Health Care Services

DASHBOARD

Overview

The Health Care Services Dashboard is a visual display of key performance indicators that are typically monitored by all health care organizations, including availability, appropriateness, safety, cost-effectiveness, and efficiency of care, consolidated into one document to make that information easily accessible to stakeholder groups and health care staff at all reporting levels. Updated monthly with the most recent data available, the Dashboard provides information from the medical, mental health, dental, and allied health programs, and encompasses more than 100 measures in 7 domains, including, but not limited to, disease management, access to care, utilization management, cost, and human resources. Depending upon the domain, the most recent results reported in the Dashboard may reflect the month prior to the release date of the Dashboard, or may be from further in the past (death rate data, for example, is updated once, annually.)

The Dashboard is designed to allow users to access greater degrees of detail for particular measures according to interest and relevance.

More Information

In each of the 7 domains on the Dashboard, viewers will find a question mark icon that links to a page with more information, orienting the viewer to the domain and providing additional information about the measures within it. An eighth question mark icon at the center of the Dashboard explains benchmarking, outlining the rationale behind color-coding and ranking of performance results. (See the "key" with colored bars for high adherence, fair adherence, and low adherence rankings.) After selecting the question mark icon to access more information, the viewer can click on the **RETURN TO DASHBOARD** link at the upper right portion of the page to go back to the Dashboard.

A glossary is also available to help users understand the terminology, ratings, and sources of information for each measure in the Dashboard. Use the following link to access the Dashboard glossary: Health Care Services Dashboard Glossary

Data Limitations

The Dashboard is intended to support headquarters and institution staff in identifying opportunities for improvement and monitoring progress toward performance objectives. However, there are limitations to the information provided on the Dashboard, specified below:

California Correctional Health Care Services (CCHCS) has standardized many data collection processes, provided training to ensure consistency in data reporting, and invested in information system modifications to improve data quality. However, much of the data featured in the Health Care Services Dashboard is gathered through multiple networked databases or self-reported by institutions, and the data have not been validated or verified. Performance objectives and benchmarks were generated internally for quality improvement purposes and are not necessarily intended to reflect compliance with court mandates or a determination regarding constitutional levels of care.

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California Correctional Health Care Services

STATEWIDE HEALTH CARE SERVICES DASHBOARD

May 2011, Released June 13, 2011, Version 2.0

PREVENTION / DISEASE MANAGEMENT

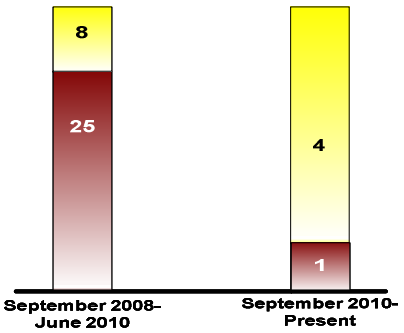
MEASURES	Prior	Most Recent
Appropriate Diabetes Care	55%	62%
Appropriate Asthma Care	51%	65%
Colon Cancer Screening	-	33%
Breast Cancer Screening	-	69%
HIV Screening	33%	72%
Therapeutic Anticoagulation	-	47%
Potentially Avoidable Hospitalizations per 1,000 inmates per year	-	13

RECEIVED TIMELY HEALTH CARE

MEASURES	6 Month Trend	Mar. 2011
Episodic Care RN: *(w/ symptoms)*		93%
Episodic Care Provider: *(routine)*		74%
Provider Chronic Care Visit		85%
Evaluated by Specialist *(high priority)*		84%
Evaluated by Specialist *(routine)*		93%
Provider Follow-Up *(routine & high priority)*		66%
Provider Follow-UP *(return from Hosp/ED)*		85%
Medications		84%
Health Care Appt. Missed Due to Custody		0.6%

MEDICAL PROGRAM INSPECTIONS

Based on number of institutions inspected through 4/2011



KEY: HIGH ADHERENCE | MODERATE ADHERENCE | LOW ADHERENCE

UTILIZATION MANAGEMENT

MEASURES	6 Month Trend	Most Recent
Specialty Care Referrals per 1,000 inmates		68
Specialty Appointments via Telemedicine		21%
Average Number of Hospital Bed days per 1,000 inmates (per year)		418
Administrative Hospital Bed days per 1,000 inmates (per year)		11
Non-Formulary Usage		6%

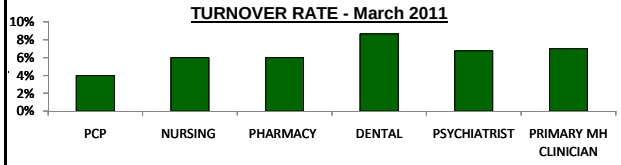
EXPENDITURES

Health Care Expenditures FY 09/10
Per Member (Inmate) Per Month

Total	**$1,235**
Direct Medical	$651
Clinical Support	$72
Dental	$84
Mental Health	$160
Pharmacy	$116
Headquarters	$152

