Quality Report (AQR), vetted the changes through CDCR, and implemented the revised AQR per instructional memorandum dated August 7, 2014 (refer to [Appendix 9](#)). The AQR, version 2.0, became effective as of August 2014 and was published on September 23, 2014. During this Tri-Annual reporting period, Field Operations staff continued to collaborate and coach institution staff on improving data collection processes. As improved processes are identified and electronic resources are developed, Field Operations staff plan to update the existing version of the Instruction Guide and Counting Rules to AQR 2.1.

CCHCS continues to receive the required monthly AQR data from institutions. As indicated in previous Tri-Annual Reports, the new time and shift system (“TeleStaff”) does not provide certain data points the institutions are required to report to complete the AQR. TeleStaff continues to require adapted data retrieval methods for medical transportation and medical guarding hourly overtime, permanent intermittent employee, and redirected staff hours. Since the institutions are unable to extract the data utilizing a single report as it relates to redirected staff hours, Field Operations staff has trained all Health Care Access Unit (HCAU) analysts at the institutions on how to obtain and calculate the information. As a result of ongoing discussion between the DAI’s Program Support Unit and Field Operations staff, the Program Support Unit staff are developing a single reporting mechanism for the field analysts to utilize.

#### Custody Access to Care Success Rate

Statewide AQRs were published for August through November 2014 during this Tri-Annual reporting period. The average custody *Access to Care Success Rate* for this period was 99.58 percent. This represents a decrease of 0.06 percentage points as compared to the previous Tri-Annual reporting period (inclusive of data from April through July 2014). Refer to Figure 13 for a summary by month of the number of institutions failing to attain the 99 percent benchmark established in the Delegation of Authority.

Figure 13 – Institutions Failing to Attain the 99 Percent Standard for the Custody Access to Care Success Rate

CMC			CCWF
COR			CMC
ISP	CIW		COR
LAC	CMC	COR	PVSP
	WSP	MCSP	SVSP
Aug-14	Sep-14	Oct-14	Nov-14

For institutions failing to attain the benchmark, ten (10) Corrective Action Plans (CAP) were required during this Tri-Annual reporting period. Nine (9) plans were received.

#### Operations Monitoring Audits

As outlined in the HCAU Delegation of Authority, Field Operations continues to conduct HCAU Operations Monitoring Audits (OMA) at the CDCR adult institutions. During this Tri-Annual reporting period, Field Operations conducted the first 11 of the Round III OMAs. The Round III OMAs are scheduled in inverse order of overall score achieved during the Round II OMAs (i.e., quickest return to poorest-scoring institutions). The Round III OMAs rely on methodology largely similar to the Round I/II OMAs, but with many significant improvements, including the following:

- Five (5) balanced components arrange the findings into broad operational aspects of health care access;
- More acute focus on custody performance, and increased opportunities for scoring partial compliance;
- Weighted questions based on risk to patient health and risk to ensuring access to care;
- Corrective action requirements based on individual question performance and weighting;
- Follow-up OMAs consisting of full re-audits for overall scores below 85 percent or CAP reviews when only a component(s) falls below 85 percent.

Of the 11 Round III OMAs conducted, official findings have been published for eight (8) institutions, averaging 87 percent compliance overall, and +2.58 percentage points over their Round II OMA scores. Four institutions scored lower than in the Round II OMA with three (3) of those remaining below the benchmark overall score of 85 percent. Refer to Figure 14.

Additionally, component scores averaged below 85 percent across these institutions in three (3) areas:

- Access to Primary Care (83.4 percent);
- Access to Mental Health Care (82.4 percent); and
- AQR / Data Validation (84.7 percent).

*Figure 14, OMA Results for Eight (8) Institutions*

<b>Audits Conducted from October – December, 2014</b>		
<b>Institution</b>	<b>Round III</b>	<b>Change from Round II</b>
San Quentin State Prison	89.4%	+9.5
Sierra Conservation Center	93.1%	+10.9
California Men's Colony	87.2%	+4.8
California State Prison – Los Angeles County	87.8%	+3.0
Salinas Valley State Prison	84.7%	-0.6
Correctional Training Facility – Soledad	84.7%	-1.2
Pelican Bay State Prison	85.5%	-0.8
California Medical Facility	83.4%	-5.0

Within the Access to Primary Care component, the substandard scores hinged upon the non-compliant institutions failing to:

1. Ensure custody staff are knowledgeable on how to access local policies and procedures governing health care access;
2. Provide notice to the Office of the Receiver upon making any change to the HCAU Post Assignment Schedule or Master Assignment Roster;
3. Document nursing staff access to restricted housing units for the purpose of conducting rounds and collecting patient health care requests;
4. Establish and implement a system that positively verifies delivery of priority health care ducats to patients;
5. Ensure any custody cancellation of health care ducats are reasonable given the circumstances; and
6. Ensure all priority health care ducat outcomes are recorded on the HCAU custody tracking sheets.

