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UNITED STATES DISTRICT COURT

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FOR THE EASTERN DISTRICT OF CALIFORNIA

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AND FOR THE NORTHERN DISTRICT OF CALIFORNIA

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MARCIANO PLATA, et al.,
Plaintiffs,

Case No. C01-1351-TEH

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v.

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

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RALPH COLEMAN, et al.,
Plaintiffs,

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

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v.

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

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JOHN ARMSTRONG, et al.,
Plaintiffs,

Case No. C94-2307-CW

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v.

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

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**NOTICE OF FILING OF RECEIVER'S
THIRTY-THIRD TRI-ANNUAL REPORT**

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**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES**

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

**Thirty-third Tri-Annual Report of the Federal Receiver
For May 1–August 31, 2016**

October 3, 2016

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.

Table of Contents

	Page
1. Executive Summary and Reporting Requirements.....	1
A. Reporting Requirements and Reporting Format	1
B. Progress during this Reporting Period	2
C. Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals.....	5
2. Status and Progress Concerning Remaining Statewide Gaps.....	8
A. Availability and Usability of Health Information (Electronic Health Records System Implementation).....	8
B. Scheduling and Access to Care.....	9
C. Care Management.....	10
D. Health Care Infrastructure at Facilities.....	12
3. Quality Assurance and Continuous Improvement Program.....	13
4. Receiver’s Delegation of Authority.....	17
5. Other Matters Deemed Appropriate for Judicial Review.....	19
A. California Health Care Facility – Level of Care Delivered.....	19
B. Statewide Medical Staff Recruitment and Retention.....	19
C. Coordination with Other Lawsuits.....	24
D. Master Contract Waiver Reporting.....	24
E. Consultant Staff Engaged by the Receiver.....	24
F. Accounting of Expenditures.....	25
1. Expenses	25
2. Revenues	25

Section 1: Executive Summary and Reporting Requirement

A. Reporting Requirements and Reporting Format

This is the thirty-third report filed by the Receivership, and the twenty-seventh 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)

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, 2016, and includes the following:

Electronic Health Records System

EHRs was successfully implemented at California State Prison, Solano (SOL) in August 2016. Planning activities continue for the next implementation at two additional institutions planned for September 2016. Statewide implementation of the EHRs is estimated to be completed by December 2017.

Office of the Inspector General – Cycle 4

The Office of the Inspector General's (OIG's) Cycle 4 Medical Inspections commenced during the week of January 26, 2015. As of the closing of this reporting period, medical inspections have been conducted at all 35 institutions. During this reporting period, medical inspections were conducted at the following CDCR institutions: High Desert State Prison (HDSP); California Men's Colony (CMC); California City Correctional Facility; Deuel Vocational Institution (DVI); Richard J. Donovan Correctional Facility (RJD); Central California Women's Facility (CCWF); California State Prison, Sacramento; and CHCF. Final reports which contain the overall ratings for all sites inspected during this reporting period are pending completion by the OIG.

During this reporting period, the Receiver delegated to CDCR authority for the medical operations at Chuckawalla Valley State Prison (CVSP) on May 18, 2016; California Correctional Institution (CCI) on June 7, 2016; Pelican Bay State Prison (PBSP) on June 22, 2016; California State Prison, Centinela (CEN) on June 22, 2016; and Sierra Conservation Center (SCC) on August 25, 2016. Institution performance continues to be monitored to ensure sustainability.

Meet and Confer sessions have been scheduled with internal and external stakeholders to discuss delegation of Avenal State Prison (ASP) and San Quentin State Prison (SQ).

Armstrong - Sign Language Interpreters

Field Operations Health Care Class Action Liaison Unit (HCCAL) continues to provide close monitoring and feedback for institutions designated for patients who rely on sign language interpreter (SLI) services to achieve effective communication. Specifically, HCCAL conducts monthly chart audits of all health care encounters for patients requiring SLI as their primary method of communication. The average percentage of health care encounters where SLI was used when required, from April through July 2016, was 73.5 percent. This indicates a four percentage point decline from the 77.5 percent average compliance rating from the previous four months.

Table 1 below shows historical performance data for the nine designated institutions over four months. As shown, California Medical Facility (CMF) and CHCF contributed significantly to the decline in overall compliance, due to their proportionately large encounter totals and poor performance ratings.

Table 1: Performance Data for Nine Designated Institutions

	April	May	June	July	4-Month Average	Total Encounters
CCWF	92.3%	90.9%	100%	100%	94.3%	53
CHCF	36.7%	80.0%	87.7%	96.7%	71.5%	267
CIM	83.3%	96.2%	100%	90.0%	94.9%	79
CMF	60.5%	36.1%	43.4%	55.8%	49.5%	551
DVI	-	83.3%	0.0%	100%	75.0%	24
LAC	-	-	-	-	N/A	0
NKSP	-	100%	90.9%	100%	94.2%	52
RJD	87.5%	87.8%	92.9%	84.7%	88.5%	270
SATF	89.5%	97.1%	96.2%	94.1%	93.4%	304

Table 1 also references compliance with providing a SLI as required, which could consist of a state employee SLI interpreter, a contract interpreter, or an interpreter accessed through the Video Remote Interpreter system. The compliance rates noted above do not include whether the encounter was appropriately documented but rather whether the appropriate interpreter resource was used.