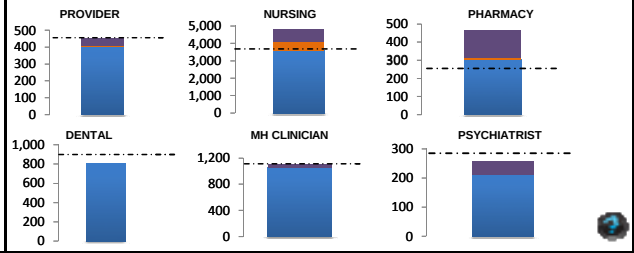
HUMAN RESOURCES

TURNOVER RATE - March 2011



WORKLOAD per DAY/TREATMENT*	6 Month Trend	Most Recent
Patient Encounters per Provider		14
Rx per Pharmacist		140
Rx per Pharmacy Tech		92
Appeals Processed per Analyst		5
Patient Encounters per MH Clinician		8
Patient Encounters per Psychiatrist		9
*Dental Assessment Tracking Evaluation Scores - Mainline		3.2
*Dental Assessment Tracking Evaluation Scores - RC		2.3

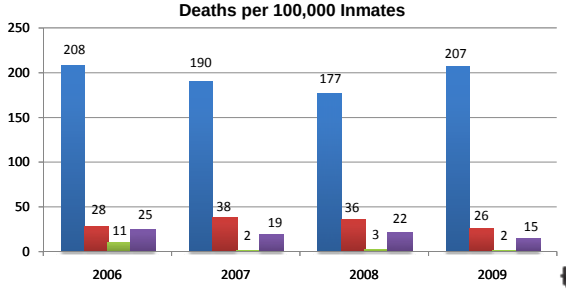
Position Authorization & Usage (February 2011)



OTHER PATTERNS/TRENDS

MEASURES	6 Month Trend	Most Recent
Appeals per 1,000 Inmates		58
Suicide Watch - Monthly Hours		18,232
Prescription per Member (Inmate)		3.8
Directly Observed & Nurse Administered Rx		43%
Emergency Dept Visits per 1,000 inmates		4.6
Hospital Admissions per 1,000 Inmates		7

Deaths per 100,000 Inmates



Glossary

Tell me about….

Prevention / Disease Management

Overview Each year, California Correctional Health Care Services (CCHCS) uses multiple data sets – morbidity and mortality data, utilization and cost information, and findings from studies in traditional health care and correctional health care settings – to identify priority areas for quality improvement initiatives. Some conditions are selected because they are high-risk for prison inmates. Patients diagnosed with diabetes, for example, are at risk for heart attack or stroke, a leading cause of potentially avoidable hospitalizations. Other conditions are selected because they are high-cost, high-volume, and/or problem-prone. Good disease management and appropriate preventive services can reduce potentially avoidable hospitalizations, save lives, and reduce costs.

Once CCHCS has identified a condition or other priority area for quality improvements, appropriate performance measures and objectives are established. In designing performance measures, CCHCS researches process and patient outcome measures commonly used in the health care industry, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, created by the National Committee for Quality Assurance. When setting program objectives, CCHCS reviews performance data from other health care organizations, including the Department of Veteran's Affairs, Medi-Cal, or other prison systems.

In an effort to promote improvement and assist institutions in achieving performance objectives, CCHCS develops and carries out a statewide initiative for each targeted condition, which includes patient registries or lists, decision support tools, professional education and development for health care provider staff, and performance reports.

Purpose CCHCS uses process and outcome measures linked to specific diseases to determine whether statewide quality improvements have helped to improve patient care. Performance measures for all priority conditions are reported in the Dashboard and updated monthly.

Specific Measures The Dashboard includes Prevention / Disease Management measures in diabetes care, asthma care, colon and breast cancer screening, Human Immunodeficiency Virus (HIV) screening, anticoagulation (blood-thinning therapy), and potentially avoidable hospitalizations. A brief description of each topic and its associated measures is included in this fact sheet.

For the purposes of Dashboard benchmarking, CCHCS performance is compared to community standards, as represented by Medicaid data, commercial plan (health maintenance organizations, preferred provider organizations, etc.) performance reported through HEDIS:

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- Equal to or greater than 75th percentile HEDIS
- Between the 25th and 75th percentiles HEDIS
- Less than the 25th percentile HEDIS

One of the reasons CCHCS aims for at least the 75th percentile in managing chronic diseases and other conditions is the potential to save taxpayers millions of dollars. In a 2010 report reviewing the achievements of regulations and initiatives for managed health plans, the Department of Managed Health Care stated, "…improving California's cardiovascular disease and diabetes measures to the national Healthcare Effectiveness Data and Information Set (HEDIS) 90th percentile standard could save 1,694 and 2,818 lives annually. These improvements would also avoid $118 million in yearly hospital costs…" (United States. Department of Managed Health Care. *A Decade of Promoting Healthier Californians*. Sacramento, 2010. Print.)

Diabetes

About 5% of inmates have diabetes, or approximately 8,000 inmates. Diabetic patients with blood vessel and heart disease are at high risk for heart attack and stroke. Patients with poor circulation may require amputation, and diabetics with eye problems are at risk for blindness.