Within the Access to Mental Health Care component, substandard scores resulted from the institutions failing to:

1. Completely and accurately document custody hourly welfare checks for patients discharged from mental health crisis beds (MHCB) for suicidal ideation, and
2. Accurately conduct daily inventories of suicide cut-down kits.

Within the AQR/Data Validation component, substandard scores resulted from the institutions failing to accurately report the following data:

1. Daily medical add-on appointments;
2. Daily medical ducat refusals;
3. Daily mental health add-on appointments;

4. Daily mental health ducats completed;
5. Daily mental health ducat refusals;
6. Daily diagnostic/specialty care ducats not completed due to non-custody related reasons;
7. Daily number of urgent/code II ambulance transports;
8. Number of medical transportation redirected staff hours;
9. Number of medical guarding redirected staff hours; and
10. Number of health care access redirected staff hours.

Thus far, in the Round III OMA schedule, the findings for eight (8) institutions have been published. Three (3) of these eight (8) institutions did not pass component five (5) of the audit with a score of 85 percent or better: CMF, Correctional Training Facility (CTF), and California State Prison - Los Angeles County (CSP – LAC). Further, these three (3) institutions did not pass the AQR/Data Validation section during the Round I and II OMAs. Component five (5) is important as this section measures and validates the quality of the Monthly Health Care AQR data which is collected and used as the basic performance indicator of HCAU information. The performance indicator derived from the AQR data is also tied to the HCAU Delegation of Authority. In December, 2014, CCHCS executive staff shared these findings with DAI executive staff in an effort to ensure that any follow-up that might be necessary can be initiated to improve performance.

**Failure to Resolve Previous Corrective Action Plan Items:**

The following institutions' Round III OMA findings indicated continuing problems identified during Round I or II OMAs, which *had not been resolved or significantly improved* as of the Round III OMAs. Refer to Figure 15.

*Figure 15 – Institutions' Round III OMA Findings*

INSTITUTION(S) WHERE OBSERVED	SPECIFIC PROBLEM OBSERVED BY AUDITORS
SQ, SVSP, CTF	Local procedures which prevent diabetic patients from access to food within 30 minutes of receiving diabetic insulin treatment.
SQ, LAC, CMC, CTF	Inaccurate reporting of data related to patients seen in the TTA, or transported via Code I or II ambulance or unscheduled transport.
SQ, LAC, CMC, CTF, CMF	Inaccurate reporting of transportation and medical guarding redirected staff hours.
SQ, SCC, SVSP, PBSP	Failure to ensure transfer of patients to MHCBS within 24 hours of referral.
SQ, SCC, CMC, PBSP	Failure to ensure post-MHCB welfare checks are completed and documented consistently.
SQ, LAC, PBSP	Failure to ensure suicide cut down kits contain all required items.
SQ, SCC, CMC, LAC	Failure to ensure suicide cut down kit inventories are accurately completed daily.
SQ	Failure to ensure patients requiring Enhanced Outpatient placement are transferred within the clinically indicated timeframe.
SQ	Not accurately documenting reasons why patients are not seen by providers.
SQ	Failure to document time of discharge of patients from MHCB.
SQ, LAC, SVSP, CTF, PBSP	Failure to document nursing rounds and pickup of CDCR 7362 in custody housing log book in restricted housing units.
SQ	Failure to ensure custody support for nursing staff during medication distribution in the adjustment center.
SCC, CMF	Custody staff are not consistently notifying nurses of patients housing changes.
SCC, LAC	Custody staff are not consistently transferring patients' medication and Medical Administration