HCCAL has partnered with Nursing Services to develop additional training and accountability tools for future efforts toward achieving compliance in this area.

Armstrong - ECHOS - SOMS - DECS Crossover

The cutover activities for institutions implementing the Electronic Health Records System (EHRS) are anticipated to ameliorate many of the long-standing discrepancies between Strategic Offender Management System (SOMS) and Disability and Effective Communication System (DECS). The cutover activities require the institution to audit the medical files of all *Armstrong* class members and correct discrepant information related to erroneous or missing CDCR 1845, Disability Placement Program Verification; CDCR 7410, Comprehensive Accommodation Chrono; and CDCR 128-C3, Medical Classification Chrono (MCC). By completing these audits and corrections, the information submitted to SOMS and DECS will be correct and accurate. These activities will also correct issues due to manual data entry errors in SOMS and loss of source documentation.

At the July 7, 2016, Court Coordination Meeting, the *Armstrong* Joint Monitoring Instrument was discussed and identified as a key milestone and precursor necessary in the overall exit strategy for this case. The section addressing health care compliance was initially field tested on April 18, 2016. The CDCR Office of Audits and Court Compliance (OACC) is working with the health care stakeholders to address the identified discrepancies discovered during the testing phase. Corrections Services has renewed discussions with CDCR stakeholders as well as OACC, who is charged with working with all stakeholders to finalize the Joint Monitoring Instrument. A meeting was held on August 11, 2016, to discuss next steps with departmental stakeholders. OACC has committed to finalize the complete Joint Monitoring Instrument, enabling submission to the plaintiffs for discussion by the end of October 2016. OACC is anticipating a final assessment of the Joint Monitoring Instrument by all stakeholders during the latter part of December 2016. Upon stakeholder approval, OACC is forecasting the initial Joint Monitoring Review will be conducted during the end of the first quarter of calendar year 2017.

Health Care Appeals Pilot

The elimination of one institutional level of review in the Health Care Appeals Pilot (Pilot) has been positive for the Health Care Appeals Offices (HCAOs) due to a reduction in the amount of duplicative work. The change in time (45 working days versus 30 + 30 working days) for the two levels of appeals has also positively impacted the HCAOs because the Pilot facilitates the timely processing of health care appeals, which in turn ensures each patient's due process rights are met.

The Pilot institutions have had positive results related to the upfront clinical triage and ability to address urgent/emergent issues immediately. If an urgent/emergent issue is identified after a preliminary urgent/emergent review, the HCAO Registered Nurse (RN) ensures the patient is seen accordingly, regardless of how the health care appeal will be processed administratively.

During the period of September 2015 through August 2016, the resolution rate (percentage of appeals resolved at the institution and not escalated to headquarters) at non-Pilot institutions was 39 percent while the Pilot institutions had a 71 percent resolution rate. That is an

82 percentage point increase in the number of health care appeals being resolved at the institution level at the Pilot institutions.

The Pilot has demonstrated the various benefits of streamlining the appeals process. It reduces the redundancy of the first and second level appeals at an institution; provides clinical expertise to triage emergent health care issues; reduces the institution's overall timeframe for dealing with appeals; and adds professional level staff to the appeals process to recognize and address emergent systemic problems that could result in future grievances and lawsuits.

Joint Commission

In February 2016, the Receiver set a target to pursue Joint Commission accreditation for some CDCR institutions beginning in calendar year 2018. During this reporting period, staff continued to work toward identifying a proposed model for implementing Joint Commission standards at CDCR institutions and resources that might be required to achieve accreditation. The planning included a meeting with staff from a Federal Bureau of Prisons facility to learn about their accreditation process, tools, and staffing model.

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 total Modified Community Correctional Facility (MCCF) patient population as of August 31, 2016, is 3,972 with a budgeted capacity of 4,218.

Although the Delano MCCF audit was conducted during the previous reporting period, the findings were pending the facility's rebuttal. After review of the refuted findings, the overall performance was deemed Inadequate.

During the months of May and June 2016, CCHCS conducted four Health Care Monitoring Audits at Golden State MCCF, Taft MCCF, McFarland Female Correctional Re-Entry Facility (FCRF), and Shafter MCCF. Golden State MCCF and McFarland FCRF received an overall rating of Inadequate, while Shafter MCCF and Taft MCCF received an overall rating of Adequate.

CCHCS has discussed the report findings with CDCR's Contract Beds Unit (CBU) who advised they understand the seriousness of the audit ratings and are taking immediate and appropriate action to address the deficient performance. CBU advised they are working very closely with the MCCFs to ensure necessary changes are implemented to correct the identified deficiencies and improve performance.

While all of the MCCFs have consistently employed a physician during this review period, there is a systemic problem in receiving completed peer reviews that detail the performance of the primary care providers. Each MCCF is required to provide a physician peer review after seeing CDCR patients for 30 days. This issue has been discussed with CBU and they have assured CCHCS they are addressing the importance of timely and accurate completion of the required reviews.

