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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.*

Case No. C01-1351 TEH

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

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.*

Case No. C94-2307 CW

26 **NOTICE OF FILING OF RECEIVER'S**  
27 **THIRTIETH 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 Thirtieth Tri-Annual Report.

3 Dated: October 1, 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**

**Thirtieth Tri-Annual Report of the Federal Receiver  
For May 1–August 31, 2015**

**October 1, 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

### A. Reporting Requirements and New Reporting Format

This is the thirtieth report filed by the Receivership, and the twenty-fourth submitted by Receiver J. 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 Turnaround Plan of Action (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 issued an order on March 27, 2014, entitled [Order Re: Receiver's Tri-Annual Report](#) wherein he directs the Receiver to discuss in each Tri-Annual Report the level of care being delivered at California Health Care Facility (CHCF); difficulties with recruiting and retaining medical staff statewide; sustainability of the reforms the Receiver has achieved and plans to achieve; updates on the development of an independent system for evaluating the quality of care; and the degree, if any, to which custodial interference with the delivery of care remains a problem.

The Receiver filed a report on March 10, 2015, entitled [Receiver's Special Report: Improvements in the Quality of California's Prison Medical Care System](#) wherein he outlined the significant progress in improving the delivery of medical care in California's prisons and also the remaining significant gaps and failures that must still be addressed. The identified gaps are availability and usability of health information; scheduling and access to care; care management; and health care infrastructure at facilities.

In an effort to streamline the Tri-Annual Report format, the Receiver will report on all items ordered by Judge Thelton Henderson, with the exception of updates to completed tasks and metrics contained in the Plan. Previous reports contained status updates for completed Plan items; these updates have been removed, unless the Court or the Receiver determines a particular item requires discussion in the Tri-Annual Report.

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

- *Appendices*: This Report references documents in the Appendices of this Report.
- *Website References*: Website references are provided whenever possible.

In support of the coordination efforts by the three federal courts responsible for the major health care class actions pending against California Department of Corrections and Rehabilitation (CDCR), the Receiver files the Tri-Annual Report in three different federal court class action cases: *Armstrong*, *Coleman*, and *Plata*. An overview of the Receiver's enhanced reporting responsibilities related to these cases and to other *Plata* orders filed after the Appointing Order can be found in the Receiver's Eleventh Tri-Annual Report on pages 15 and 16. ([http://www.cphcs.ca.gov/receiver\\_othr\\_per\\_reps.aspx](http://www.cphcs.ca.gov/receiver_othr_per_reps.aspx))

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

## **B. Progress during this Reporting Period**

Progress towards improving the quality of health care in California's prisons continues for the reporting period of May 1 through August 31, 2015, and includes the following:

### Office of the Inspector General – Cycle 4

As reported in the Twenty-ninth Tri-Annual Report, the Office of Inspector General's (OIG's) Cycle 4 Medical Inspections commenced during the week of January 26, 2015. Since that time, 12 Medical Inspections have been conducted at the following CDCR institutions: Folsom State Prison (FSP); Correctional Training Facility (CTF); California Rehabilitation Center (CRC); California Correctional Center (CCC); North Kern State Prison (NKSP); Chuckawalla Valley State Prison (CVSP); California State Prison, Solano; Kern Valley State Prison; California Correctional Institution (CCI); Pelican Bay State Prison (PBSP); Valley State Prison; and Centinela State Prison. Final OIG reports have been issued for FSP, CTF, CRC, CCC, and CVSP. The overall rating by the OIG for FSP, CTF, CRC, and CVSP was Adequate; while, CCC's overall rating by the OIG was Inadequate.

The Receiver delegated authority for the medical operations at FSP to CDCR on July 13, 2015. The transition back to the CDCR Secretary's authority occurred without incident, and the institution performance continues to be monitored to ensure sustainability. Meet and Confer sessions to discuss delegation of additional institutions are scheduled for late October 2015.

### Armstrong

California Correctional Health Care Services (CCHCS) staff continue in their progress to implement a reliable solution for providing sign language interpreters at all clinical encounters. A CCHCS stakeholder workgroup was convened to address adoption of an on-demand technology solution to provide sign language interpreters remotely through a system very similar to the technology used by CCHCS Telemedicine Services. CCHCS Information

Technology (IT) staff were instrumental in developing a technology link that enables clinicians to access a sign language interpreter remotely any time, day or night. CCHCS stakeholders then amended applicable policies and procedures to include provisions for the use of Video Remote Interpreter (VRI) services.

On June 22, 2015, testing of the VRI portable workstations began at the California Medical Facility (CMF). During the reporting period, weekly check-in calls between CMF and CCHCS headquarters staff have revealed the VRI service is performing as designed. Staff from CMF have commented on the reliability and ease of use of the VRI equipment. A demonstration of the system was provided to the plaintiffs' counsel, the *Armstrong* court expert, and other stakeholders on August 4 and 5, 2015.

A VRI training presentation was developed by Nursing, IT, and Field Operations staff. Training will be provided on-site to institution staff as part of the deployment and implementation schedule as shown in Table 1 below.

*Table 1: Institution Deployment and Implementation Schedule*

Date(s)	Institution
September 21, 2015	California Substance Abuse and Treatment Facility
September 22, 2015	North Kern State Prison
September 28 – 29, 2015	Richard J. Donovan Correctional Facility
September 30, 2015	California Institution for Men
October 9, 2015	California Health Care Facility
October 13, 2015	Deuel Vocational Institution
October 19, 2015	Central California Women's Facility

### Environmental Improvements

For decades, the CDCR has encountered significant challenges in its ability to successfully clean and sanitize its medical facilities due to a lack of resources, training, policies and procedures, and application of a recognized standard for both cleaning and auditing health care clinical areas. Over the years, this ultimately resulted in the failure to provide a reasonable and acceptable standard of care and delivery of medical services, due to the poor conditions of its direct and indirect patient care areas.

The Receiver took action through a partnership with California Prison Industry Authority (CALPIA). [Appendix 1](#), CALPIA Health Facilities Maintenance Program, highlights the Receiver's orchestrated plan to identify and employ viable means and resources to successfully standardize, implement and sustain a level of cleanliness and sanitization that meet a community standard of care on a statewide level. This plan is in its final stages of successful

implementation in direct and indirect patient care areas throughout the CDCR. The results have been measured and underscore that the CDCR is on track. After years of struggle, the CDCR is now making progress in providing sound infection control and sanitation in the working and treatment environments for both staff and patients.

#### Coccidioidomycosis Skin Test Mass Screening in the California Out-of-State Correctional Facilities (COCF), August 6–10, 2015

All of the 6,952 inmates in California Out-of-State Correctional Facilities (COCF) at the time of mass screening were offered the coccidioidomycosis (cocci) skin test. Of those who were offered, 2,344 consented, for an acceptance rate of 33.7 percent. Of those who accepted, all were administered and completed the test. Among the 2,344 inmates who completed the test, 197 (8.4 percent) had a positive result.

None of those tested had an immediate adverse reaction (a reaction that occurred within 30 minutes of test administration). Sixty-one (2.6 percent) reported at least one of ten adverse reactions at the time of reading. The most common adverse reactions when read were itching (2.4 percent) or rash (one [1] percent) at the site of administration. The other adverse reactions were reported for less than one (1) percent of those tested.

The COCF acceptance, positive result, and adverse event rates are comparable to those found with the in-state mass screening event in January 2015.

#### Cocci Skin Test Status Among Inmates in the Men's Institutions

Of the 5,420 inmates currently housed in Avenal State Prison (ASP) or Pleasant Valley State Prison (PVSP), 4,751 (87.7 percent) have declined the cocci skin test. Among inmates in all of the other institutions, 51,425 (47.6 percent) of 107,974 have declined. The 10.2 percent positive result rate among inmates at ASP or PVSP is four times the positive rate in the other institutions (2.5 percent). Of the 104 (1.9 percent) inmates at ASP or PVSP with a negative result, 19 (18.3 percent) were previously diagnosed with cocci disease and are not restricted from ASP and PVSP; 85 (81.7 percent) are restricted (and should be transferred out). All inmates at ASP and PVSP have been offered the skin test, while 16,428 (15.2 percent) inmates in the other institutions have not been offered. Among those who have not been offered, 5,613 (34.2 percent) are currently eligible for placement at ASP or PVSP, and therefore of high priority to be offered. Refer to Table 2 for Cocci Skin Test Status Among Inmates in the Men's Institutions.