	Record to new facility when moving the patient.
SCC	Failure to ensure sufficient supervisory oversight of general HCAU custody operations.
CMC	Custody staff unaware of how to access local policies and procedure governing health care access.
CMC	Custody designee not consistently attending QMC meetings.
CMC	Custody peace officers not consistently carrying personal cardiopulmonary resuscitation mouth shields.
CMC	Warden or designee not consistently attending Emergency Medical Response Review Committee meetings.
CMC	Incident reports involving controlled application of oleoresin capsicum pepper spray do not document consultation with a clinician.
CMC, LAC	Failure to accurately report the number of daily medical ducats.
CMC, LAC, CMF	Failure to accurately report the number of daily mental health ducats.
CMC, CTF	Failure to accurately report the number of daily medical add-on appointments.
CMC, LAC, CTF, CMF	Failure to accurately report the number of daily mental health add-on appointments.
CMC, LAC, CTF	Failure to accurately report the number of daily specialty/diagnostic add-on appointments.
CMC, CMF	Failure to accurately report the number of daily specialty/diagnostic ducat refusals.
LAC, SVSP, CTF	Morning mental health check-in meeting is not consistently taking place daily in administrative segregation unit (ASU), and do not include the ASU sergeant and a licensed mental health clinician.
LAC	Failure to accurately report the number of daily dental add-on appointments.
LAC, CTF, CMF	Failure to accurately report the number of daily medical ducat refusals.
LAC, CMF	Failure to accurately report the number of daily mental health ducats completed.
LAC, CMF	Failure to accurately report the number of daily mental health ducat refusals.
LAC, CTF	Failure to accurately report the number of daily mental health ducats not completed due to non-custody reasons.
LAC	Failure to accurately report the number of daily dental ducats completed.
LAC	Failure to accurately report the number of daily dental ducats and add-on appointments not completed due to non-custody reasons.
LAC	Failure to accurately report the number of emergent/Code III ambulance transports.
LAC	Failure to accurately report the number of offsite specialty care vehicle transports.
LAC	Failure to accurately report the number of patients transported offsite for specialty care services.
LAC	Failure to accurately report "other" health-care-related vehicle transports.
LAC	Failure to accurately report non-health-care-related vehicle transports.
LAC	Utilizing inmates to distribute priority health care ducats to other inmates.
LAC	Failing to complete the CDCR 7225 patient refusal of treatment form, including a face-to-face interview with a health care provider to ensure the patient is aware of the risks of refusing treatment.
SVSP	Not holding QM Meetings once per month, at minimum, as required.
SVSP	Failure to ensure CDCR 7362, <i>Health Care Services Request</i> , are readily available in all housing units and clinics.
CTF, CMF	Failure to accurately report the number of daily medical appointments not completed for non-custody reasons.
CTF, CMF	Failure to accurately report the number of daily specialty/diagnostic ducats completed.
CTF, CMF	Failure to accurately report the number of daily specialty/diagnostic ducats not completed due to non-custody reasons.
PBSP	Appointments for nurse triage are not completed via the priority health care ducat process.
CMF	Failure to comply with the Delegation, in providing notice to the Office of the Receiver upon making changes to the HCAU Post Assignment Schedule or Master Assignment Roster.
CMF	Failure to accurately report the total number of daily specialty/diagnostic ducats.
CMF	Failure to accurately report the total number of daily mental health ducats not completed due to custody related reasons.
CMF	Failure to accurately report the total number of daily specialty/diagnostic ducats not completed due to custody related reasons.
CMF	Distribution of "HS" (hours of sleep) medications prior to 2000 hours.

On November 25, 2014, CCHCS Field Operations staff met with leadership from the DAI to provide recommendations regarding redistribution of HCAU custody positions and transportation vehicles. CCHCS Field Operations provided DAI with a comprehensive analysis of current HCAU position utilization. This analysis reflected the changing workload in many institutions based on the clustering of high risk patients at intermediate institutions and as well as, the large scale movement of inmates based on implementation of revised medical classification criteria related to coccidioidomycosis risk factors. The recommendations included the following adjustments:

1. Appropriate Triage and Treatment Area/Central Health Building Staffing
2. DVI Outpatient Housing Unit Staffing
3. Intermediate Institution Workload Shifts
4. Patient Movement at CHCF/DWN
5. Spontaneous Medical Transports
6. Dialysis deactivation at SATF

DAI staff were receptive to the information presented and the results of their deliberations will be reported in the next Tri-Annual report.

#### Transportation Vehicles

During this Tri-Annual reporting period, CDCR has successfully delivered 47 of the 61 vehicles that were identified for replacement in the second quarter of 2014. CCHCS began taking delivery of 41 transportation vehicles in October 2014, and received the final vehicle during December 2014. The medical transportation vehicles have not been placed into service as of this Tri-Annual reporting period as they are waiting the installation of the required security modifications and law enforcement telecommunications radios. These vehicles are projected to be placed into service during the second quarter of 2015.

In September 2014, CDCR initiated procurement for the first of the 13 medical Emergency Response Vehicles (ERVs). During this Tri-Annual reporting period, CCHCS has taken delivery of six (6) ERVs. CCHCS has been advised that based on CDCR's strategy of purchasing up to their authorized delegation (\$100,000), CCHCS can purchase only three (3) ERVs at a time. A third procurement effort for three (3) additional ERVs was initiated on December 1, 2014, and is pending award.

CDCR has recently informed CCHCS they are unable to fund the purchase of the remaining five (5) para-transit vehicles and one (1) para-transit 22-passenger bus with current year funds, which were all identified and requested over one (1) year ago. Upon the request of CCHCS staff for a procurement plan that addresses the ongoing vehicle replacement for fiscal year (FY) 2015–16 and beyond, staff were informed that a formal procurement plan to replenish medical transportation vehicles has not been developed and all future purchases will be contingent on sufficient budget allocations.