Out-of-State Contract Facilities

The out-of-state patient population has remained relatively consistent during the reporting period. The total California Out-of-State Correctional Facilities (COCF) patient population as of August 31, 2016, is 4,814 with a budgeted capacity of 4,900. There were no COCF onsite audits conducted during this reporting period. However, there was one Sentinel Event identified at La Palma Correctional Center in July 2016 that is currently under review by Corrections Corporation of America.

Transportation Vehicles

The responsibility of providing an adequate health care transport vehicle fleet was delegated to CDCR in October 2012. Since that time CCHCS has been working with CDCR to establish a cohesive procurement plan that addresses the replacement of health care transport vehicles while working within the structure of the departmental Vehicle Fleet Assessment Plan.

Working collaboratively with CDCR, CCHCS assisted in establishing standardized specifications for all transportation vehicles. The last Tri-Annual Report outlined the methodology Division of Adult Institutions (DAI) was taking on standardizing and uniformly equipping each transport vehicle. The systemic assembly of the security modifications has proved to be very successful, allowing the newly received vehicles to be retrofitted and placed into service in a much shorter timeframe.

During the previous reporting period, CDCR's DAI had procured a total of 62 health care transport vehicles with Fiscal Year (FY) 2013–14 funding and that all vehicles had been received and placed in service with the exception of three vehicles waiting telecommunication installations. That work has now been completed and all vehicles are in service.

Within FY 2015–16, the CDCR's Office of Business Services (OBS) submitted proposed procurement orders for 227 vehicles that had been identified for replacement according to the Fleet Assessment Plan. Of the proposed purchase orders, 202 (89 percent) were identified as health care vehicles. CDCR's DAI has accepted delivery of 27 health care transport vehicles; five vehicles have been placed in service with completed security modifications, while 22 vehicles are in the process of receiving security modifications and telecommunication installation (the projected in service date is the first quarter of 2017). The remaining 175 health care transport vehicles are subject to delivery from the manufacturer.

During the last Tri-Annual Report, CCHCS reported the escalating demand for additional resources to accommodate and manage the movement of the disabled wheelchair-dependent patients to on-site and off-site medical appointments. Working in collaboration, the Assistant Deputy Director, Operations within CDCR's DAI and the Deputy Director, CDCR's OBS, deferred post-manufacturer security costs for vehicles procured in FY 2015–16 to FY 2016–17, and purchased an additional 35 vehicles (ten Americans with Disabilities Act [ADA] five-passenger vans, five ADA nine-passenger vans, and 20 transportation vans) to replenish an aging and deteriorating Health Care Access fleet. It is anticipated that CDCR will take delivery on these vehicles during the fourth quarter of calendar year 2016.

The CDCR reported to CCHCS during the last reporting period the purchase of an additional 23 ADA health care transport vehicles to accommodate the expanding patient population at the new "In Fill" activations at both Mule Creek State Prison and RJD with FY 2014–15 funding. All vehicles have been placed into service with the exception of five buses, which are awaiting the Department of General Services inspection. The five remaining vehicles are expected to be in service by the end of October 2016.

In addition to the procurement of the vehicles identified for the "In Fill" activations, CDCR submitted procurement orders utilizing FY 2014–15 funding for eight ADA health care transport vehicles (two para-transit vans, six para-transit buses) to accommodate the expanding ADA patient population. CDCR has received delivery of seven para-transit vehicles. Five of the eight vehicles have received all security modifications and placed into service and the remaining three vehicles are currently undergoing the security modifications, which are anticipated to be placed into service at the end of the fourth quarter of 2016.

CCHCS and CDCR are working cooperatively to ensure the right vehicle is dedicated to the right mission, which also includes ensuring the appropriate numbers of vehicles are assigned to the right institution.

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 Thirty-Second Tri-Annual Report, Cerner Corporation was 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 Organization Solution. The project is presently in the statewide deployment phase.

Funding requested in the Governor's May Revision to the Governor's proposed budget for FY 2016–17 was approved. The approved funding supports continuing EHR project activities to complete remaining functionality, statewide implementation, and integration of an electronic dental record solution into the EHR.

During this reporting period, in response to feedback from institutions that have implemented EHR, adjustments were made to the EHR solution and supporting clinical processes to better support efficient and effective use of the solution. The EHR project conducted refresh sessions with each of the sites that had implemented the EHR to orient them to the adjustments made to the solution and associated clinical workflows.

EHR was successfully implemented at SOL in August 2016. Planning activities continue for the next implementation at two additional institutions planned for September 2016. Statewide implementation of the EHR is estimated to be completed by December 2017.

Overall, the EHR project is 66 percent complete, and activities continue to implement remaining EHR functionality and complete statewide implementation of the EHR.

B. Scheduling and Access to Care

In August 2016, regional teams presented and held one-day training sessions on Scheduling and Access to Care for their respective institutions. This learning session focused on establishing a scheduling system infrastructure and strategies for both managing demand for services and optimizing appointment supply. Throughout the training, institution executive teams identified areas of improvement specific to their institutions and created a Detailed Action Plan based on the following:

- Review of scheduling pre-assessments completed prior to training which evaluated existing scheduling system infrastructure.
- Institution's Scheduling Diagnostic report which offers care-team level demand, supply, and efficiency data.