<b>Table 2 - Cocci Skin Test Status<sup>1</sup> Among Inmates in the Men's Institutions</b>													
Institution	Inmates	Declined		Positive		Negative		Other <sup>2</sup>		Not Offered		High Priority	
		N	%	N	%	N	%	N	%	N	%	N	% (of Not Offered)
ASP/PVSP	5,420	4,751	87.7	555	10.2	104	1.9	10	0.2	0	0.0	0	0.0
Other	107,974	51,425	47.6	2,653	2.5	36,501	33.8	967	0.9	16,428	15.2	5,613	34.2
Total	113,394	56,176	49.5	3,208	2.8	36,605	32.3	977	0.9	16,428	14.5	5,613	34.2

<sup>1</sup> Data available in the QM Cocci Risk Registry as of September 15, 2015.

<sup>2</sup> Includes pending or invalid results and tests not done for medical reasons.

The high proportion of inmates at ASP and PVSP (87.7 percent) and overall statewide (49.5 percent) who have declined the cocci skin test coupled with the small number of positive tests (3,208) raises concerns about achieving the degree of disease prevention anticipated based on consultation with the Centers for Disease Control and Prevention.

### **C. Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals**

Although progress continues for this reporting period, the Receiver continues to face the following challenges:

#### In-State Contracting for Community Correctional Facilities

The Modified Community Correctional Facilities (MCCF) continue to face challenges with hiring and retaining qualified physician and nursing staff. Continued on-site audits and the completion of detailed case reviews have revealed a steady decline in MCCF performance as it relates to patient care. The consistent decline can be attributed to the high turnover in nurses and physicians resulting in inconsistent transfer of knowledge to clinical/medical providers, the unfamiliarity with policies and procedures, and the overall lack of commitment by providers as revealed through detailed case reviews and on-site audits. For example, a physician refused to commit to a daily work schedule consisting of normal business hours, but instead, chose to wake patients at 1:30 a.m. to conduct sick call. As another example, a physician failed to complete the required documentation in the medical record after the patient encounter and then returned weeks later to complete the charting after it was discovered there was no documentation to support the necessary clinical services provided.

Recommendations were made to CDCR regarding the need for a full-time physician with additional nursing support staff at each MCCF in an effort to correct the performance issues identified during the review of medical charts and from the completion of on-site audits. CDCR is in the process of finalizing their contract amendment with the MCCFs to include a physician

40 hours per week as well as a Licensed Vocational Nurse (LVN) for physician and administrative support. Five (5) of seven (7) MCCFs already have a full-time physician or physician assistant working 40 hours per week, and all seven (7) MCCFs have employed the required LVN support at 40 hours per week.

#### Out-of-State Contract Facilities

In May 2015, CCHCS implemented a new compliance audit tool, which identified systemic medical care deficiencies, relating to the quality of medical care provided at the four COCFs. Working in collaboration with CDCR's Contract Beds Unit, a meeting with the vendor's executive management was held on August 12, 2015, to discuss and voice CCHCS' expectation of improved performance in their provision of care to the patient population.

As CDCR surpassed the federal court mandate to decrease overcrowding within the California prison system, CDCR is simultaneously reducing the COCF population and returning the patient population to a correctional institution or an MCCF within California. The first out-of-state facility is projected for closure by December 31, 2015. From May 1 through August 28, 2015, the out-of-state population reduced by 1,354 inmates: from 8,144 down to 6,790.

In recognition of the large numbers of inmates expected to return to California from the out-of-state facilities, CCHCS staff worked in collaboration with the vendor's medical team in establishing a cocci virus education and testing process. The testing process was successfully completed in early August 2015.

#### Transportation Vehicles

During the reporting period, the Receiver's Office was informed that the Assistant Deputy Director (ADD) of Operations within the Division of Adult Institutions (DAI) now provides oversight of health care transportation vehicles. While the procurement tasks continue to reside with the Office of Business Services, the involvement of DAI in the process was a welcomed change. Over the past several months, CCHCS has seen progress in the area of vehicle modifications, such as the required security modifications and installation of the telecommunication radios, for those vehicles purchased with fiscal year (FY) 2013–14 funding. CDCR successfully completed the retrofitting for 39 out of the 41 transportation vehicles purchased. The remaining two (2) vehicles are scheduled to be completed in September 2015.

In spring 2014, CCHCS identified 13 Emergency Response Vehicles (ERVs) requiring replacement. CDCR reported the procurement bid process for the ERVs did not have the expected response from potential bidders as anticipated. These challenges extended the procurement process. CCHCS received ten (10) of the 13 identified ERVs. The most recent procurement bid process was successful in obtaining one (1) of the remaining three (3) ERVs. Subsequently, additional procurement bids will be required to fulfill the original requirement of 13 ERVs. The procurement of the 22-passenger para-transit bus was finalized and CDCR/CCHCS is expecting to take delivery during the third quarter of 2016.

The Secretary's decision to shift management and oversight of the health care vehicle procurement process to DAI's ADD of Operations appears to have refocused CDCR's efforts in establishing a procurement plan for the ongoing replacement of health care transportation vehicles. In addition, a fleet inventory survey was distributed to all institutions. This process required input and approval by both the Warden and the Chief Executive Officer of each institution. Just as there has been a shift in the population of high-risk patients to medically classified intermediate institutions, a shift of transportation vehicles could better meet the needs for medical transportation.

Most recently, the Receiver's Office was advised of CDCR's replacement vehicle plan for FY 2014–15 which includes a total of 185 vehicles. Of these vehicles, only 22 (12 percent) are identified as health care vehicles. In response to questions about the plan, CDCR reports they have identified \$10 million dollars for vehicle procurement in FY 2015–16, and at the direction of the Secretary, Department staff committed to utilizing 95 percent of the FY 2015–16 funding to purchase health care transportation vehicles. CDCR made a commitment to work collaboratively with CCHCS to identify the right vehicle for the right mission at each of the institutions.

#### Legionnaire's Disease

On August 27, 2015, CCHCS' Public Health Branch was notified of a confirmed case of Legionnaire's Disease and an outbreak of pneumonia among inmates at San Quentin State Prison. Soon thereafter, additional confirmed cases of Legionnaire's Disease were reported (i.e., an outbreak). Because outbreaks of Legionnaire's Disease are usually associated with either inhalation of aerosolized potable water or mist from cooling towers, both the showers and the air conditioner for the medical facility were turned off.

Investigation and response teams were formed, which included the following:

- Clinical operations and surveillance;
- Epidemiologic investigation;
- Environmental investigation;
- Occupational health response;
- Custody operations; and
- Communications.

For the week of investigation and response, a modified incident command structure was established with daily teleconferences that included reports from each team. Throughout the response, there was active collaboration with the California Department of Public Health, Marin County Health Department, and the Centers for Disease Control and Prevention. CDCR's Facilities Management employed an environmental health consultant to advise on the environmental investigation and to provide recommendations on immediate remediation (e.g., cooling tower cleaning) as well as a long-term prevention plan (e.g., maintenance and surveillance testing of the cooling towers). Statewide Public Health Nurses from CCHCS

provided to all inmates at San Quentin State Prison in-person education on Legionnaire's Disease and the need to report to medical if they developed symptoms.

There were 81 cases of radiographically confirmed pneumonia (n=80) or lab confirmed legionellosis (n=13) with onsets from August 10 through September 15, 2015. The median age was 56 years (range=25 to 83 years); 13 patients were hospitalized; and there were no deaths. Among staff, there were three confirmed cases; one case of pneumonia; and 12 reported cases currently under investigation.

Evidence from both the descriptive epidemiologic investigation and the environmental investigations were most consistent with contaminated cooling towers as the cause of the outbreak; persons walking near buildings with contaminated cooling towers can inhale the mist from those towers. There were no maintenance records available for the cooling towers.