## **B. Other Transition-Related Activities**

### Regional Health Care Executives

As part of transition activities, the Receivership has been in discussions with the CDCR regarding what would be the appropriate organizational model for oversight of institutional health care. Under CDCR, both dental and mental health had previously adopted and had in place a geographical “regional” model for organizational oversight of their activities. As part of the movement towards transitioning medical care back to the State, the Receivership felt that creation of cohesive, interdisciplinary regions that included medical leadership would lead to a more sustainable model for the future. As a result, the Receivership hired four (4) RHEs and worked with CDCR to align each region geographically so that all health care services (medical, mental health and dental) are overseen using the same regional structure. The four (4) regions are as follows:

- Region I: Pelican Bay State Prison, High Desert State Prison (HDSP), California Correctional Center, Folsom State Prison, California State Prison - Sacramento, Mule Creek State Prison, California State Prison - San Quentin, CMF, and California State Prison - Solano;
- Region II: CHCF, Stockton, Sierra Conservation Center, DVI, Central California Women’s Facility, Valley State Prison, CTF, Salinas Valley State Prison, and California Men’s Colony (CMC);
- Region III: PVSP, ASP, California State Prison - Corcoran, Substance Abuse Treatment Facility (SATF), Kern Valley State Prison, North Kern State Prison (NKSP), Wasco State Prison, California Correctional Institution, CSP - LAC, and California City Prison; and
- Region IV: California Institution for Men, CIW, CRC, Ironwood State Prison (ISP), Chuckawalla Valley State Prison (CVSP), Calipatria State Prison, CEN, and RJD.

Each Region consists of a RHE, along with program and administrative staff. The RHE are responsible for oversight and monitoring of the prison health care operations within their region. They participate in weekly leadership meetings with Headquarters Executives and serve as the liaison between the prison facilities and Headquarters.

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

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

The newly established Health Care Leadership team at CHCF continues to focus on provider recruitment and ensuring the highest quality of health care. During part of this Tri-Annual reporting period, CHCF was on pause for medical Correctional Treatment Center (CTC) and Outpatient Housing Unit (OHU) intake. However, CHCF remained open for intake for Enhanced Outpatient Program (EOP) Level of Care (LOC) and MHCBC LOC. The following, additional specific updates for CHCF are provided:

#### Medical Services

- During this Tri-Annual reporting period, the medical leadership developed a process which will help ensure patients will be seen by their Primary Care Provider (PCP) in a timely manner. This plan includes changing PCPs from four (4) days per week, 10 hours per day work schedule and standardizing all PCPs to five (5) days per week, eight (8) hours per day work schedule. Additionally, dedicated providers will see both High Acuity and Low Acuity patients. Physician recruitment and retention has not yet stabilized at CHCF and efforts are underway to seek out new recruitment strategies and widen the search for talented physicians.
- CHCF initiated a Hepatitis C Virus (HCV) clinic. Patients are referred based on clinical interventions and the Master Registry identification process. Patients are then screened for inclusion in the HCV program utilizing the latest and most clinically appropriate drug protocols. Post-HCV care is also provided through this HCV clinic.
- Access to Care numbers, as reflected in the December 2014 CHCF Dashboard, have remained in compliance.
- A Sepsis-focused workgroup was initiated to review the high number of patients who are returned from an outside hospital with a diagnosis of Sepsis.
- CHCF is utilizing Headquarters Telemedicine to assist with primary care coverage.

#### Mental Health Services

- During the Major Sustainability tour in December 2014, the Mental Health Regional Team noted “continued growth and a strong motivation to continue your forward movement. Your facility and staff are new and large, spread across an immense campus, and yet you have begun to create a strong team, committed to delivering good patient care!” In addition, Regional Team noted the Medical EOP Interdisciplinary Treatment Team (IDTT) as being “a highly functional IDTT,” who went “above and beyond to accommodate emotional needs and concerns and medical needs.”
- Point-in-time data taken from the On Demand Mental Health Performance Report on January 9, 2015, indicated a nearly 50 percent increase in overall ranking for the mental health department at CHCF. In addition, during this Tri-Annual reporting period, CHCF QM

dashboard indicator Diagnostic Monitoring (e.g., psychiatric medications, consents and labs) increased from 60 percent to 84 percent through the efforts of the quality improvement measures.

- CHCF has filled 90 percent of the mental health positions and 93 percent including candidates in the pre-employment process.
- CHCF's Administrative Segregation Unit (ASU) EOP hub activated in December 2014, and during the first month, the average weekly structured treatment hours offered was over 13 hours per patient per week, and the ASU Prescreen is at 100 percent.
- Mental Health launched a comprehensive group therapy program for over 300 medical patients who are in the Correctional Clinical Case Management System LOC and housed in CHCF's CTC and OHU.
- Mental Health is working with medical staff on the development and implementation of two (2) best practice interdisciplinary treatment programs: one (1) program is for the treatment of HCV and the second is for interdisciplinary transplant team program.

#### Dental Services

- CHCF has two (2) dental clinics that are fully operational and maintain an average monthly compliance rate of 99.07 percent of patients being seen within required timeframes, and a monthly statewide compliance rate of 96.9 percent which consists of 7362 Triage, Dental Treatment Plans, and Exams.

#### Nursing Services

- A Wound Care program was established in response to patients with chronic wounds. CHCF has a professionally credentialed Registered Nurse (RN) Wound Specialist, who assesses complex wounds and identifies treatments to promote healing. The RN Wound Specialist works with the PCP and Nursing staff to implement treatment.
- Reboot Data Workgroups have developed audit tools which specifically measure compliance of the huddle scripts and follow-ups needed. These audit tools and findings have improved the procurement of supplies, notification and resolution of plant issues and fosters clinical communications.