Standardizing Scheduling Practices

Based on previously conducted onsite observations and focus group sessions through the Scheduling Process Improvement workgroup, additional EHR scheduling support tools such as user guides for EHR scheduling have been created and are now available to EHR institutions. The EHR scheduling guides have also been incorporated into training for institutions that are preparing for EHR deployment.

Scheduling Tools and Reports

During this reporting period, new and upgraded monitoring tools were released to assist institutions in identifying and addressing potential risks to patients, correcting inaccurate or incomplete orders and scheduling data, and monitoring scheduling process reliability and efficiency.

- Scheduling Diagnostic Report. The Scheduling Diagnostic Report breaks down a number of key indicators by care team, including access measure performance, rescheduling and bundling rates, the rate of nursing referrals to the primary care provider, and productivity data. This report allows clinic managers and institution leaders to identify unexplained variation in demand and supply across care teams, find best practices that might be shared through the institution, and provide targeted technical assistance to care teams as appropriate. During this reporting period, additional measures were added to the report along with EHR data. The report is now available to all institutions and updated monthly.
- Scheduling Registry. The Scheduling Registry was developed to provide EHR institutions with scheduling reports that were previously available through MedSATS. This new tool allows institution staff to:
 - Effectively manage clinic schedules by providing a view of pending orders;
 - Clean up queues by identifying incomplete orders that should have been closed out or may no longer be clinically relevant; and

- Run real-time scheduling performance reports with drill-down views by care team, provider type, and specific Dashboard measures.

During this reporting period, Scheduling Registry testing and validation was completed and the registries formally released statewide. Refer to [Appendix 1](#), EHR Medical Scheduling Registry Memorandum. Institutions can access the Scheduling Registries through the Quality Management Portal under “Care Team Tools.”

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 was tested at CHCF in October and November 2015. Development of policy and training for the use of this tool is delayed while the focus is placed on implementing the Complete Care Model (CCM) and the EHR, and is expected to resume early 2017.

In the spring of 2016, the Care Coordination subgroup completed the development of the core CCM series of policies and procedures, incorporating 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 CCM policy, which is the anchor of the series, was implemented in July 2015. The following series of policies and procedures were approved and released for statewide implementation in June of 2016:

- Scope of Patient Services Procedure
- Care Teams and Patient Services Procedure
- Population and Care Management Procedure
- Care Management/Care Coordination Procedure
- Outpatient Housing Unit Policy and Procedure

The Care Coordination subgroup continues to update a wide variety of Inmate Medical Services policies and procedures to be reflective of the CCM of health care delivery. The following policies and procedures were also approved and distributed to the field this summer:

- Health Care Transfer Policy and Procedure – July 2016
- Individual Hunger Strike Policy and Procedure – August 2016
- Mass Organized Hunger Strike Policy and Procedure – August 2016

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

- Establishing Patient Service Plans which is 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 integrated into the learning sessions for the CCM in 2016.
- Further developing and expanding the role of nursing as partners on the Primary Care Team to provide planned, proactive patient care as health coaches, health educators and chronic care managers.

With the core policies and procedures for CCM completed and the statewide training and implementation underway, PMCC has transitioned to the Complete Care Oversight Team (CCOT) with a focus on implementation, operations and monitoring of CCM. In addition, CCOT will facilitate greater integration of Mental Health and coordination and integration with the ECHOS project with CCM.

Transfer Subgroup

In fall 2014, the Transfer subgroup of the PMCC Committee 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 MCC application. This application automatically transfers the MCC 128-C3 information to the SOMS simultaneously. Custody staff check the medical hold attribute in the MCC 128-C3 and place a hold as required. The subgroup has completed statewide education to both clinical and custody staff. During this reporting period, CCHCS has provisioned RN staff statewide on the ability to place a temporary medical hold on a patient to prevent inappropriate and unsafe transfers.

The Health Care Transfer policy and procedure has been updated to reflect the above changes, and training and education on the new process was completed in 2015. During this reporting period, CCOT is working collaboratively with regional teams and headquarters to streamline Reception Center processes and processes related to patient movement. This work will serve to further standardize the transfer process by utilizing new tools such as an automated Patient Summary sheet, a transfer check-list and the EHRS as it is implemented statewide.

D. Health Care Infrastructure at Facilities

Clinical facility upgrades through the Health Care Facility Improvement Program projects are progressing. During this reporting period, three (CVSP, Ironwood State Prison [ISP], and PBSP) of the last five projects were submitted for State Fire Marshal (SFM) and Department of Finance (DOF) approval of working drawings and to proceed with construction. DOF approved working drawings and to proceed with construction for PBSP in late July 2016 and for KVSP and PVSP in late August 2016. Approval of CVSP and ISP are pending. Working drawings for Calipatria State Prison and CEN are being finalized and will be submitted for approval to proceed with construction.

Also during this reporting period, construction of two new Complex Primary Care Clinics was completed at California State Prison, Los Angeles County (LAC) while construction activities progress at most of the other institutions. As for the Statewide Medication Distribution (SWMD) projects, construction at CVSP was completed and activated in June 2016. To date, SWMD projects at five of the 22 institutions have been completed and activated.