Later test results of environmental samples revealed that the water in two of the cooling towers at the top of the Central Health Services Building had high concentrations of *Legionella pneumophila* serogroup 1, which is the most common cause of Legionnaire's disease. No potable water samples had high concentrations of *Legionella pneumophila*. Several environmental factors played a role in the propagation of *Legionella pneumophila* bacteria, including excessive ambient air temperatures (e.g., a heat wave) in the San Francisco Bay area approximately two weeks prior to the outbreak, and excessive build-up of debris (e.g., sludge) in the water pans associated with the cooling towers. The cooling towers have now been cleaned, the filters have been removed from the showers, and the institution is back to normal operations.

The above incident underscores the contribution of the prison facility environment to health care outcomes. Regular maintenance and upkeep of building sites can mitigate the spread of communicable disease and other adverse health care outcomes. San Quentin Plant staff are developing detailed procedures addressing appropriate operations and maintenance of the cooling towers to reduce or eliminate future *Legionella pneumophila* propagation. Minimizing the potential for future Legionnaires Disease outbreaks will be the subject of a statewide conference call with Correctional Plant Managers, facilitated by the CDCR Facility Planning, Construction and Management Division and will address the need for employing best practices associated with *Legionella pneumophila* prevention.

The next Tri-Annual Report will include an update of additional clinical findings and conclusions and additional information regarding plans to mitigate future incidents, including collaborative CCHCS/CDCR planning, monitoring, and auditing.

## **Section 2: Status and Progress Concerning Remaining Statewide Gaps**

As reported in the [Receiver's Special Report: Improvements in the Quality of California's Prison Medical Care System](#), and as cited in [Judge Thelton Henderson's Order Modifying Receivership Transition Plan](#), the following statewide gaps remain: availability and usability of health information, scheduling and access to care, care management, and health care infrastructure at facilities. The following are updates on each of the remaining gaps:

### **A. Availability and Usability of Health Information**

As reported in the Twenty-eighth Tri-Annual Report, Cerner Corporation has been selected to provide a commercial "off-the-shelf" Electronic Health Records System (EHRS) 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 EHRS project is part of a larger organizational transformation project entitled ECHOS – Electronic Correctional Healthcare Operational System. The project is presently in the Testing Phase.

During this reporting period, the EHRS project team performed several rounds of system testing on workflows for more than 192 health care delivery processes. The Learning and Adoption team reviewed and approved the testing plan and materials. Additionally, all train-the-trainer participants have been identified and training rooms reserved and provisioned. Project Communication and Organizational Change Management team members have continued engaging Change Ambassadors from the field and headquarters to provide solution demonstrations (e.g., effective communication, medication administration and scheduling) to their respective sites and staff. The Go Live team developed the Go Live and solution Cut-over Plan and Dashboard that will be used to track progress to Go Live at the Pilot sites.

The EHRS project team continues to support the integration of an electronic dental record solution into the EHRS and is presently monitoring the completion of the requirements document.

Overall, the ECHOS project is 78 percent complete, and implementation of the EHRS will begin in late October 2015.

### **B. Scheduling and Access to Care**

#### Performance Evaluation and Improvement Tools – Scheduling Process Diagnostic Report

In Phase 2 of the Scheduling Process Improvement (SPI) Initiative, a new management report was developed to provide specific care team scheduling data, including population and care team characteristics; Scheduling and Access performance results from the Health Care Services Dashboard; and data to inform demand and supply management.

The Scheduling Process Diagnostic Report is designed to provide performance data at the care team level so that institution leaders and local scheduling champions may use the information

to identify and address variations between care teams, and to identify best practices or struggling teams where targeted assistance may be provided.

The Scheduling Process Diagnostic Report that was previously only available to institutions participating in the SPI Phase 2 project or the Focus Institutions Improvement Collaborative is now fully automated and available for all institutions through the Quality Management Portal. Refer to Figure 1 below for the first page of the Scheduling Process Diagnostic Report.

Figure 1, Scheduling Process Diagnostic Report – Page 1

SCHEDULING PROCESS DIAGNOSTIC REPORT							
ESP							
June 2015							
OVERVIEW	CARE TEAM						
Patient Panel Characteristics	SW	ESP	Facility A	Facility B	Facility C	Facility D	Other
Total Number of Patients	117,738	3,080	728	785	784	736	47
High Risk Patients	12% (13,987)	9% (284)	6% (43)	12% (95)	9% (70)	8% (58)	38% (18)
Medium Risk Patients	40% (47,422)	46% (1,431)	41% (299)	52% (406)	44% (346)	50% (368)	26% (12)
Low Risk Patients	48% (56,329)	44% (1,365)	53% (386)	36% (284)	47% (368)	42% (310)	36% (17)
EOP Patients	5% (6,275)	2% (54)	7% (53)	0% (0)	0% (0)	0% (0)	2% (1)
Access Measures	SW	ESP	Facility A	Facility B	Facility C	Facility D	Other
RN Triage Completed within 1 Business Day	96%	96%	98%	95%	95%	93%	100%
PCP Urgent Referrals Completed within 1 Calendar Day	94%	100%	100%	100%	N/A	100%	N/A
PCP Routine Referrals 14 Calendar Days	83%	91%	93%	94%	98%	79%	N/A
Chronic Care Appts. Seen as Ordered	84%	86%	85%	90%	98%	78%	0%
Chronic Care Appts. Seen as Ordered for High Risk patients	87% (2,781)	85% (35)	88% (7)	92% (12)	100% (4)	75% (12)	N/A
Chronic Care Appts. Seen as Ordered for Medium Risk patients	82% (4,424)	85% (140)	83% (38)	88% (38)	97% (29)	80% (35)	0% (0)
Chronic Care Appts. Seen as Ordered for Low Risk patients	84% (1,288)	89% (54)	92% (12)	92% (11)	100% (14)	77% (17)	N/A
Return from Higher Level of Care Follow-up Seen within 5 Calendar Days	87% (866)	92% (23)	67% (4)	100% (3)	100% (4)	100% (7)	100% (5)
Medical Appts. Seen as Scheduled	76%	64%	60%	57%	76%	68%	80%

### C. Care Management

In summer 2014, CCHCS established the Population Management Care Coordination (PMCC) Committee with two 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 summer 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 (e.g., Correctional Treatment Centers [CTCs]) to ensure appropriate staffing based on patient acuity level. This tool has been integrated with the Patient Risk Stratification Tool for Population Management to make it more comprehensive and will be tested at CHCF in fall 2015. Policy and training for the use of this tool is in development with an implementation targeted for early 2016.

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 and statewide implementation in October 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 policy and procedure, Reference Manual and Operational Guide. Training on Care Management of Complex Care Patients is planned for late 2015 and implementation in early 2016.
- Developing, modifying and updating the 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. The Complete Care Model policy, which is the anchor of the series, was implemented in July 2015. The following series of policies and procedures have been completed and are in various stages of the vetting and approval process:
  - Care Teams and Patient Services Procedure
  - Scheduling and Access to Care Procedure
  - Scope of Patient Services Procedure
  - Population and Care Management Procedure
  - Outpatient Housing Unit Policy and Procedure
  - Correctional Treatment Center Policy and Procedure
  - Patient Care During Pregnancy and Childbirth Policy and Procedure

Next steps will be training development and implementation planning that will occur in winter 2015, with statewide implementation beginning in early 2016 and rolling out concurrently with EHRS. Developing Disease Management Protocols for Nursing Care Managers is the next phase, planned for late 2016.

#### Transfer Subgroup

In fall 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 (SOMS) simultaneously, and places a movement warning on the patient. The subgroup has completed statewide education to both clinical and custody staff. CCHCS has provisioned Registered Nurse (RN) staff statewide on the ability to place a temporary medical hold on a patient to prevent inappropriate and unsafe transfers.