Diabetes Performance Measures

- The Statewide score is a composite of three performance measures described in the following:
  - ✓ Percent of diabetic patients with controlled diabetes (as reflected by Hemoglobin A1C percentage of less than 8%.)
  - ✓ Percent of diabetic patients with appropriate cholesterol levels.
  - ✓ Percent of diabetic patients whose blood pressure is under control.
  - ✓ Percent of diabetic patients who have received a retinal screening in the past year.

Asthma

About 10% of inmates have asthma, a chronic lung disease that causes inflammation and constricts airways. When asthma is poorly controlled, patients may have repeated trips to the hospital for treatment. A severe asthma attack can be life-threatening.

Asthma Performance Measure

- Percent of asthmatic patients prescribed an ongoing maintenance medication (an inhaled corticosteroid) to reduce the likelihood of asthma attacks.

Cancer Screening

In 2009 and several preceding years, cancer was the leading cause of death for California prison inmates. Some cancers, such as breast and colon cancers, have a high likelihood of favorable outcomes if detected and treated early. Once the disease has progressed and metastasized, treatment by surgical removal and chemotherapy is traumatic, costly, and may not prevent a patient's death.

Cancer Screening Performance Measure

- Percent of eligible inmates 50 years and older screened for colon cancer through colonoscopy or annual fecal occult blood testing.
- Percent of eligible female inmates 50 to 64 years old offered a mammogram in the preceding 24 months.

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RETURN TO DASHBOARD

HIV Screening

The United States Centers for Disease Control and Prevention (CDC) reports that the rate of Human Immunodeficiency Virus (HIV) infection is approximately 1.7 percent in United States correctional settings, approximately 6.3 times the rate of infection within the general population. Identifying inmates infected with HIV has many benefits, such as the opportunity for those inmates to modify high risk behaviors in order to prevent transmission of HIV. Inmates who have an HIV infection can be treated when clinically indicated to prevent the development of Acquired Immune Deficiency Syndrome (AIDS), avoid opportunistic infections and costly AIDS-related complications, and improve health outcomes.

Performance Measure

- Percent of inmates processed through Reception Centers who had an HIV screening test.

Anticoagulation (Managing Patients on Blood-Thinning Medications)

Anticoagulation refers to managing patients who take blood-thinning medications to treat conditions like atrial fibrillation, some cancers, and other conditions associated with blood clots. Anticoagulation is a high-risk treatment which typically lasts from three to six months or indefinitely depending on clinical diagnosis. Patients taking anticoagulants must be monitored closely to maintain a blood-thinning rate within therapeutic levels to avoid life-threatening complications. A blood-thinning rate that is too high can lead to hemorrhages, whereas a blood-thinning rate that is too low can lead to deep vein thrombosis, pulmonary emboli, strokes or heart attacks.

Performance Measure

- Percent of all patients on blood-thinning medication whose most recent blood clotting test was performed within the last 30 calendar days and its result was within therapeutic levels.

Potentially Avoidable Hospitalizations

Thousands of inmates are sent to community hospitals for emergency department visits and/or admission to an inpatient bed. Each admission is assigned a diagnostic code as part of the billing process indicating why the patient needed hospital services. In the health care industry, certain diagnostic codes are closely linked to the quality of outpatient clinic care – it is assumed that if the patient receives appropriate care from their doctor, there should be little or no need to be hospitalized for that particular diagnostic code. Using billing information, CCHCS began to track hospitalizations that might have been avoided if medical care at the prison was appropriate. Monitoring potentially avoidable hospitalizations will help staff identify and address areas of the primary care model that are not functioning effectively.

Performance Measure

- Number of potentially avoidable hospitalizations per 1,000 inmates.

Data Sources Data for this section of the Dashboard comes from that Guardian Pharmacy database, Quest and Foundation Laboratory databases, Inmate Locator data, self-reporting from institutions (cancer screening logs), Distributed Data Processing System, and third party claims data.

Data for this section of the Dashboard is updated as Performance Reports are released, which generally follow a schedule of quarterly, semi-annual, or annual reporting. Potentially avoidable hospitalization data is updated monthly, with data that is usually from the month before the Dashboard is released.

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Tell me about….

Receiving Timely Health Care

Overview This section of the dashboard monitors whether inmates are able to access health care services, such as care for a chronic condition or consultation with a nurse, provider, or specialist, within required timeframes.

Health care organizations monitor access to care as an essential performance indicator. When patients receive timely access to health care services, acute and chronic conditions can be managed before they result in adverse health outcomes and costly complications.

Providing adequate access to care can prove challenging in correctional settings. Special security procedures, such as lockdowns, can affect clinic hours. In just scheduling a doctor's appointment, custody staff must consider factors, like whether patients scheduled for appointments in the same time period are from rival gangs, to ensure clinic safety. When health care services involve off-site appointments at a specialist's office or a community hospital, institutions must arrange transportation and guarding. Strategies like telemedicine, which allow primary care providers and specialists to evaluate patients remotely, help institutions overcome provider network limitations and recruitment difficulties and increase access to services.