Schedule delays continue to occur due to but not limited to the following: SFM design reviews; DOF approvals; onsite construction and fire alarm conditions; efforts to safeguard operational continuity of care; and the necessary swing space. The revised schedules reflect completion of construction in late 2018.

Section 3: Quality Assurance and Continuous Improvement Program

Process Improvement Techniques – Lean White Belt Certification Initiative

The Receiver and CDCR Secretary Scott Kernan announced in an August 2016 memorandum that Lean White Belt certification would be offered to CCHCS and CDCR executives, managers and other interested staff in institution and regional training sessions beginning September 2016, with a goal of providing an introduction to Lean to over 1,800 staff statewide by the end of the year.

The second phase of the training will take place in early 2017 and will expand the training team at the regional offices, offering monthly classes to interested staff statewide. By summer 2017, CCHCS will offer web-based tutorials on Lean concepts and tools as part of the Learning Management System, available on-demand to all CDCR staff.

Performance Evaluation and Improvement Tools – Automated Huddle Report

Care teams across the state download the Automated Huddle Report daily to keep current on critical health care events impacting their assigned patient panel and prepare for that day's scheduled patients. More than 200,000 reports have been accessed since its initial release in January 2016. CCHCS continues to receive regular feedback from the field related to possible improvements to the Automated Huddle Report and will continue to refine the report to meet care team needs.

In August 2016, CCHCS updated the Automated Huddle Report to include the following:

- **Abnormal Labs.** This section is now pre-populated, giving Care Teams the ability to view any Quest Priority 1 or 2 Lab Results without depending on sporadic alerts to individual care team members from Quest or the EHRS.
- **Triage and Treatment Area Visit Information for EHRS Institutions.** All EHRS institutions are now able to see which patients were in the Triage and Treatment Area (TTA) within the past 24 hours as long as the appropriate form was completed during their visit. This addition will help to alleviate a communication issue that occurs when certain information documented within the TTA is not accessible by most medical staff.

Performance Evaluation and Improvement Tools – Dental Registry

In August 2016, Dental Program leaders released a new Dental Registry which is a listing of all patients who have selected risk factors and/or are currently taking any active medications that can affect a patient's dental care. The Dental Registry includes patients with several conditions or factors not currently available in the Master Registry (such as patients susceptible to dry mouth, taking bisphosphonate medication, or with bleeding disorders) and allows dental staff to:

- Manage the entire patient population who have conditions related to or are currently utilizing dental services.

- View appointment information, allowing users to easily find a patient's last dental appointment and any future appointments.
- Easily group patients by their assigned dentists or dental clinics.

Patient Safety Priority – Medication Process Improvement Initiatives

As discussed in previous Tri-Annual Reports, the Statewide Patient Safety Committee has established a Medication Process Improvement Initiative to identify, prioritize, and address systemic medication process vulnerabilities.

Patient Safety Initiative – Medication Administration and EHR Institutions

One of the challenges noted by institutions during EHR implementation was that health care staff were unable to quickly and easily detect when a group of patients (e.g., patients in Yard D) had missed medications, and health care staff lacked a readily, accessible Health Insurance Portability and Accountability Act-compliant report to communicate with custody staff which patients needed to be brought to medication lines held throughout the day. To respond to this operational need and ensure patients that missed medication receive necessary follow-up, CCHCS created a new Medication Line (Med Line) Report for EHR institutions. Utilizing the stores of new medication data captured daily within the EHR, the Med Line Report helps medical staff work with custody staff to ensure that patients are available at pill lines and provides real-time data on which patients have and have not received their medications, allowing for proactive management and resolution of potential access issues, reducing waste and cost. Some features of the Med Line report are:

- “Pre-Med Line View” of all patients who have medication that needs to be administered during the chosen time at the specified pill line.
- “Post-Med Line View” of all patients who failed to show up for the pill line.
- Multiple filter options, including the ability to select individual pill lines and pill line times.

On average, timely medication administration at the three EHR institutions has improved since the beginning of the year, but the figure has been holding steady at 83 percent for several months, which is seven percentage points below the statewide goal. Drill down data reveals that access to medications upon transfers from one institution to another or one care team to another is a major factor in timely medication administration, and during this reporting period CCHCS continued to work with Master Black Belts in Lean Six Sigma to improve medication continuity upon transfer.