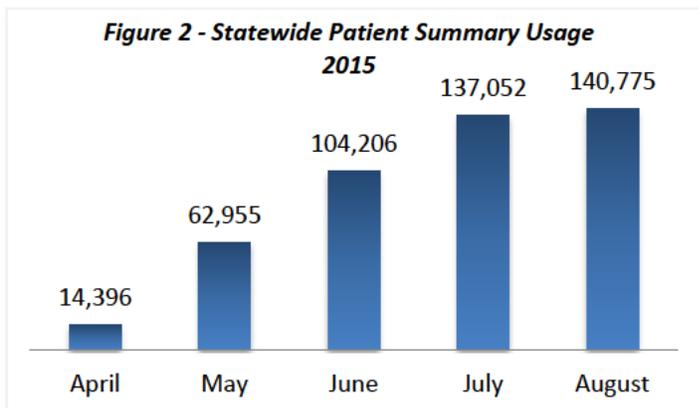
The Transfer subgroup has also updated the Health Care Transfer policy and procedure, which is currently undergoing final revisions as recommended during the approval process. Several new tools were developed and are included in the draft procedure, including an automated Patient Summary sheet, which will also be an essential tool for care management, and a transfer check-list. Train-the-trainer training for the new transfer tools and processes was conducted in April 2015. Training of all institutional nursing staff and statewide implementation was completed on July 31, 2015. In addition, the transfer training was modified and adapted for training of custody staff and includes a custody classification registry. This registry provides custody and health care staff with a quick reference to factors that impact patients' transfer and institutional placement eligibility, such as custody level and Americans with Disabilities Act code, clinical risk level and cocci restriction, and patients on a medical hold or those who should be considered for a medical hold. This registry allows custody staff to filter patients prior to finalizing and sending the transfer lists and decreases the chance of unsafe transfers from last minute add-ons of patients who are or should be on a medical hold.

#### Performance Evaluation and Improvement Tools – Patient Summary

Initially developed in early 2015 as a tool for screening clinical factors in patients selected for transfer and coordinating care during transfer, the Patient Summary, included as [Appendix 2](#), is now also used by care teams during daily huddles and as a decision support tool during complex care management activities. Designed as a snapshot to include the most relevant patient health information, the Patient Summary provides clinicians with clinical data on a single patient from multiple sources, including:

- Patient Demographics.
- Scheduling and Access to Care – Disability status, accommodations, upcoming appointments, and prior high priority specialty appointments.
- Medication Management – Allergies, active medications, and polypharmacy.

- Care Management – Prior higher level of care events, durable medical equipment, and most recent Medical Classification Chrono.
- Disease Management and Prevention – Existing alerts from patient registries, diagnoses, and preventive care screening information.



Since its release in April 2015, the Patient Summary has increased in overall views more than 800 percent, from just 14,396 views in April to 140,775 presently in August. Refer to Figure 2 for the Statewide Patient Summary Usage in 2015.

Patient Summary usage among individual institutions may fluctuate; however, overall, every institution statewide has shown an increase in

access each month since implementation. For example, some institutions such as Deuel Vocational Institution have increased usage from 559 views to 10,475 in five months, an increase of 1,774 percent. As Patient Summary usage continues to climb, we expect to see decreases in problems often associated with the patient transfer process such as medication errors and medication discontinuity.

#### **D. Health Care Infrastructure at Facilities**

Clinical facility upgrades through the Health Care Facility Improvement Program (HCFIP) projects are progressing. Preliminary plans for all projects have been approved by the State Public Works Board (SPWB) with the last five (5) projects (Calipatria State Prison, Centinela State Prison, Chuckawalla Valley State Prison, Ironwood State Prison, and PBSP) receiving approval at the SPWB meeting on August 17, 2015. Of the 32 HCFIP projects, working drawings for 23 were approved by the Office of the State Fire Marshal (SFM) and submitted to the Department of Finance (DOF) for approval to proceed to bid and/or construction. To date, DOF approved 15 projects to proceed to bid, and 16 projects to proceed to construction. The DOF has also approved the award of construction contracts for 12 projects (CCI, California Institution for Women [CIW]/California Institution for Men, California Men's Colony, CTF/Salinas Valley State Prison [SVSP], FSP/California State Prison, Sacramento, Mule Creek State Prison [MCSP], NKSP/Wasco State Prison, and Richard J. Donovan Correctional Facility), and Notices to Proceed have been or are in the process of being issued.

In addition, Inmate Ward Labor (IWL) initiated significant procurement and mobilization activities. IWL construction activities are underway for HCFIP projects at 13 institutions and for Statewide Medication Distribution projects at 19 institutions. Schedule adjustments continue to occur to account for SFM limited design review resources; to reflect general contractor bid

and award process dates; to reflect actual Notice to Proceed dates; and to ensure CDCR/CCHCS efforts concerning integration of operational continuity plans and swing space. The revised schedules continue to reflect completion of construction at ASP in 2015 and for the remaining projects in 2016 and 2017.

CDCR still sustains the commitment, focus, and ability to manage construction and activation of these complex projects, while addressing schedule and budget challenges and significant challenges in maintaining operational continuity in the facilities during construction.

### **Section 3: Quality Assurance and Continuous Improvement Program**

#### New Quality Management Resources

At the beginning of FY 2015–16, the Quality Management Section received budget authorization to establish 30 new positions predominately located in the four regions. The positions are intended to support full implementation of the quality management system, which in turn supports an adequate, sustainable health care system in the future.

With the addition of the regional positions, there now are quality management resources within the three organizational levels: headquarters, regions, and institutions. Regional Quality Management teams will provide on-site technical assistance to institutions, facilitating problem analysis and process redesign. These units will assist in staff development and mentoring of institution-based Quality Management Support Units. Regional teams will also be responsible for evaluating local quality management systems, identifying institution strengths and weaknesses, and facilitating efforts to build an effective quality management infrastructure and processes.

In addition, Regional Quality Management teams will provide targeted technical support to low-performing institutions within their regions. Having staff in closer proximity to these institutions will allow for more long-term initiatives and resource-intensive activities to enact infrastructure, leadership, and cultural changes.

#### Major Statewide Improvement Initiative – Focus Institutions Improvement Collaborative

In his Order Modifying Receivership Transition Plan dated March 10, 2015, Judge Thelton Henderson identified variation in performance across institutions as one of a handful of major remaining barriers to successfully transitioning institutions back to State control. The new *Plata* transition plan includes special emphasis on bringing a group of low-performing institutions (referred to here as “focus” institutions) up to constitutional adequacy through a partnership between CCHCS staff and the *Plata* court experts.

After consultation with the court experts and other stakeholders, CCHCS identified seven (7) focus institutions for participation in this improvement collaborative. Because Region IV is not represented among the group of focus institutions, the Region IV executive team elected to bring in three (3) optional institutions at their discretion. Refer to Table 3 below for each region and their focus institutions.

Table 3, Regions I-IV and their Focus Institutions

Focus Institutions			Optional
Region 1	Region 2	Region 3	Region 4
California Health Care Facility	Deuel Vocational Institution	California State Prison, Los Angeles County	Ironwood State Prison
Mule Creek State Prison	Salinas Valley State Prison	California State Prison, Corcoran	Chuckawalla Valley State Prison
-	Central California Women's Facility	-	Richard J. Donovan Correctional Facility

Initial on-site reviews by the Regional Health Care Executive teams and the *Plata* court experts found that core elements of the health care services delivery system known as the Complete Care Model are missing at the focus institutions. Recognized as the organization's dominant strategy for delivering timely, safe, cost-effective care, the Complete Care Model is in the process of being codified in policies and procedures. Though each of the seven (7) focus institutions struggle with challenges specific to the institution's particular health care mission, resource needs, and cultural issues, they all share a common problem – they lack the basic building blocks of a primary care system and will continue to struggle until those building blocks are put into place in a sustainable way.

To assist focus institutions in implementing core elements of the Complete Care Model, CCHCS brought focus institutions together as an improvement collaborative to:

- Gain a thorough understanding of Complete Care Model requirements and expectations of leadership.
- Receive standardized training and tools to help institutions put new primary care structures and processes in place.
- Engage in group problem-solving to overcome barriers to successful implementation of the Complete Care Model and share best practices.

Each learning session of the improvement collaborative focuses on a different element of the Complete Care Model, including Care Team Infrastructure; Scheduling and Access to Care; Population Management; Complex Care Management; Care Coordination; and the Quality Management System. A dedicated webpage on the Quality Management Portal with online resources was developed and made available to focus institutions as each learning session was rolled out (refer to Figure 3).

Figure 3, Focus Institutions: Targeted Technical Assistance in 2015.



Through August 2015, executives from the focus institutions, along with their Regional counterparts convened for three learning sessions where they received focused training on sustainable processes, best practices and tools and decision support for implementation. The final learning session will take place in October 2015 (over a period of two days) and will cover Care Coordination and the Quality Management System.