#### Resource Management

- The Resource Management Committee (RMC) has been established and meets monthly. This Committee is responsible for the oversight and review of the CHCF Financial Services Subcommittee, which includes management of the monthly budget plans, purchasing, and contracts. The RMC's area of responsibility also includes the Supply Chain, Dietary Services, Environmental Services, IT, Position Management, Staff Training, Space Review and Physical Plant. This is accomplished through a highly effective interdisciplinary team headed by the Chief Support Executive and includes members from each of the disciplines listed above. Currently, the Financial Services Subcommittee's focus is on fiscal review with reduction of overtime, contract medical costs and position management control.

- In November 2014, Facility E installed temporary covered structures and additional lighting on both sides of the clinic for patients to utilize while waiting for their medication. CHCF has implemented a controlled release of all patients receiving medication to reduce wait times outside the clinic.
- During this Tri-Annual reporting period, CHCF has made great strides in filling nursing vacancies and aggressive recruitment continues. The current RN vacancy rate is 31 percent and CHCF expects a significant decrease after current hiring documents are processed.
- Significant efforts are underway to recruit a third Chief Physician and Surgeon (P&S).
- CHCF In-Service Training has resumed Annual Training for CCHCS staff; staff are hard-scheduled 60 days prior to their birth month. In December 2014, 44 percent of staff completed the Annual Training requirements.
- The funding authority for Food Services' Career Executive Assignment and all associated positions were moved from CCHCS to CDCR.

#### Quality Management

- The Health Care Appeals Unit continues to address the backlog of overdue appeals, and available resources were identified and re-directed to support the process. In October 2014, the appeals numbers were 649 total open appeals and 446 total overdue appeals. As of January 2015, the numbers are 347 total open and 219 total overdue appeals. This is a reduction of 53 percent in open appeals and 49 percent in overdue appeals. Refer to [Appendix 10](#) for CHCF's Appeals Trend Chart.
- Town Hall meetings were initiated to provide all staff an opportunity to meet and ask questions of the leadership team. The first meetings occurred over three (3) days with three (3) meetings per day in late November 2014. Over half of the CHCF staff attended, and based on survey results, staff and leadership both considered the effort a success. The next Town Hall meetings are scheduled to occur in February 2015.
- CCHCS staff continue to work collaboratively with CDCR and Department of State Hospitals in anticipation of routine California Department of Public Health Surveys, Headquarters monitoring tours and court monitor tours.
- The processes to successfully monitor Armstrong compliance, such as audits, reporting structures and conducting inquiries were implemented when the Americans with Disabilities Act (ADA) Compliance Analyst position was filled in September 2014. The implementation has created an influx of allegations and inquiries. Timeliness of responses will improve as processes develop and implementation becomes more consistent. CHCF has successfully addressed 158 overdue allegations and will continue to improve compliance by the timely identification of deficiencies.

## B. Statewide Medical Staff Recruitment and Retention

As of December 2014, 85 percent of the nursing positions have been filled statewide (this percentage is an average of six [6] State nursing classifications). More specifically, 57 percent of institutions (20 institutions) have filled 90 percent or higher of their RN positions, and 23 percent of institutions (eight [8] institutions) have filled between 80 and 89 percent of their RN positions. Only 20 percent (seven [7] institutions) have filled less than 80 percent of their RN positions. The goal of filling 90 percent or higher of the Licensed Vocational Nurse (LVN) positions has been achieved at 63 percent of institutions (22 institutions), and 11 percent (four [4] institutions) have filled between 80 and 89 percent of their LVN positions. Only 26 percent of institutions (nine [9] institutions) have filled fewer than 80 percent of their LVN positions.

The major contributing factor in this decrease of filled positions is the addition of new Psychiatric Technician and LVN positions statewide resulting in a decrease in overall percentage filled rates. With this in mind, overall nursing percentage fill rates should increase as CCHCS begins to fill these new positions.

During this Tri-Annual reporting period, hiring-related initiatives for nursing classifications continued where a variety of online job postings were the focus of hiring activities. 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 continues to monitor 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 this Tri-Annual reporting period. As of December 2014, 91 percent of physician positions are filled statewide (this percentage is an average of all three [3] State physician classifications). More specifically, 60 percent of institutions (21 institutions) have achieved the goal of filling 90 percent or higher of their P&S positions. Of these 21 institutions, 13 have filled 100 percent of their P&S positions. Additionally, 20 percent of institutions (seven [7] institutions) have filled between 80 and 89 percent of their P&S positions, and 20 percent (seven [7] 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 continue to recruit at medical conferences. CCHCS’ present and future recruitment efforts for nursing and primary care provider classifications will continue to include the following:

Sourcing – While sourcing remains a valuable recruiting tool, it is workload intensive. Consequently, this aspect of our overall recruiting efforts is on hold until such time as final decisions are made regarding Workforce Development’s additional staffing request.