Access to medications can also be problematic. With frequent inmate transfers, delivery of medications may be interrupted as inmates move from one institution to another. Medication distribution is labor-intensive. For many medications, particularly those with an underground value in the correctional setting, such as mental health medications, inmates must stand in line and take the medication while a nurse observes and verifies that the pill has been swallowed.

California Correctional Health Care Services (CCHCS) policies and procedures include timeframe requirements for accessing different types of health care services. Timeframes most closely linked to patient outcomes are reflected in the access measures on the dashboard.

The final access measure, "Medical appt. missed due to custody," which is not benchmarked, tracks medical appointments that were missed because of custody factors, such as lockdown or other problems moving an inmate from cell to yard clinic or specialist's office.

Purpose The access measures help statewide and local health care managers understand whether patients are able to access services within required timeframes and identify program areas where there may be barriers to access.

Specific Measures The Dashboard covers roughly 12 access measures, considered among the most important for improving patient outcomes.

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CCHCS has set benchmarks for performance on medical access measures:

- Greater than 85% (high adherence to policies and procedures)
- 75% – 85% (moderate adherence to policies and procedures)
- Less than 75% (low adherence to policies and procedures)

Access measures included in the Dashboard are listed in the table below:

Measure Title	Description	Timeframe	Policy Reference
Episodic Care Registered Nurse (RN)	When an inmate fills out a form to request health care services with a description of his or her medical symptoms, a registered nurse is required to evaluate the inmate face-to-face to determine whether the inmate needs to see a primary care provider and whether the referral should be urgent or routine.	1 business day	IMSP P&P Volume 4, Chapter 4
Episodic Care Primary Care Provider (PCP)	Inmates who fill out a form to request health care services may be referred to a primary care provider for an appointment. This measure applies to timeliness of referred routine appointments.	14 calendar days	IMSP P&P Volume 4, Chapter 4
PCP Chronic Care Visit	Patients with chronic conditions, such as asthma, hypertension, and diabetes, see a primary care provider on a regular basis to evaluate disease progress and plan interventions to improve the patient's health status.	At least once every 180 calendar days, more often as necessary	IMSP P&P Volume 7, Chapter 1
Evaluated by a Specialist (high priority)	On occasion, inmates are referred to a specialist, such as a cardiologist or oncologist, for an evaluation beyond what a primary care provider is trained to provide. Specialty referrals that are considered urgent are given "high priority" status.	14 calendar days	IMSP P&P Volume 4, Chapter 8
Evaluated by a specialist (routine)	On occasion, inmates are referred to a specialist, such as a surgeon, for an evaluation beyond what a primary care provider is trained to provide. Specialty referrals that are non-urgent are referred to as routine referrals.	90 calendar days	IMSP P&P Volume 4, Chapter 8
PCP Follow-Up (routine and high priority)	After a patient has been to see a specialist, the patient must be seen by a primary care provider, who reviews the report from the specialist, including recommendations and any diagnostic study results.	High priority - 3 business days; routine – 14 calendar days	IMSP P&P Volume 4, Chapter 8
PCP Follow-Up (return from Hosp/ED)	When a patient has been transferred to a community hospital for inpatient treatment or evaluation in the emergency department, the patient must be seen by his or her primary care provider after being discharged back to the institution.	5 calendar days	IMSP P&P Volume 4, Chapter 3
Medications	CCHCS tracks three medication access measures: continuous receipt of essential medications for chronic care patients, receipt of medication upon transfer to another institution, and receipt of medications upon return from a community hospital.	Chronic care – continuous; within 1 day upon transfer to an institution or return from community hospital or emergency department	IMSP P&P Volume 4, Chapter 11

Data Sources Institutions use standardized methodology and reporting tools (the Access Measure Audit Tool and Health Care Access data collection process) to collect access measure data monthly; the information is self-reported from each institution to the Dashboard.

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RETURN TO DASHBOARD

Data for this section of the Dashboard is updated monthly, but is usually two months behind the actual release of the Dashboard (e.g., if the Dashboard is released in June, the most recent access measure data would be for the month of April). Please see the Trended Composite View or Institution Scorecard to see the month referenced for the most recent data.

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Tell me about….

Medical Program Inspections (Office of the Inspector General)

Overview Through a 2008 interagency agreement, the Office of the Inspector General (OIG) conducts medical inspections at California's 33 prisons to evaluate the delivery of medical care. The OIG medical inspection covers either 19 or 20 components (inspections at female prison include an additional component for women's health services) and approximately 150 measures. The measures are linked to requirements in current California Correctional Health Care Services (CCHCS) policies and procedures. In calculating an institution's overall score, the OIG assigns greater weight to components that have greater impact on patient outcomes, such as chronic care, urgent care, and health screenings.