*Plata* court experts have also provided valuable training on Lean Six Sigma methods for improving processes to medical and nursing staff and conducted focused case reviews to assist the primary care teams in identifying the lapses in continuity of care, level of care, and treatment planning.

As a result of the targeted support from the *Plata* court experts, the Regional team support, and the improvement collaborative, the focus institutions have demonstrated considerable improvement as evidenced on the Health Care Services Dashboard, an aggregate of performance measures for Medical, Mental Health and Dental. Most focus institutions now actively monitor their processes and monthly Health Care Services Dashboard adherence and have embedded tools and standardized processes and workflows in the improvement efforts to patient population and care management metrics; scheduling and access to care; timeliness of care; medication management; complex care; and staff performance and morale. Positive trends have begun to form around care team performance, scheduling practices and population health patient coordination. Plans are in place to focus on health information strategies and tying the quality management system to the focused work to ensure sustainability.

#### Performance Evaluation and Improvement Tools – Cervical Cancer Screening Registry

Cervical cancer screening is an important part of preventive health care for women, and pursuant to clinical literature, regular screening and appropriate follow-ups can reduce cervical cancer deaths by up to 80 percent. In response to requests from front-line providers at the female institutions, CCHCS developed and released a patient registry to monitor and manage cervical cancer screening for female patients. The new registry lists all female CDCR patients, when they were last screened for cervical cancer, the type of screening, screening results, and any declinations for screening. The registry also provides information about previous abnormal screening results (refer to Figure 4).

Figure 4, Central California Women's Facility

Identification & Housing						Cervical Cancer Screening* - Pap Smear and Human Papilloma Virus (HPV)								Prev. Abnormal Result	
CDCR#	Last Name	DOB	Age	Cell Bed	Care Team	Hyst. Flag	Most Recent Pap Date	Most Recent Pap Result	Result Note	Pap Refusal	HPV Results	HPV Date	Maximum Screening Due Date*	Previous Abn. Pap	Previous Abn. Pap Date

Also during this reporting period, Continuing Medical Education (CME) was developed in the form of Enduring Materials to help providers use the registry. The CME emphasizes the latest United States Preventative Services Task Force recommendations on cervical cancer screening, reviews the role of Human Papillomavirus testing in cervical cancer screening, and provides guidelines for the management of abnormal pap smears based on guidelines from the American Society for Colposcopy and Cervical Pathology.

From March through August 2015, patient lists from the Cervical Cancer Screening Registry were accessed more than 950 times at the three institutions with female patients and by CCHCS headquarters staff.

#### Patient Safety Priority – Quarterly Patient Safety Dashboard

Reports of health care incidents have been collected by CCHCS since 2012. Although data from the reports had been summarized and analyzed for various projects and audiences, it was not readily available for health care staff until recently. The first quarterly Patient Safety Dashboard was released in May 2015.

Each quarterly Patient Safety Dashboard provides statewide and institution data regarding incidents reported through the Health Care Incident Reporting System during a specific reporting period. The Patient Safety Dashboard displays current and prior period results, allowing institutions to quickly see aggregate data and compare themselves with statewide reporting trends. The Patient Safety Dashboard includes a summary of incident reports received, details related to medication errors and root cause analyses, and record-level data for deeper analysis and trending (refer to [Appendix 3](#), Patient Safety Dashboard).

An additional feature of the Patient Safety Dashboard is a focus on medication-related incidents, as they represent over 90 percent of all health care incidents reported. The Patient Safety Dashboard provides summary information of reported incidents by medication error level, medication type, and common process breakdowns associated with reported incidents.

An institution may use the Patient Safety Dashboard as a tool to inform and monitor patient safety improvement activities. CCHCS staff can access the Patient Safety Dashboard via the Patient Safety Portal link on Lifeline. For example, if an institution determines that it will focus

on medication management as an area for improvement, it can review medication-related incident trends to identify specific drugs or medication processes that most frequently contributes to medication errors and adverse events.

In each issuance of the Patient Safety Dashboard, a summary of major statewide patient safety findings and activities for the reporting period is provided, which may include links to best practices and other resources. For example, a recent summary indicated the following:

- During the second quarter of 2015, there were 1,394 health care incidents reported through the Health Care Incident Reporting System, which is a 46 percent increase from the second quarter of 2014. Outreach efforts are expected to improve system usage, as incidents likely still are under-reported.
- Medication errors continue to comprise about 90 percent of all reported health care incidents and 90 percent of reported medication errors were near misses, which were not associated with harm to patients.
- Insulin, Warfarin and Opioids continue to be the medications most frequently identified in reported medication errors. The Statewide Patient Safety Committee initiated an Insulin Workgroup to identify processes to reduce the risk of errors associated with insulin. In addition, CRC recently submitted an excellent Root Cause Analysis report on improving the safety of insulin administration.

#### Patient Safety Priority – Medication Process Improvement Initiatives

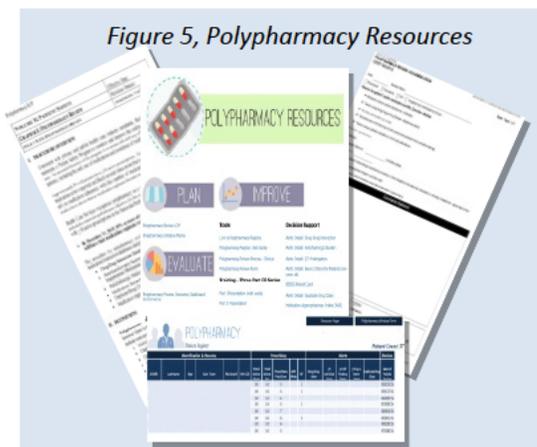
The 2014 Patient Safety Report identified that medication-related process problems, representing over 90 percent of all reported health care incidents, was a major factor in adverse patient outcomes and frequently contributed to potentially avoidable hospitalizations.

The Statewide Patient Safety Committee established a Medication Process Improvement Initiative to identify, prioritize, and address systemic medication process vulnerabilities. It has chartered two workgroups to develop tools, resources, training, and best practices to improve patient safety around specific medications or medication classes and to improve medication-related processes.

The first workgroup established under the Medication Process Improvement Initiative involved improving care for patients prescribed ten or more medications (polypharmacy); the polypharmacy initiative is in the implementation stage and an update is provided below.

#### *Patient Safety Initiative – Polypharmacy*

In early 2015, the Statewide Patient Safety and Pharmacy and Therapeutics Committees formed an interdisciplinary workgroup to manage patients who may be at risk for adverse effects due to medication regimens involving multiple drugs (polypharmacy).



The workgroup developed multiple tools and resources designed to help care teams manage these complex patients including a new Polypharmacy Registry; CDCR 7540 Polypharmacy Review Form; resource page; sample Local Operating Procedure; and statewide continuing education training (refer to Figure 5).

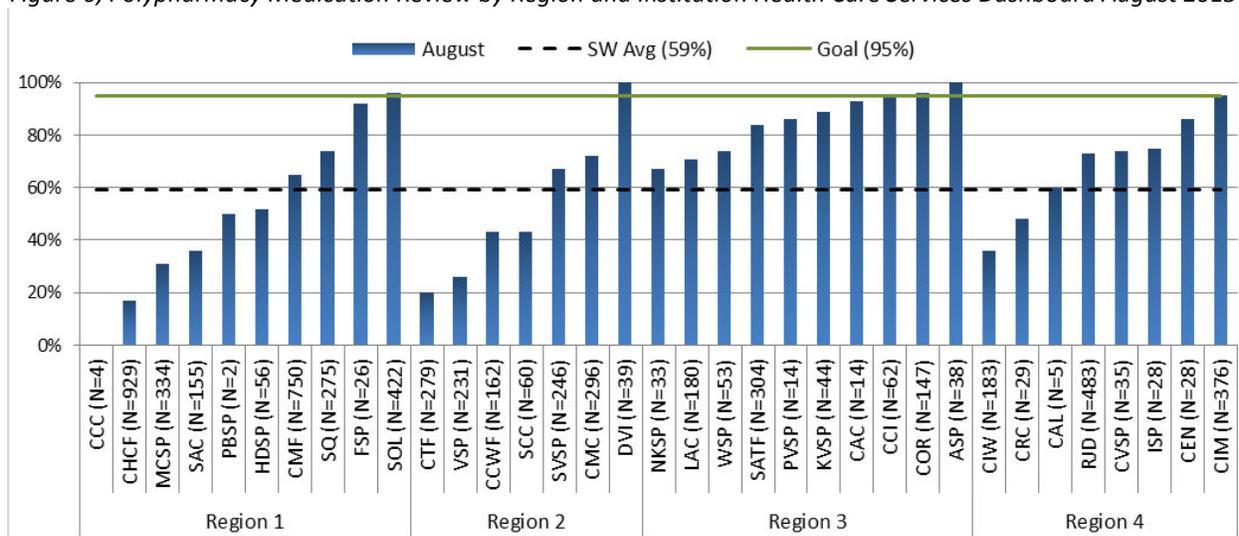
The Health Care Services Performance Improvement Plan 2013–15 also identifies polypharmacy as a priority area with the following performance objective:

“By December 31, 2015, 95% or more of patients prescribed 10 or more medications will have their medication regimens reviewed consistent with requirements.”