Visa Sponsorship Program – The Visa Sponsorship program provides opportunities for international candidates looking to gain experience in the United States. 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. This program has proved invaluable in our recruiting efforts for psychiatrists and has started to be utilized for other classifications including Nurse Practitioner and Recreation Therapist. To continue and expand this effective program, we have included language promoting visa sponsorship in all advertising for the P&S classifications.

Classification Salary Review – In an effort to ensure that CCHCS remains competitive in an ever-changing market, we have contracted with CPS Human Resource Consulting to survey total compensation of health care professionals throughout the field on a nationwide level. The results of this will allow us to compare our current pay plan structure against those of our top competitors (both public and private) and make necessary recommendations. Additional surveys will be requested on a regular basis to identify potential salary trends so that we can stay abreast of the current labor market and remain competitive in the future.

Professional Conferences – CCHCS continues to identify 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. In the past six (6) months, Workforce Development and associated program staff have attended Osteopathic Physicians and Surgeons of California’s Fall Conference in Monterey, California, and provided recruitment materials to the National Commission on Correctional Health Care for their annual meeting in Las Vegas, Nevada.

This tactic allows us to increase CCHCS name recognition and brand awareness among both attendees and the health care community at large. Additionally, recruitment opportunities at these events are more personal. CCHCS is able to speak directly to potential candidates in a way that no online posting or print advertisement can.

Educational Programs Within Our Institutions – As a result of surveying our 35 institutions in July 2014 about the types of educational programs being utilized, 13 institutions were identified as implementing formal health care education programs including rotations, clinical, externships, and internships. These programs covered multiple Medical, Mental Health, Allied Health, and Dental Programs. CCHCS is working to expand these programs as a viable source for future candidates.

Workforce Development is working directly with programs to provide and implement statewide standards to our health care student rotations in order to improve ease and consistency for students and institutional leadership. In addition, we are working to increase the number of students/residents rotating through CDCR institutions.

Workforce Development is standardizing the health care related educational program process across all institutions and is developing surveys to follow-up with both students and clinical leaders to ensure that these programs continue to improve and be of value to both students and the institutions. Additionally, Workforce Development will begin to engage with these students after their participation in our health care educational programs is complete in an effort to convert these soon-to-be medical professionals from interns and students to full-time employees.

Correctional Medicine Fellowship Program – CCHCS is in the process of developing a 24-month curriculum for a Correctional Medicine Fellowship program. The Correctional Medicine Fellowship program is aimed at providing two (2) fellows per cohort with a high quality, advanced and comprehensive cognitive and clinical education that will allow them to become competent, proficient, and professional Correctional Medicine Physicians. The American Osteopathic Association now provides board certification in Correctional Medicine which CCHCS hopes to pursue. This program will allow a physician who has completed a three-year residency in Family Medicine, Internal Medicine, or Physical Medicine and Rehabilitation the opportunity for advanced training by completing a two-year Correctional Medicine Fellowship. Upon completion of the program, fellows will additionally have earned a Masters in Public Health, and may be eligible to sit for their boards.

The advantages of this new Correctional Medicine Fellowship program includes, but is not limited to the following:

- Creating a platform to train and retain physicians who are board certified in Correctional Medicine for the State of California.
- Promoting excellence in Correctional Medicine and improving CCHCS' image, prestige, and position in the community.
- Promoting physician recruitment by attracting young graduates to Correctional Medicine.
- Setting future standards for quality in Correctional Medicine.
- Reducing recruitment costs by hiring at least two (2) fellows per year at a reduced salary.
- Creating future leaders in Correctional Medicine and improving succession planning.
- Creating opportunities for our medical executives and primary care providers to have advanced academic exposure and, in turn, boost morale.

These combined efforts (Visa Sponsorship Program, compensation analysis, outreach advertisement, educational programs) will help ensure that CCHCS has a consistent pipeline of quality physician candidates to fill vacancies as they arise and enhance our image as a competitive employer of choice.

For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September through December 2014. These reports are included as [Appendix 11](#). 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 major focuses of the Receiver is developing a robust system that can continue to function effectively once medical care has been returned to CDCR. As mentioned in previous Tri-Annual reports, the Receiver has identified the following elements necessary for sustaining the reforms he has achieved or 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. Providing adequate resources and focus to ensure facilities and equipment are serviced, maintained, and repaired or replaced in order to meet the health and safety needs of inmates and staff;
9. A system for equipment and fleet management, including inventory, routine maintenance and planned replacement;
10. A health care leadership structure with a direct reporting relationship to the Secretary of CDCR;
11. A time-tested regional leadership structure; and
12. A culture in which patient care is a valued priority.

The recently released proposed Governor's Budget for FY 2015–16 include proposals from the Receiver to strengthen our QM and Recruitment/Retention efforts, as well as increase clinical staffing for CHCF as recommended by the recent report authored by Health Management Associates. The Receiver views these three (3) proposals as necessary for insuring that both clinical and operational systems are in place to deliver appropriate medical care to the patient population.