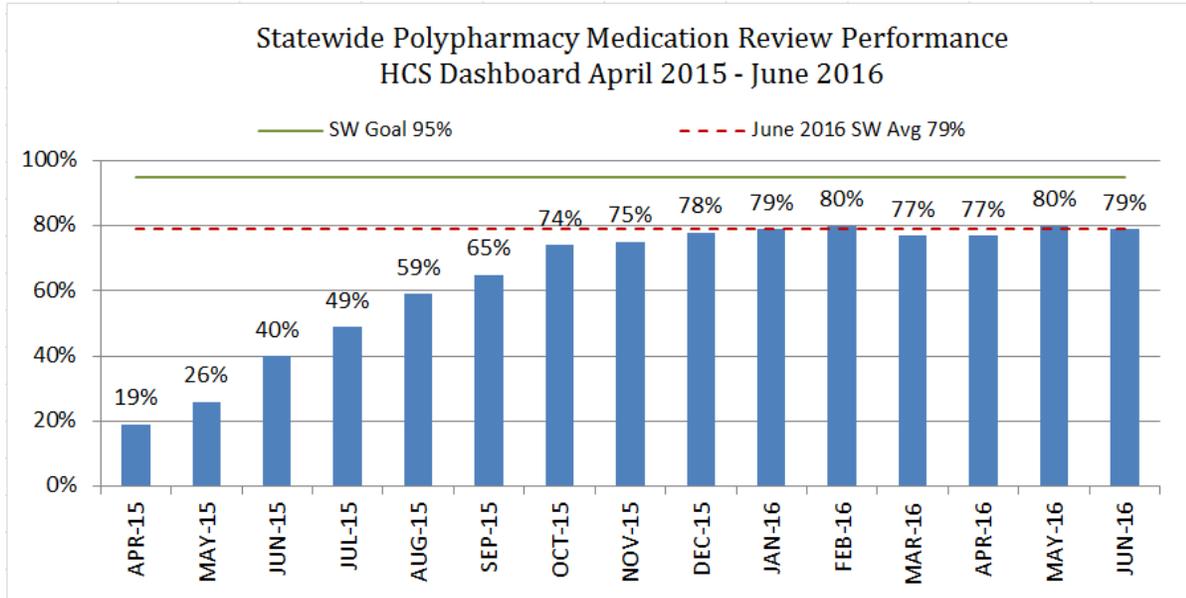
Patient Safety Initiative – Polypharmacy

Polypharmacy has been identified as a risk factor contributing to adverse patient outcomes at CCHCS and continues to be a priority improvement area in the Statewide Performance Improvement Plan (PIP) 2016–18, with a statewide goal as follows:

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

Between April and September 2015, the proportion of polypharmacy patients who had received a medication review in the past 12 months statewide increased by at least six percent per month; however, performance reached a plateau during the remainder of 2015 and through June 2016. (Refer to Figure 1).

Figure 1: Statewide Polypharmacy Medication Review Performance, April 2015–June 2016



With recent CCM infrastructure changes, care teams now have a regular forum to verify that patients have had a polypharmacy review in monthly Population Management Working Sessions. Because Population Management Working Session activities fall under the oversight of the Regional Health Care Executives, the Patient Safety Committee transferred polypharmacy monitoring to the Regional Health Care Executives and their executive teams in September 2016. The regional team will monitor progress on this PIP measure regularly and intervene as appropriate.

Patient Safety Initiative – Keep-On-Person Initiative

In May 2016, the Statewide Patient Safety Committee established a Keep-On-Person (KOP) Medication Initiative to address a number of adverse outcomes reported by institutions involving KOP medications. In many of these instances, a patient was prescribed KOP medication, though they had risk factors such as a previous overdose attempt that might contraindicate such an order.

During this reporting period, a multidisciplinary workgroup was convened to identify interventions to ensure appropriate KOP prescribing. Workgroup members met and brainstormed potential technical solutions to:

1. Establish standardized criteria for KOP eligibility.
2. Improve or develop KOP medication safeguards in EHRs, such as alerts or flags for patients for whom KOP medication might be inappropriate.
3. Incorporate alerts or flags in non-EHR patient tools and resources such as registries.

Section 4: Receiver’s Delegation of Authority

Receivership Transition Plan

During this reporting period, the Receiver delegated to CDCR authority for the medical operations at CVSP on May 18, 2016; CCI on June 7, 2016; PBSP on June 22, 2016; CEN on June 22, 2016; and SCC on August 25, 2016. Institution performance continues to be monitored to ensure sustainability. Meet and Confer sessions have been scheduled with internal and external stakeholders to discuss delegation of ASP and SQ.

Access Quality Report

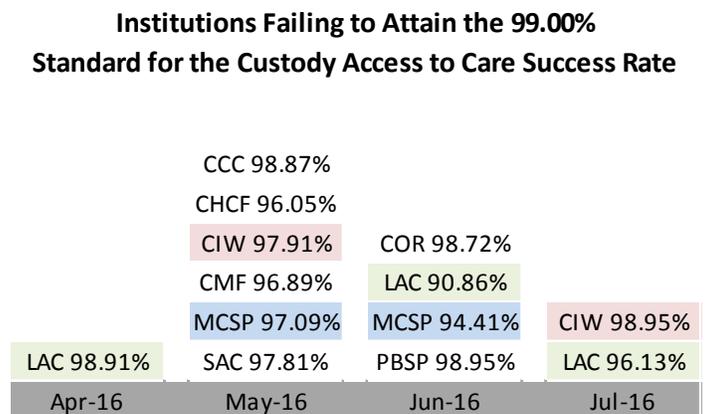
Field Operations staff continues to receive the required monthly Access Quality Report (AQR) data from institutions and publish the monthly statewide AQR. Refer to [Appendix 2](#) for the Executive Summary and Health Care Access Quality Report for April through July 2016. Field Operations staff continues to use the AQR version 3.0, which replaced version 2.0 as of November 2015.