Progress toward this goal is monitored monthly in the Health Care Services Dashboard, effective this reporting period.

Since the initial release of the tools and resources to support management of patients with polypharmacy, there has been a steady increase toward meeting the statewide goal. Baseline statewide performance in April 2015 was 19 percent. As of the August 2015 Health Care Services Dashboard, 59 percent of all patients statewide had a polypharmacy medication review within the past 12 months and five (5) institutions statewide met or exceeded the statewide goal of 95 percent (refer to Figure 6). Reporting will remain in monitoring status (not color-coded) until early 2016 to allow institutions a period of time to operationalize a local polypharmacy review process.

Figure 6, Polypharmacy Medication Review by Region and Institution Health Care Services Dashboard August 2015



*Patient Safety Initiative – Insulin*

In July 2015, the Statewide Patient Safety Committee established an improvement project focused on preventing insulin-related medication errors. Insulin was selected because it was involved in more than 200 medication errors reported by CCHCS staff since 2013, and in 2014,

one in five of the most serious medication errors (Level 4 to 6 errors) involved insulin. Insulin is recognized nationally by organizations such as the Joint Commission and Institute for Safe Medication Practices as a high-risk medication in both acute care and ambulatory settings.

During this reporting period, an interdisciplinary workgroup analyzed the factors that cause insulin errors, including medication packaging that makes it easy to confuse different types of insulin and insulin lines that are subject to frequent interruptions. The workgroup identified three interventions that could reduce risk of errors for insulin patients:

- Implement a new color-code tray system to make it easier to differentiate between the different types of insulin during administration of the medication.
- Guard insulin lines against distractions by educating staff on the importance of administering insulin without interruption and posting “Do Not Disturb” signs.
- Educate patients about insulin administration errors and involve them in verifying that they are receiving the appropriate type and amount of insulin.

The above interventions are expected to be released in early fall and will include staff and patient education, and a process to track results.

#### Quality Management and the Electronic Health Record System

Starting in late October 2015, electronic tools used for CCHCS performance evaluation and improvement will begin integrating data from EHRS. Combining data from an EHRS extract with data from existing systems ensures that these tools essential for sustaining improvements patient care will continue to provide an up-to-date, accurate, comprehensive and longitudinal view of factors that drive CCHCS performance. Examples of the quality management tools that will incorporate this new data set include the Health Care Services Dashboard, Patient Registries, Patient Summary, and other reports described in previous Tri-Annual Reports.

## Section 4: Receiver's Delegation of Authority

### Receivership Transition Plan

As reported in the previous Tri-Annual Report, Judge Thelton Henderson issued an order on March 10, 2015, modifying the plan for how health care will be transitioned back to the State of California. Using the successful model that was used to resolve the dental lawsuit under *Perez*, the new plan focuses on transitioning prisons back one at a time after the Receiver, through several steps, determines that a prison is providing adequate medical care.

Under the plan, the OIG first completes their medical inspection of the prison and provides an overall rating regarding the care provided (as previously reported, the OIG has redesigned its medical inspection process by enhancing its quantitative compliance testing and adding qualitative clinical case reviews). There are three rating categories: Proficient, Adequate, or Inadequate. Upon receipt of the OIG's final report, the Receiver will then consider the OIG report, as well as data from the Health Care Services Dashboard and other internal monitoring tools. If the Receiver determines that an institution is suitable for return to CDCR control, he will execute a revocable delegation of authority to the Secretary of CDCR to take over management of that institution's medical care. The Receiver's delegation creates a rebuttable presumption that medical care provided in the prison is constitutionally adequate.

In addition, prior to executing any delegation of authority, the Receiver must meet and confer with both parties to the lawsuit, as well as consult with the court experts. Under the new order, any party that disagrees with the Receiver's delegation decision (either to delegate or not delegate) may challenge the decision by filing a motion in court. However, that party would have the burden of proof.

The Receiver will also continue to determine the appropriateness and timing of delegating additional core headquarters functions to CDCR. When a prison or headquarters function is delegated to CDCR, the Receiver will provide monthly monitoring reports to the Court that provide a public record concerning the performance of the operations. A delegation can be revoked by the Receiver after meeting with both parties and the court experts. However, if the Receiver leaves all delegations in place without revocation for a one-year period certifying that all functions and institutions have been delegated, it will create a rebuttable presumption of system-wide constitutional adequacy and sustainability. When that occurs, the Prison Law Office will have 120 days in which to challenge the presumption. If no such motion is filed, the Court will proceed with steps to terminate the Receivership and the underlying *Plata* case.

The Receiver delegated authority for the medical operations at FSP to CDCR on July 13, 2015. The institution's performance continues to be monitored to ensure sustainability. While no additional institutions have been subsequently delegated, meet and confer sessions with both parties to discuss the potential for delegation of additional institutions are scheduled for late October 2015.

Access Quality Report

Field Operations staff continue to receive the required monthly Access Quality Report (AQR) data from institutions and publish the monthly statewide AQR. Refer to [Appendix 4](#) for the Executive Summary and Health Care AQR for April through July 2015. Due to recent turnover in institution Health Care Access Unit (HCAU) Analysts, Field Operations staff provided AQR training at CCHCS headquarters on July 1, 2015. Staff from eight institutions attended.

Field Operations staff continue to collaborate and coach institution staff on improving data collection processes, specifically with tracking and reporting patient access to mental health group appointments. Institutions are reminded of the statewide mandate which requires the outcomes of all priority health care ducats, inclusive of those issued for mental health group appointments, be recorded on a custody tracking sheet for data validation purposes. During the review period, institutions (most notably MCSP) showed improvement, and the overall custody performance indicator was again exceeded.

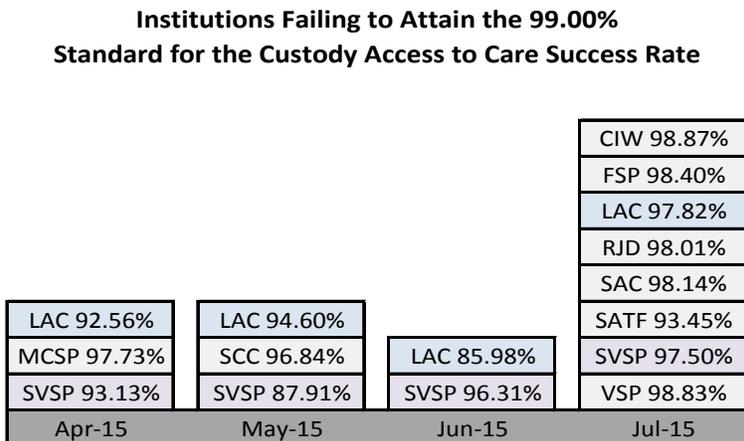
As indicated in the previous Tri-Annual Reports, the time and shift system (“TeleStaff”) does not provide certain data points the institutions are required to report to complete the AQR. Field Operations continues to discuss potential solutions with DAI’s Program Support Unit.

Custody Access to Care Success Rate

Statewide AQRs were published for the months of April, May, June, and July 2015 during this Tri-Annual Reporting period. The average custody *Access to Care Success Rate* for this period was 99.19 percent, above the Receiver’s benchmark of 99 percent. This represents an increase of 5.44 percentage points as compared to the Twenty-ninth Tri-Annual reporting period (inclusive of data from December 2014 through March 2015).