#### **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 Cycle 3, the OIG's Cycle 4 medical inspections were halted pending an assessment of the Comprehensive Inspection Tool. During the Tri-Annual reporting period, CCHCS, the parties, and the *Plata* Court Experts continued to work 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.

The OIG conducted two (2) additional pilot medical inspections at HDSP and CMC during the week of October 6, 2014. During that same week, the *Plata* Medical Experts conducted their own, separate inspection at HDSP for the purpose of comparing their findings with those of the OIG. To ensure neither report's findings were compromised, both the OIG and the *Plata* Court Experts provided their respective reports only to the Receiver. Once both entities had completed their reports, both reports were provided to all stakeholders by the Receiver. Various stakeholders conducted their own analysis, and, while differences of opinions remain, the findings of the OIG and HDSP were similar in content. Findings and remaining issues were discussed at a stakeholder meeting on January 8, 2015, and the Inspector General indicated that the OIG medical inspections will commence as planned in January 2015. The OIG finalized their medical inspection monitoring tool and methodology, and Cycle 4 of monitoring commenced during the week of January 26, 2015.

The definition of constitutional adequacy of care was discussed at stakeholder meetings in July and September 2014, as there are varying opinions between the parties regarding what this means. Additional stakeholder meetings took place during the Tri-Annual reporting period to discuss this remaining issue, but a final agreement has not been reached. Until this distance between the parties is addressed, there may remain a gap between the standard applied by the OIG and the stakeholders' views of constitutional adequacy.

##### **1. Joint Commission**

CCHCS has actively reviewed various models of independent performance evaluation and is considering accreditation by the Joint Commission. The Joint Commission is the oldest, most respected, and largest standard-setting and accrediting body in the United States. The Joint Commission accredits more than 20,000 health care organizations nationwide including the Federal Bureau of Prisons which provides a successful model of health care accreditation in a correctional environment.

The Joint Commission offers a broad range of accreditation programs covering various service delivery models with standards that set expectations for organization performance that are reasonable, achievable and measurable. The Joint Commission standards are informed by scientific literature, subject matter experts, and government agencies (including the Centers for Medicare & Medicaid Services), and are approved by the Board of

Commissioners. Joint Commission accreditation will provide CCHCS a means to compare to other organizations' infrastructure, processes, and performance.

At this time, CCHCS is in the preliminary phase of assessing the feasibility of accreditation which includes an internal gap analysis and two (2) mock accreditation audits to be conducted by the Joint Commission Resources (the teaching and consultative arm of the Joint Commission). The mock audits and gap analysis will provide a more formal assessment; will clearly define the differences between the Joint Commission Standards and actual practice within CCHCS; and will inform the development of a Joint Commission survey tool and process that is appropriate to our correctional health care organization. Following the results of the mock audits, CCHCS will determine if Joint Commission accreditation would be beneficial to our patients and the organization, and CCHCS will have a roadmap for preparing our system for the accreditation journey.

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

As announced in the previous Tri-Annual Report, CCHCS Field Operations staff have been tasked with developing proposed policy and training recommendations to address the role of custody staff during clinical encounters.

Based on competing priorities, particularly with the investment of time which has been required for the pending implementation of the DME policy, there has been little progress on this initiative. During this Tri-Annual reporting period, subject matter experts from CDCR's DAI, Mental Health, Dental, Nursing and Medical Services have been identified. The first work group meeting will take place in the near future.

#### **F. Coordination with Other Lawsuits**

During this Tri-Annual reporting period, regular meetings between the three (3) Courts, *Plata*, *Coleman*, and *Armstrong* (Coordination Group) class actions have continued. A Coordination Group meeting was held on December 2, 2014. Progress has continued during this Tri-Annual reporting period and is captured in meeting minutes.

##### **1. Armstrong**

CCHCS staff continue to make steady progress in numerous areas to strengthen and sustain an effective Disability Placement Program.

In September 2014, the remaining institutions' Health Care Compliance Analysts were hired following the establishment of one (1) position at every institution in the FY 2013–14 Governor's Budget. The positions were established to improve the ability to comply with the *Armstrong* Remedial Plan and effect change. Corrections Services submitted the necessary justification to establish a Health Care Compliance Analyst at each of the 34 institutions. Working through the Legislative process, positions for all 34 institutions were

approved and allocated. All of the institutions, with the exception of CVSP (sharing position with ISP) now have a full-time Health Care Compliance Analyst who supports the CEO in managing efforts to achieve and sustain compliance with the CCHCS' Disability Placement Program. All of the new analysts have received training provided at each of the four (4) regional CCHCS offices by Health Care Class Action Liaison (HCCAL) unit staff.