Custody Access to Care Success Rate

During this reporting period, statewide AQRs were published for the months of April 2016 through July 2016. The average custody *Access to Care Success Rate* for this period was 99.35 percent, above the Receiver’s benchmark of 99 percent. This represents a decrease of -0.08 percentage points as compared to the Thirty-Second Tri-Annual reporting period, which included data from December 2015 through March 2016.

Refer to Figure 2 for a summary, by month, of the number of institutions failing to attain the 99 percent benchmark established in the delegation. The primary reason an institution fell below the benchmark is attributed to an increase in the number of ducats not completed due to a modified program which resulted in the cancellation and rescheduling of health care appointments at the affected institutions.

Figure 2: Institutions Failing to Attain the 99.00% Standard for the Custody Access to Care Success Rate



For institutions failing to attain the benchmark, 13 Corrective Action Plans were required from April through July 2016.

Operations Monitoring Audits

During the reporting period, Field Operations staff conducted 14 Health Care Access Unit (HCAU) Operations Monitoring Audits: Round IV Six-Month Limited Review(s) were conducted at CMC, due to a failure of Component 5; LAC, due to a failure of Component 2; CMF, due to a failure of Component 1; and 11 Round IV Annual Audits at various institutions.

As part of the HCAU audit process, CCHCS implemented the referral of ongoing deficiencies (critical issues) directly to the institution's respective CDCR DAI Associate Director and CCHCS Regional Health Care Executive for review. Under this new philosophy of heightened accountability and transparency, it is incumbent upon CDCR's DAI and the CCHCS Regional Health Care Executive to provide sufficient oversight and leadership in order to achieve sustained resolution of critical issues.

During the reporting period, Field Operations staff published the results of the 14 aforementioned audits: Of these 14 audits, ten were referred for CDCR DAI and CCHCS level of review.

Corrections Services staff completed pre-delegation site reviews at eight institutions during the reporting period including CCI, CIM, SCC, CEN, PBSP, CVSP, CRC, and KVSP. Based on these reviews, there were custody practices identified at some locations that were deemed inconsistent with access to care requirements. The issues identified at some of the sites included shortcomings associated with priority ducats, scheduling, privacy, escorting, use of patient waiting rooms, and provider safety. In response to these findings, the information was presented to all Chief Executive Officers, Chief Medical Executives, and Chief Physician and Surgeons (P&S) during separate meetings conducted during the month of May 2016. Recognizing the seriousness of the issue, the Director of CDCR's DAI requested that the same information be presented to Wardens and other executives within CDCR's DAI. The Corrections Services Director, Field Operations Deputy Director and Correctional Administrator made subsequent presentations at separate statewide meetings attended by Wardens, Captains and Correctional Administrators. A follow-up memorandum was distributed to all Chief Executive Officers and Wardens regarding these issues on August 8, 2016.

Section 5: Other Matters Deemed Appropriate for Judicial Review

A. California Health Care Facility – Level of Care Delivered

CHCF's health care leadership remains focused on ensuring the delivery of consistent quality health care services to its patient population. Quality improvement systems have assisted CHCF in making significant gains in meeting this mission, as evidenced by overall improvement in its Institution Health Care Performance ranking. 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. Of the 41 provider positions at CHCF, 30 are currently filled with the break-out as follows:

- P&S: 34 positions, 22 filled, 11 vacant*
- Nurse Practitioners: 3 positions, 4 filled*
- Physician Assistants: 4 positions, 4 filled

*One P&S position is pending reclassification to a Nurse Practitioner.

B. Statewide Medical Staff Recruitment and Retention

As of August 2016, 85 percent of the nursing positions have been filled statewide (this percentage is an average of four State nursing classifications). More specifically, 54 percent of institutions (19 institutions) have filled 90 percent or higher of their RN positions. This represents a negligible change from the previous Tri-Annual Report. For institutions with less than 90 percent staffing rates, 29 percent (ten institutions) have filled between 80 and 89 percent of their RN positions. Consequently, 17 percent (six 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 34 percent of institutions (12 institutions), whereas 34 percent (12 institutions) have filled between 80 and 89 percent of their LVN positions. At this time, 31 percent of institutions (11 institutions) have filled fewer than 80 percent of their LVN positions. However, there are significant recruiting efforts in process to ensure the number of LVN vacancies are addressed.

In addition, the proposal to establish a Medical Assistant (MA) classification was approved by the State Personnel Board. The MA classification will be used in a provider support capacity. It is anticipated the eligible list for MA will be released in early December 2016 allowing institutions to begin using the classification in the first quarter of 2017.