Refer to Figure 7 for a summary, by month, of the number of institutions failing to attain the 99 percent benchmark established in the delegation. The spike for the month of July 2015 is attributed to an increase in the number of modified programs which resulted in the cancellation and rescheduling of health care appointments at the affected institutions.

*Figure 7, Institutions Failing to Attain the 99.00% Standard for the Custody Access to Care Success Rate*



During this reporting period, 17 Corrective Action Plans (CAP) were required to be submitted for institutions failing to attain the benchmark from March through June 2015. Field Operations received 16 of these CAPs.

#### Operations Monitoring Audits

As of the close of this reporting period, Field Operations has completed three annual audits of every institution. Field Operations continues to conduct six-month reviews for institutions receiving low (i.e., below 85 percent) overall or component scores in the Round III audit cycle. Additionally, as of August 2015, Field Operations conducted the first of its *fourth* round (Round IV) of annual HCAU audits.

Cumulatively, Round I, II, and III scores indicate an average net improvement of 2.8 percentage points overall. While five (5) institutions (SVSP, CTF, MCSP, CIW and CMF) scored overall below 85 percent during the entire Round III cycle of audits, the majority rose above that mark substantially. Notably, of those institutions audited during this reporting period, none scored overall below 85 percent.

Despite this trend toward improvement, significant compliance failures remain and new non-compliance issues, thought to have been successfully resolved, continue to surface. Many institutions struggle to comply with simple documentation requirements, and others show weak compliance in areas directly impacting patient care, such as monitoring of patients recently discharged from Mental Health Crisis Beds (MHCB), ensuring MHCB transfers occur timely, and ensuring patients with prescribed keep-on-person medications have unobstructed access to those medications. While many institutions have matured in embracing health care as a normal and essential function, pockets of cultural resistance remain. One example is reluctance to allow close custody patients to receive Hour-of-Sleep medications at a central pill window. Another example is the lack of cooperation from non-HCAU custody staff when assistance is requested from HCAU custody staff. Despite the repeated development and submission of CAPs for the same audit findings, correcting these repeated deficiencies has not been a priority.

Additionally, Field Operations is in the process of engaging the Office of the Director, DAI, regarding adoption of standardized policies and procedures to resolve some of the most common deficiencies. Primarily these involve patients' placement into administrative segregation and the proper handling of prescribed keep-on-person medications. Despite custody staff's demonstrated knowledge of applicable policy and procedure, this expectation is not being adhered to in practice. Another repeated deficiency is establishing the proof of practice for issuance of priority health care ducats to patients prior to their scheduled appointments (average Round III score: 43.6 percent).

Field Operations is now seeking to leverage the leadership and direction of the Director's office to sharpen the focus and accountability at those institutions that cannot seem to address repeated audit findings.

## Section 5: Other Matters Deemed Appropriate for Judicial Review

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

CHCF's health care leadership team remains focused on ensuring the delivery of quality health care to its patient population. During the reporting period, CHCF remained open to intake for Enhanced Outpatient Program, Special Outpatient Program, and Department of State Hospitals admissions, as well as limited intake to its medical CTC and Outpatient Housing Units (OHU). Additional updates related to level of care delivery at CHCF include the following:

#### Medical Services

- CHCF has made great strides in facilitating care despite limited provider resources. A recently added Program Improvement Work Plan measure focuses on developing a model of care that reinforces and supports a patient-centered culture. Recognizing the shortage of providers, the primary care teams will rely heavily on the nursing staff for consistency. This project sets up a structured process for observing teams as they conduct daily huddles and providing teams with feedback and support. In addition, primary care teams will discuss Population Management, which includes reviewing and addressing findings from patient registries, as well as analysis of each primary care team's performance trends over time and necessary improvement activities in each daily huddle.
- A six-month policy exception for CHCF's OHU was granted in February 2015 and was renewed in August 2015 for an additional six months. In February 2015, CHCF's CTC was also granted a program flex by the California Department of Public Health.
- CHCF had a significant backlog of overdue polypharmacy medication reviews. This issue was immediately rectified, and as of August 31, 2015, over 95 percent of the reviews have been completed.
- Appeals staff continue to work diligently on reducing the number of overdue appeals. CHCF is currently at 18 percent overdue, compared to 82 percent overdue one year ago.
- Medication safety and non-formulary medications remain priorities at CHCF and have been successfully managed by workgroups. During the reporting period, the number of non-formulary medications prescribed by medical providers and the number of medication errors have both remained on consistent downward trends. This was a result of additional audits conducted and training provided.

#### Quality Management

- CHCF implemented an institution-wide Medical Inspection Program (MIP) in June 2015. The MIP is a comprehensive quality assurance program, which includes both qualitative and quantitative measures, encompassing and assessing all aspects of health care delivery within the facility. The ultimate goal is to establish a comprehensive self-monitoring quality assurance process, which will allow the health and overall functioning of CHCF to be measured. This process will provide staff and managers the information they need to successfully manage the delivery and quality of patient care.

- In May 2015, CHCF implemented a Chronic Care/Case Management program incorporating End Stage Liver Disease (ESLD), Asthma, Diabetes and Colon Cancer Screenings. The first area of focus was on diabetic and ESLD patients. A test program was implemented in select housing units in June 2015 and then officially rolled out to the entire institution in July 2015. The program is a comprehensive process involving increased training and collaboration between nursing, medical, and allied health staff, in addition to the facilitation of increased patient education.
- CHCF remains focused on promoting and training on the Patient Safety Program and Patient Safety Portal, particularly on the importance of reporting errors for improvement in patient safety.

#### Nursing Services

- CHCF's Patient Falls Workgroup, which meets on a monthly basis, continues to make significant progress as evidenced by the decrease in the number of falls. In May 2015, nursing staff were trained on new fall management protocols, post-fall assessment and investigation forms, as well as a new hourly rounding checklist.
- A Palliative Care/Multidisciplinary Workgroup was chartered and includes members from medical, nursing, custody, and religious services. They are working to develop a program similar to CMF's Compassionate Companion Program.
- Increased areas of improvement and focus include a pneumonia vaccination program, sepsis prevention and early intervention plan, colon screening (which is currently 99 percent on the Health Care Services Dashboard), and meeting compliance with intake appointments.
- CHCF Institutional Utilization Management (UM) recently established revised institutional goals based on 2014 trends and the 57 percent high-risk patient base. Workgroups and Quality Improvement teams have been chartered to address identified issues. During the reporting period, goals were met related to a reduction in community hospital bed days, readmissions, and specialty referrals.

#### Resource Management

- The Resource Management Committee continues to meet monthly. This Committee is responsible for the oversight and review of the CHCF Financial Services Subcommittee and Position Management Sub-Committee, which focuses on fiscal review including areas of overtime, contract medical costs, and position management control. Significant areas of improvement during the reporting period include:
  - Strong efforts by nursing staff have reduced overtime by approximately \$700,000 per month from July 2014 to June 2015.
  - Staff in blanket positions were rolled over into permanent full-time positions.
  - Reduction in urgent orders from an average of 20 or more per month to zero (0).
  - Stabilized par levels in housing units.
- During the reporting period, CHCF was able to hire a Correctional Health Care Administrator II and Associate Warden of Health Care. Even with these significant hires, critical management positions such as a Chief Physician & Surgeon, Health Program

Manager I, Health Program Manager II, and Supervising Registered Nurse II positions remain vacant.

- CHCF In-Service Training resumed Annual Training for CHCF-CCHCS staff in January 2015. The percentage of staff receiving New Employee Orientation and CTC Training is currently at 95 percent compliance.

#### Utilization Management

- To facilitate the CHCF provider staff management of hospitalized patients and discharge planning, the headquarters UM team has increased its facilitative role, actively assisting with high-risk patient discharge planning and individual patient transitional support after the patient has returned to CHCF. This effort has kept CHCF from accruing any administrative bed days and led to small improvements in potentially avoidable hospitalizations and readmissions. Continued and on-going headquarters support will be necessary to achieve sustainable improvements. In addition, UM continuously surveys CHCF's patient population for medical parole candidates and is assisting the institution with these applications. Since January 2015, 189 patients at CHCF have been formally screened for expanded Medical Parole.