By January 2011, the OIG had completed initial medical inspections at California's 33 prisons and began a second round of inspections. After each medical inspection, the OIG issues a report, which includes the institution's score on each measure and component, as well as an overall score, among other information. OIG medical inspection reports are posted on the Internet at this location: http://www.oig.ca.gov/pages/reports/medical-inspections.php.

Purpose An important purpose of the OIG medical inspections is to provide information to support health care system improvements. Administrators use OIG medical inspection scores to help set priorities for improvements and monitor progress of the health care system.

Specific Measures The Statewide Health Care Services Dashboard places institutions into one of three categories based on overall score:

- Greater than 85% (high adherence to policies and procedures)
- 75% – 85% (moderate adherence to policies and procedures)
- Less than 75% (low adherence to policies and procedures)

Using this scale, the viewer can see how many institutions from the first and second round of inspections fall into the high, moderate, or low adherence categories.

Data Sources Data for this section of the Dashboard comes from the publicly-available OIG medical inspection reports. Source data can be found on the Internet at this address: http://www.oig.ca.gov/pages/reports/medical-inspections.php.

Data for this section of the Dashboard is updated as each OIG report is released.

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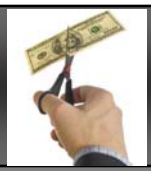
Tell me about….



Utilization Management

Overview Utilization management refers to the overall management of health care resources to promote positive patient outcomes and cost-effective delivery of care. It is important that services are provided to patients only when medically necessary and at the appropriate level of care, not just because health care resources may be limited and costly, but because over- and under-utilization presents risks to patients. When patients receive treatments that are not medically necessary (over-utilization), their health may be compromised by the treatment or side-effects; when patients do not have timely access to the services they need (under-utilization), a condition that might have been well-managed may become difficult to control and more costly. Appropriate utilization protects patients from these consequences and ensures that resources are available for the patients who truly need them.

California Correctional Health Care Services (CCHCS) manages several types of health care services in delivering care to California's prison inmates, including:

- **Specialty services** – consultations with specialists, diagnostic tests (e.g., ultrasounds and MRIs), and surgical procedures;
- **Bed days** – days spent as a patient at a community hospital; a subset of these, **administrative bed days**, refer to hospital days that are potentially avoidable and may be related to unavailability of medical beds in the prison setting, such Correctional Treatment Center beds;
- **Non-formulary drugs** – medications not on the list of cost-effective medications, prescribed to patients through a special approval process.

To promote effective utilization management, CCHCS distributes prevention and disease management guidelines and utilization criteria that are based upon current medical evidence; provides statewide staff development programs to raise awareness of current guidelines and utilization criteria; and offers decision support tools to primary care teams, such as guideline summaries and pocket guides, chart review tools, forms, and performance reports. CCHCS has invested in the expansion of telemedicine services, which connects patients with providers statewide through videoconferencing. Telemedicine saves costs relating to guarding and transporting patients to off-site appointments with specialists and expands network capacity.

Purpose Each year, CCHCS sets objectives for improving resource use. Reviewing utilization management measures allows CCHCS staff to monitor progress toward utilization management and quality objectives and encourages appropriate use of health care services and treatments.

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Specific Measures

Each measure under Utilization Management has an associated performance objective. Scoring is ranked as follows:

Measure	Score	Ranking
Specialty care referrals per 1,000 inmates	≤75	High performance
	75-85	Moderate performance
	>85	Low performance
Percentage of specialty appointments by telemedicine	>30%	High performance
	25%-30%	Moderate performance
	<25%	Low performance
Average number of hospital bed days per 1,000 inmates per year	≤500	High performance
	500-650	Moderate performance
	>650	Low performance
Administrative hospital bed days per 1,000 inmates per year	≤2	High performance
	2-10	Moderate performance
	>10	Low performance
Percentage non-formulary usage	≤3%	High performance
	3.1-5%	Moderate performance
	>5%	Low performance

Data Sources

Data for this section of the Dashboard comes from the InterQual database, Census and Discharge Data Information System (CADDIS), Guardian Pharmacy database, Telemedicine Scheduling System, third party claims data, and the CDCR Population Report.

Data for this section of the Dashboard is updated monthly. For most measures (Non-formulary usage, specialty care referrals per 1,000 inmates, and average number of hospital beds days per 1,000 inmates, the data reported is generally from two months prior to the release of the Dashboard. For some utilization management measures (e.g. specialty appointments via telemedicine, or average number of hospital bed days per 1,000 inmates), the data may be from five months or more prior to the release date of the Dashboard.

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Tell me about….

Human Resources

Overview In 2008, Receiver J. Clark Kelso adopted six goals to achieve medical reform within prison health care services (*The Federal Receiver's Turnaround Plan of Action, 2008*, available at the following link: http://www.cphcs.ca.gov/receiver_tpa.aspx). The third goal was to "recruit, train and retain a professional quality medical workforce." California Correctional Health Care Services (CCHCS) has since built a robust workforce of health care professionals through competitive compensation and by greatly improving recruitment practices.