Another positive improvement was the initiation of a new format used to respond to reports generated from the Armstrong Monitoring Tours. In the past, institutions would complete a CAP after each tour report was received. The Warden and the CEO are now asked to work collaboratively and provide one (1) jointly signed response addressed to the RHE and the respective Associate Director. The new memorandum format provides a more thorough response and addresses each concern identified in the report. The responses are routed through the respective Associate Director and RHE. This process improves collaboration, raises awareness, and allows for a more comprehensive response to the plaintiffs' counsel.

HCCAL staff have also partnered with Policy and Risk Management Branch staff in developing a new Wheelchair Tracking log, Sign Language Interpreter (SLI) log, DME log, DME receipt, as well as updating the EC Inquiry Template. The Wheelchair Tracking log provides accountability for all wheelchairs throughout the entire repair and maintenance processes. The SLI log provides accountability by documenting patient's name, date, reason, and length of SLI appointment. The DME Log will provide each institution the ability to track all patient DME and identifying the usage and condition of each item. The DME receipt was created to document and record the delivery of DME to each patient. The EC Inquiry Template has been updated to ensure the standardization of the EC inquiry, while ensuring the court-mandated information is captured on all inquiries.

In another collaboration, HCCAL staff have partnered with CDCR's CAMU. In an effort to simplify inmate requests for accommodation and eliminate needless bureaucratic processes and paperwork, CDCR and CCHCS have implemented a new process known simply as the Reasonable Accommodation Panel (RAP). The process requires a panel of staff to meet once a week with the sole purpose of responding to patient requests and solve complex multidisciplinary issues that impact patient requests for accommodation. The RAP is comprised of institution staff to include: a health care provider, Health Care Compliance Analyst, the custody ADA Coordinator, CAMU Correctional Counselor II, medical and custody appeals staff. The combined panel meets on a weekly basis to address each submitted CDCR 1824, Reasonable Modification or Accommodation Request. The RAP was successfully tested at the California SATF in late 2014, and during this Tri-Annual reporting period, NKSP and CMF have implemented the new process and have entered into the test-phase. It is the intent of both CCHCS and CDCR to implement the new process at several additional institutions early in 2015. The process has been shown to reduce complaints, reduce unresolved reasonable accommodation requests, and provide assistance to patients in a more efficient and timely fashion.

This Tri-Annual reporting period also concluded with the highest overall increase in institution performance as measured by CDCR's Office of Audits and Court Compliance (OACC) *Armstrong* Disability Placement Program Compliance Reviews. Twenty-four (24) institutions now have compliance scores of Substantial Compliance (scores at or greater than 90 percent). Nine (9) institutions have scores in the Partial Compliance range (80-89.9 percent) and there is for the first time no institution in the Non-Compliance category (79 percent or less). There has been a very tangible and measurable improvement statewide.

Field Operations staff have also completed work on the health care component of a new proposed audit instrument that would consolidate the current OACC *Armstrong* Disability Placement Program Compliance Review and the plaintiffs' Monitoring Tours into one collaborative review. CCHCS has proposed that Section III, Health Care Operations, of the proposed audit instrument include 27 questions aimed at measuring institution compliance with various data elements which are used to gauge institution compliance with the Disability Placement Program. The questions must be discussed with plaintiffs before this section can be finalized.

Finally, in an effort to promote EC during clinical encounters for deaf patients who are placed in Administrative Segregation Units (ASU), CCHCS staff have proposed to implement the use of Video Remote Interpreters to comply specifically with United States District Judge Claudia Wilken's June 4, 2013, order, included as [Appendix 12](#), requiring the use of SLIs during licensed psychiatric technician and nursing rounds in ASU. The proposal was approved during this Tri-Annual reporting period, a scope of service was written, and a request seeking bids from qualified vendors has been posted on *Bidsync* with bid submissions due by January 21, 2015.

#### **G. 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 13](#), is a summary of the contracts the Receiver awarded during this Tri-Annual 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).

**H. Consultant Staff Engaged by the Receiver**

The Receiver has not engaged any consultant staff during this Tri-Annual reporting period.

## **Section 7: An Accounting of Expenditures for the Reporting Period**

### **A. Expenses**

The total net operating and capital expenses of the Office of the Receiver for the four-month period from September through December 2014 were \$441,085 and \$0, respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 14](#).

### **B. Revenues**

For the months of September through December 2014, the Receiver requested transfers of \$450,000 from the State of California 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 2014–15 to CPR from the State of California is \$800,000.

All funds were received in a timely manner.

## **Section 8: Conclusion**

The accomplishments and activities during the Tri-Annual reporting period indicate that we are turning an important page in our efforts to improve the quality of prison medical care. In particular, we have clearly moved beyond the confines of the RTPA and are now making second-generation improvements. The new and improved Health Care Services Dashboard, release of the first Patient Safety Report, new initiatives on polypharmacy and ESD, the imminent rollout of the interfacility transfer process by the PMCC Committee, and the new DME policy, among other things, evidence a health care organization that has developed self-sustaining quality improvement processes. This is a new and hopeful level of organizational maturity, the results of which should ultimately be reflected in the institutional assessments that the OIG will be conducting during 2015.