#### Telemedicine

- CHCF continues to utilize telemedicine providers to assist with chronic care management. The primary focus was on Special Outpatient and Enhanced Outpatient treatment areas and has since expanded to include outpatient and OHU treatment areas. CHCF utilized 579 Telemedicine Primary Care encounters in July 2015, representing 38 percent of all Telemedicine Primary Care encounters statewide in the same time period. Additionally, CHCF continues to work with headquarters to address the availability of off-site specialist's appointments and potential specialty appointment alternatives (e.g., contract with other area hospitals, provide additional on-site services) to increase access to care and ensure compliance timeframes are met.

#### Ongoing Priorities

- Recruitment and retention for providers and management positions continues.
- CCHCS is working collaboratively with CDCR and Department of State Hospitals in anticipation of routine California Department of Public Health Surveys, headquarters monitoring tours, and federal court monitoring tours.

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

As of August 2015, 80 percent of the nursing positions have been filled statewide (this percentage is an average of four [4] State nursing classifications). More specifically, 29 percent of institutions (ten [10] institutions) have filled 90 percent or higher of their RN positions. For institutions with less than 90 percent staffing rates, 37 percent (13 institutions) have filled between 80 and 89 percent of their RN positions. Additionally, 34 percent of institutions (12 institutions) have filled less than 80 percent of their RN positions. The goal of

filling 90 percent or higher of the LVN positions has been achieved at 57 percent of institutions (20 institutions), and 26 percent (nine [9] institutions) have filled between 80 and 89 percent of their LVN positions. Only 17 percent of institutions (six [6] institutions) have filled fewer than 80 percent of their LVN positions.

During this 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, [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 continue 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 reporting period. As of August 2015, 89 percent of primary care provider positions were filled statewide (this percentage is an average of all three [3] State primary care provider classifications). More specifically, 57 percent of institutions (20 institutions) have achieved the goal of filling 90 percent or higher of their Physician and Surgeon (P&S) positions. Of these 20 institutions, 15 have filled 100 percent of their P&S positions. Additionally, 23 percent of institutions (eight [8] 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.

The decrease in the number of institutions reporting 90 percent filled for both primary care provider and nursing positions can be partially attributed to several institutions receiving additional positions since CCHCS’ last reporting date. CCHCS is actively recruiting and hiring for these new positions.

Workforce Development is proceeding with various recruitment strategies to improve this decreasing trend. Job postings for physicians continue to be placed online at the CCHCS’ recruitment website and 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 include the following:

Centralized Hiring Efforts – Workforce Development is implementing a centralized hiring program designed to quickly and efficiently fill P&S positions by ushering candidates through the recruiting and hiring process with a principal point of contact from initial application through first date of hire. Strategically combining the recruiting efforts with a centralized hiring approach in one unit will provide a streamlined, end-to-end guided process that should result in an increase in CCHCS’ filled P&S positions in a shorter period of time. This program will be implemented first at CHCF before being rolled-out statewide.

Sourcing – With Workforce Development’s new staff being hired and trained, the unit is currently searching for vendors to provide the most appropriate platform for CCHCS’ sourcing efforts. Sourcing will allow Workforce Development to access resumes posted on specific

websites by health care professionals who are actively seeking employment and to engage directly with them.

Visa Sponsorship Program – The Visa Sponsorship Program provides opportunities for CCHCS to recruit and hire international clinicians who have been trained in the United States and wish to remain and practice in this country. CCHCS is an exempt employer, which allows the Department to provide targeted recruitment to clinician-students who are in the United States on a student visa. Due to this exempt status, CCHCS is able to provide unlimited J-1 Waivers. Additionally, CCHCS also sponsors TN, H-1B, and PERM petitions. This program has proved invaluable in CCHCS' recruiting efforts for psychiatrists and has been utilized for other classifications, including P&S, Clinical Psychologist, Nurse Practitioner, and Recreation Therapist. To continue and expand this effective program, we have included language promoting visa sponsorship in all advertising for Staff Psychiatrist and P&S classifications.

Classification Salary Review – In an effort to ensure that CCHCS remains competitive in an ever-changing market, Classification and Pay (C&P) is conducting annual and periodic salary reviews of several medical and mental health classifications. C&P concluded salary analyses for 17 classifications in September 2015. This was achieved by reviewing data sets provided by CPS Human Resource Consulting (contracted to survey total compensation of health care professionals throughout the field on a nationwide level), the Medical Group Management Association, and the California Primary Care Association. The resulting data was then combined with additional analysis of data gathered by CCHCS to provide a more thorough and comprehensive review of our current pay plan structure against those of our top competitors (both public and private), and make necessary recommendations. Additional surveys will be conducted on a regular basis to identify potential salary trends so that CCHCS can remain informed and competitive in the current labor market.

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. Since the last Tri-Annual Report, Workforce Development and associated program staff have attended two California-located conferences for the P&S classifications and one conference for the Executive classifications. Additionally, CCHCS has maintained a presence at one out-of-state conference for the P&S classification and will be attending one out-of-state conference for correctional health care professionals and one out-of-state-conference for Executive classifications. This strategy allows CCHCS to increase name recognition and brand awareness among both attendees and the health care community. Furthermore, recruitment opportunities at these events are more personal, allowing CCHCS to speak directly to potential candidates in a way that no online posting or print advertisement allows.

Educational Programs Within Our Institutions – As of this reporting period, 13 institutions continue implementing health care training programs, including clinical rotations, externships, and internships. As Medical Services renews agreements with various schools, all institutions within the CDCR system are included. This is especially important for medical school residents

and other advanced degree programs, as elective rotations can take place at any institution for residents and masters-level students. These programs represent 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 for our health care student rotations in order to improve ease of access to institutional clinics and improve consistency for students and institutional leadership. In addition, CCHCS is working to increase the number of students/residents rotating through CDCR institutions. Workforce Development is ready to engage with these students after their participation in our health care educational programs is complete, to encourage them to apply for civil service full-time employee positions within their fields.

Medical School Outreach – Workforce Development is also working directly with California medical schools in an effort to promote CCHCS as an employer of choice. This includes both allopathic (M.D.) and osteopathic (D.O.) medical schools. The goal is to create not only a recruitment opportunity for hiring newly licensed and board certified physicians, but to encourage medical schools to more fully integrate correctional medicine into their curriculum.

Exit Survey – CCHCS is analyzing the data results from the Exit Survey at one of its institutions, reviewing survey feedback, and readying the survey to be rolled-out statewide. The survey measures organizational issues most commonly recognized to influence job satisfaction and will allow CCHCS to define areas of improvement to aid in increasing retention of its health care 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 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 the new Correctional Medicine Fellowship program include, but are 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 fellows per year at a reduced salary.
- Creating future leaders in Correctional Medicine and improving succession planning.
- Creating opportunities for CCHCS' medical executives and primary care providers to have advanced academic exposure and, in turn, boost morale.

These combined efforts (e.g., 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 CCHCS' 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 May through August 2015. These reports are included as [Appendix 5](#). 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. Coordination with Other Lawsuits**

During the reporting period, regular meetings between the three federal courts, *Plata*, *Coleman*, and *Armstrong* (Coordination Group) class actions have continued. Coordination Group meetings were held on May 4, June 11, and July 22, 2015. Progress has continued during this reporting period and is captured in meeting minutes.

#### **D. 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.

During the last reporting period, the Receiver has not used the substitute contracting process for any solicitations relating to services to assist the Office of the Receiver in the development and delivery of constitutional care within CDCR and its prisons.

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

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

## **F. Accounting of Expenditures**

### **1. Expenses**

The total net operating and capital expenses of the Office of the Receiver for the year ended June 2015 were \$1,536,943 and \$0, respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 6](#).

For the two months ending August 31, 2015, the net operating and capital expenses were \$217,668 and \$0, respectively.

### **2. Revenues**

For the months of May and June 2015, the Receiver requested transfers of \$425,000 from the State to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the Office of the Receiver. Total year-to-date funding for the fiscal year 2014–15 to CPR from the State of California is \$1,625,000.

For the two months July and August 2015, the Receiver requested transfers of \$200,000 from the State to the CPR to replenish the operating fund of the Office of the Receiver.

All funds were received in a timely manner.