Generally, in an industry that employs professional staff, turnover is a significant cost-driver. In the correctional health care system, turnover also means the loss of valuable institutional knowledge about the organization and its history, an institution and its patients, as well as knowledge of strategic projects and objectives. The continuity and quality of patient care may be affected while new providers become familiar with patients and their medical needs, and repeatedly investing in orientation and training for new staff is costly. Operational efficiency may also be diminished when a limited workforce attempts to pick up the work for vacant positions.

Aside from maintaining staff levels, CCHCS is also focused on the workload of staff who provide direct patient care or those who support the delivery of health care services that have a direct impact on overall patient care. Measuring workload allows CCHCS to trace the effects of changes to the organization's technologies, innovations, and policies.

Workload data assists management in resource allocation decisions. CCHCS leadership is responsible for reaching an appropriate balance between workload levels and the quality of care provided. While the workload data provided in the Dashboard does not capture the full universe of work performed by the classifications listed in the "Turnover/ Workload" section, it does give managers an ability to assess some workload aspects that affect patient care.

Purpose Changes in policies and procedures can affect the availability and cost-efficiency of resources. Turnover and workload data is monitored to ensure that patients receive access to services and appropriate quality of care.

Specific Measures

- The **turnover rate** measures the annualized percentage of all primary care providers, nursing staff, and pharmacy staff that voluntarily leaves CCHCS, with the goal set to less than 10% turnover.

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- **Patient encounters per primary care provider (PCP)** indicate the average number of direct patient face-to-face encounters that a primary care provider (physician or mid-level) has with patients each month, which is averaged to an 8-hour work day.
- **Rx per pharmacist and Rx per pharmacist technician** indicate the average number of prescriptions filled per day. The ability of pharmacy staff to fill prescriptions in a timely manner affects the medication dispense and administration requirements mandated in policy.
- **Appeals processed per analyst** indicate average number of appeals processed per analyst per day. Processing appeals in a timely manner means that institutions can address patient complaints and reach resolutions within a satisfactory timeframe.
- **Patient encounters per primary mental health clinician (PC)** indicates average number of patients seen per assigned primary mental health clinician (psychologist or social worker) per day.
- **Patient encounters per psychiatrist** indicate the average number of patients seen per psychiatrist per day.
- **Dental workload.** Dental Assessment Tracking Evaluation Scores (DATES) values assess the degree to which CDCR dentists perform multiple procedures during appointments. DATES values are based on the quantity and types of procedures a dentist performs during an encounter (e.g., fillings, extractions, periodontal care, and root canal treatment). The goal DATES value for mainline dentists is between 3.5 and 5.5. The goal DATES value for Reception Center dentists is between 2.0 and 3.5.

At the bottom of the "Human Resources" domain of the Dashboard, there are a series of human resources charts that show the proportion of staffing costs statewide that are attributed to health care civil service employees ("filled positions"), overtime by civil service employees, and registry staff services (contract employees). The human resources charts correspond to major categories of clinical staff shown below in Table 2.

The use of overtime hours and registry staff has a significant effect on cost. The management goal is to reduce and carefully manage those areas of expenditures by recruiting and retaining civil service health care professionals and optimizing operational efficiencies.

Table 2.

Position Type	Detailed Information
Provider	Receiver's Medical Executive, Chief Medical Officer, Chief Physician & Surgeon (P&S), P&S– CF, P&S– IM/FP, Physician Assistant and Nurse Practitioner
Nursing	Receiver's Nurse Executive, Supervising Registered Nurse, Registered Nurse, Licensed Vocational Nurse , Certified Nursing Assistant, Psychiatric Technician
Pharmacy	Pharmacist, Pharmacy Services Manager and Pharmacy Tech
Dental	Supervising Dentist, Dentist and Dental Assistant
Mental Health Clinician	Chief Psychologist, Senior Psychologist, Staff Psychologist and Social Worker
Psychiatrist	Chief Psychiatrist, Senior Psychiatrist, Staff Psychiatrist

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Data Sources Data for this section of the Dashboard comes from the publicly-available Receiver's Turnaround Plan of Action Monthly Report (click here to see reports: http://www.cphcs.ca.gov/receiver_tri.aspx) and the following internal reports: Provider Productivity Tool, Dental Readiness Assessment Tool, Guardian Pharmacy Database, Health Care Appeals Report, and Mental Health Tracking System. The Provider Productivity Report uses a standardized methodology and is self-reported by institutions to the Dashboard on monthly. Human resources data is reported monthly on the Position Management Report.

Data for this section of the Dashboard is updated monthly and generally reflects results from two months prior to the release of the Dashboard (e.g., if the Dashboard is released in June, the results in this section are generally from April), with the exception of the position authority and usage data. Position authority and usage data is updated monthly and covers performance three months prior to the Dashboard release.

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Expenditures

Overview While the delivery of adequate medical care is a primary purpose and goal of California Correctional Health Care Services (CCHCS), the organization must also demonstrate fiscal accountability to stakeholders and the public in its role as a government agency. For the health care system to be sustainable under state control, services must be cost-effective. Performance measures that evaluate expenditures help to ensure that appropriate resource management continues.