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, wwwSimplyHired.com, and www.JuJu.com. Each job posting typically represents multiple

vacancies at an institution. CCHCS staff continue to monitor vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

In general, P&S recruitment efforts continued to focus on “hard-to-fill” institutions during this reporting period. As of August 2016, 84 percent of primary care provider positions were filled statewide (this percentage is an average of all three State primary care provider classifications). At this time, 40 percent of institutions (14 institutions) have achieved the goal of filling 90 percent or higher of their P&S positions. Of these 14 institutions, 12 have filled 100 percent of their P&S positions. Additionally, 20 percent (seven institutions) have filled between 80 and 89 percent of their P&S positions, and 40 percent (14 institutions) have filled less than 80 percent of their P&S positions. As of this reporting period, the following Table 2 represents current P&S statewide hiring status:

Table 2: Current Statewide Hiring Status for P&S

Institution	Candidates in Pre/Post Interview Process by Institution	Tentative Offers Accepted	Formal Offers Accepted – Not Started
ASP	0	0	0
CAC	0	0	0
CAL	0	0	0
CCC	0	0	0
CCI	0	0	0
CCWF	0	0	0
CEN	0	0	0
CHCF	1	2	0
CIM	0	0	0
CIW	0	0	0
CMC	4	3	0
CMF	0	1	0
COR	0	1	0
CRC	0	0	0
CTF	0	0	0
CVSP	0	0	0
DVI	0	0	0
FSP	2	0	0
HDSP	0	0	0
ISP	0	1	0
KVSP	0	0	0
LAC	3	0	0
MCSP	0	0	0
NKSP	0	0	0
PBSP	0	0	0
PVSP	0	0	0

Institution	Candidates in Pre/Post Interview Process by Institution	Tentative Offers Accepted	Formal Offers Accepted – Not Started
RJD	1	1	0
SAC	5	2	0
SATF	0	1	0
SCC	0	0	0
SOL	2	0	0
SQ	0	0	0
SVSP	2	2	0
VSP	1	1	0
WSP	4	0	0
Grand Total:	25	15	0

Workforce Development is continuing with various recruitment strategies to support and improve this trend. Job postings for P&S vacancies 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 has implemented 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. This program was implemented first at CHCF and was rolled out statewide in January 2016. Since the implementation of this program at CHCF in September 2015, 20 P&S candidates have been hired at CHCF. Additionally, 18 P&S candidates have been hired at the remaining 34 institutions statewide, with 40 candidates in the hiring process currently.

Sourcing – Workforce Development has recently secured contracts with PracticeLink and LinkedIn that will allow the promotion of career opportunities with CCHCS and provide Workforce Development with a robust pool of candidates with whom to directly engage via sourcing. Both sites provide Workforce Development access to resumes posted on specific websites by health care professionals who are actively seeking employment. These resumes are contacted by recruiters and interested candidates are forwarded directly to the Centralized Hiring Unit or related hiring program.

Recruitment of Medical Residents – In conjunction with current P&S recruiting efforts, and to proactively provide a pathway for new physicians to view correctional medicine as a viable career option, Workforce Development has expanded its efforts to recruit medical residents. The implementation of a recruitment plan featuring print ads in national career guides, attendance at resident-specific events, and targeted digital marketing in the form of E-Blasts to residents throughout the United States is underway. Additionally, the sourcing information

detailed above will also be utilized to provide another avenue for direct resident outreach. Of the four residents who were engaged with CCHCS as of the date of the last Tri-Annual Report, all four have been hired, and two additional residents are currently prepared to join CCHCS' provider workforce upon their graduation in July 2017.

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. Additionally, CCHCS also sponsors TN, H-1B, and PERM petitions. This program is currently used in CCHCS' recruiting efforts for psychiatrists and has been utilized for other classifications including P&S, Psychiatrists, Clinical Psychologists, Nurse Practitioners, and Recreation Therapists. To continue and expand this effective program, CCHCS have included language promoting visa sponsorship in all advertising for the P&S classification and targeted recruitment of medical residents.

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 Thirty-second Tri-Annual Report, Workforce Development has attended a total of two California-based 2016 conferences for the P&S classification, with an additional two California-based P&S conferences booked for this fall. Additionally, CCHCS will be attending one out-of-state conference for correctional health care professionals. This tactic 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.

Educational Programs Within Our Institutions – As of this reporting period, all 35 institutions either have or are working on implementing health care training programs for physicians. Currently CCHCS is engaging with six educational institutions to provide clinical rotations to resident physicians.

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 – After analyzing the data results from the piloting of the Exit Survey at one of its institutions, CCHCS is readying the survey to be implemented 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.

Military Outreach – Workforce Development continues engaging with Transition Assistance Programs at local military bases in an effort to court clinicians transitioning out of military service and into the private sector. Future efforts will focus on leveraging the military relationships that many of CCHCS' current physicians have with their respective branches of service.

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, 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 2016. These reports are included as [Appendix 3](#). Included at the beginning of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: Executive Leadership Filled Percentage and Turnover Rate, Clinical and Nursing Management Filled and Turnover Rate, Primary Care Providers Filled Percentage and Turnover Rate, Nursing Filled Percentage and Turnover Rate, and Pharmacy Filled Percentage and Turnover Rate.

C. Coordination with Other Lawsuits

Meetings between the three federal courts, *Plata, Coleman, and Armstrong* (Coordination Group) class actions have occurred periodically. A Coordination Group meeting was held on July 7, 2016.

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 2016 were \$1,370,904 and \$0, respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as [Appendix 4](#).

For the two months ending August 31, 2016, the net operating and capital expenses were \$199,166 and \$0, respectively.

2. Revenues

For the months of May and June 2016, the Receiver requested transfers of \$300,000 from the State to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the Office of the Receiver. Total year-to-date funding for the FY 2015–16 to the CPR from the State of California is \$1,375,000.

For the two months July and August 2016, the Receiver requested transfers of \$175,000 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.