Because many improvement initiatives are chosen to improve not only the quality of care, but also the value of services, improvement initiatives usually affect cost-effectiveness. Cost measures help to assess the impact of those improvement initiatives. For example, patients diagnosed with diabetes should receive regular medications and follow-up appointments with their primary care provider to closely monitor their disease. If a patient's condition becomes unstable due to a lapse in care, their health can deteriorate, which may require costly medical treatment at a hospital. If institutions statewide are successful in improving diabetes care, there should be cost avoidance associated with specialty and inpatient services, among other expenses.

Purpose Institutions use the reporting of expenditures relating to medical, dental, and mental health services to make management decisions about the allocation of resources, and effectiveness and efficiency of health care delivery.

Specific Measures Expenditure data is aggregated and reported per fiscal year. Figures in this section represent average expenditures per inmate per month (following the "per member per month" reporting used by many managed care organizations). Table 1 below identifies the types of expenditures that are included in each area.

Table 1.

Area	Type of Expenditure
Direct Medical – Costs associated with direct medical care	• Civil service salaries & wages related to direct patient care, such as costs for nurses, physicians, and other classifications that provide direct patient care; benefits, temporary help, and overtime for institution-level civil service clinical staff • Costs associated with facility operations, supplies, equipment for direct patient care • Externally provided medical services, including: specialty services, emergency department, laboratory services, registry clinical staff • Medical supplies used by health care staff such as syringes, gloves, etc.
Clinical Support – Costs for services that support direct patient care, like pharmacy staffing, laboratory services, telemedicine, inmate appeals, health records, transcription, and dictation	• Civil service salaries & wages related to clinical support services; benefits, temporary help, and overtime for institution-level civil service clinical, administrative, and ancillary staff • Costs associated with facility operations, supplies, equipment for clinical support services

- more -

Tell me about…Expenditures / Page 2

Dental Program	Total expenses at institutions for dental services, including: • Civil service salaries & wages related to dental care; benefits, temporary help, and overtime for institution-level civil service clinical, administrative, and ancillary staff • Costs associated with facility operations, supplies, equipment for dental service delivery
Mental Health Program	Total expenses at institutions for mental health services, including: • Civil service salaries & wages related to mental health services; benefits, temporary help, and overtime for institution-level civil service clinical, administrative, and ancillary staff • Costs associated with facility operations, supplies, equipment for mental health patient care • Medications for psychiatric conditions, excluding medication provided at community emergency department or hospital
Pharmacy	• All medications dispensed to inmates, excluding medication provided at community emergency department or hospital
Headquarters– Costs associated with administrative services, most located at headquarters, such as human resources, legal services, policy and risk management, and executive office support	• Civil service salaries & wages related to headquarters staff; benefits, temporary help, and overtime for institution-level civil service clinical, administrative, and ancillary staff • Costs associated with facility operations, supplies, equipment for headquarters staff • Administrative costs, such as costs for 19 major health care projects and information technology costs

Data Sources Data for this section of the Dashboard comes from the Business Information System (BIS).

Data for this section of the Dashboard is updated annually.

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Tell me about….

Other Patterns / Trends

Overview The measures found in this section are not benchmarked but they are of interest to management, relate to other measurements, and are considered important enough for regular monitoring.

Purpose The metrics reported in Other Patterns and Trends provide supplemental data to support management decisions, and may be benchmarked in the future.

Specific Measures

- **Appeals per 1,000 inmates** indicate the rate of appeals submitted per 1,000 inmates. A high number of appeals may represent a break down in the medical services provided to inmates. Changes in policies or health care staff workload may contribute to spikes in appeals.
- **Suicide Watch Monthly Hours** indicate the total number of hours used for suicide watch during the month for all 33 adult institutions. Suicide watch hours may be reduced through clinically appropriate interventions that support patients through mental health crisis.
- **Prescriptions Per Member Per Month** are the average number of prescriptions per inmate per month, including refills, based on total prescriptions dispensed and the inmate population during that month. There are approximately 500,000 prescriptions that are filled per month between the 33 adult institutions. Health care services management and clinical leaders have offered continuing education, and focused training and select reports to providers in an effort to improve patient care through the proper use of medically necessary drugs and clinically appropriate interventions.
- **Directly Observed & Nurse Administered Prescriptions** identify the percentage of total prescriptions per month that are prescribed as directly observed (DOT) or nurse administered (NA) medications. Institutions monitor DOT and NA medications because they are a significant driver of nurse and pharmacy workload, and may contribute to increases in the need for overtime or registry staffing.
- **Emergency Department Visits per 1,000 Inmates** count the number of trips to a community emergency department per 1,000 inmates per month. Emergency services require external resources and additional custody staff that result in higher-costs. Timely treatment of patients with serious medical conditions and appropriate utilization management can reduce the need for outside emergency services.
- **Hospital Admissions per 1,000 Inmates** count the number of admissions to a community hospital per 1,000 inmates per month. Timely treatment of patients with serious medical conditions and appropriate utilization management can reduce the need for community hospital services.

- more -

- **Deaths per 1,000 inmates** chart data for the most recent 4 years of inmate deaths. Board certified physicians or licensed mid-level providers review the care provided to a patient and complete a death review, separating each instance into one of four categories:
  - ✓ **Non-Preventable deaths**: In the judgment of the reviewer, the patient's death could not have been prevented or delayed by more optimum health care. The majority of deaths are not preventable based on the judgment of the independent physician reviewer.
  - ✓ **Possibly Preventable deaths**: In the judgment of the reviewer, better medical management or improvement in the system of care might have prevented or delayed the patient's death. Over the past few years, the number of possibly preventable deaths per 100,000 inmates has decreased.
  - ✓ **Likely Preventable deaths**: In the judgment of the reviewer, better medical management or improvement in the system of care would likely have prevented or delayed the patient's death. Over the past few years, the number of likely preventable deaths per 100,000 inmates has decreased.
  - ✓ **Suicide**: When an inmate takes their own life. CCHCS strives to avoid these events by training health care staff to identify and treat patients who show signs of physical, emotional, or mental distress. Suicides are also categorized in one of the three preventability categories above.

Data Sources Data for this section of the Dashboard comes from the Health Care Appeals Report, Fiscal Suicide Watch Tracking Database, Guardian Pharmacy Database, and the Census and Discharge Data Information System.

Data for this section of the Dashboard is updated monthly and results usually reflect the month prior to release of the Dashboard, with the exception of the "Deaths per 100,000 Inmates" graph. The "Deaths per 100, 000 Inmates" graph is updated annually.

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California Correctional Health Care Services Dashboard
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RETURN TO DASHBOARD

Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
MEDICAL PROGRAM INSPECTIONS							
Overall Score	**Goal: >85% adherence** High: >85% Moderate:75%-85% Low: <75%	X	X	X	X	The Office of the Inspector General (OIG) uses a series of "yes" (adherence) or "no" questions in 20 components of medical delivery (e.g., Chronic Care). Each inspection question is weighted and scored by calculating the percentage of "yes" answers for each question from all items sampled. That percentage is then multiplied by the question's weight to arrive at a weighted score. The total score is calculated by summing the number of weighted subject points earned and dividing that value by the overall number of weighted points possible. Reported percentages reflect the most recent OIG inspection results. See OIG site for details.	OIG Medical Inspection Results
Chronic Care				X	X	Percentage adherence with standards for care and medication for inmate-patients with specific chronic care conditions (affecting functioning and prognosis for more than six months). Chronic care conditions examined include asthma, Warfarin (anticoagulation) therapy, diabetes, HIV (Human Immunodeficiency Virus), and hypertension.	
Clinical Services				X	X	Percentage adherence with standards for access to primary health care services, focusing on recently received services from any prison facility or administrative segregation unit clinic, including sick call (episodic care), processes (doctor or nurse line), medication management, and nursing.	
Health Screening				X	X	Percentage adherence with standards for new-arrival screening for health care conditions that require treatment monitoring, and continuity of care.	
Specialty Services				X	X	Percentage adherence with standards for approval, denial, and scheduling of outside specialty services (e.g., physical therapy, oncology, surgery, and cardiology).	
Urgent Services				X	X	Percentage adherence with standards for provision of care preceding and following an Inmate-patient visit to a community hospital or emergency department.	
Emergency Services				X	X	Percentage adherence with standards for medical emergency response, focusing on "man/woman down" situations and adequacy of staff response to "man/woman down" emergency drills.	
Diagnostic Services				X	X	Percentage adherence with standards for timely provision of radiology and laboratory services (e.g., X-ray, blood tests) and follow-up of clinically significant results.	
Access to Health Care Information				X	X	Percentage adherence with standards for effective filing, storing, and retrieval of medical records and medical information.	
Preventive Services				X	X	Percentage adherence with standards for providing cancer screening and influenza immunizations.	
All Other Components				X	X	Range of percentage adherence with OIG-audited medical system standards not included in the categories above.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
DENTAL PROGRAM AUDIT							
Overall Score	Pass Fail	X	X	X	X	Average percentage adherence to standards in the Clinical Process, Patient Safety, and Quality of Care categories of the Dental Readiness Assessment Tool; reported percentages reflect the most recent audit month results or six month trend, depending on view.	Dental Readiness Assessment Tool
Clinical Process	Pass: ≥75% Fail: <75%		X	X	X	Percentage adherence to standards in the Clinical Process category of the Dental Readiness Assessment Tool; reported percentages reflect the most recent audit month results or six month trend, depending on view.	
Patient Safety	Pass: ≥80% Fail: <80%		X	X	X	Percentage adherence to standards in the Patient Safety category of the Dental Readiness Assessment Tool; reported percentages reflect the most recent audit month results or six month trend, depending on view.	
Quality of Care	Pass: ≥90% Fail: <80%		X	X	X	Percentage adherence to standards in the Quality of Care category of the Dental Readiness Assessment Tool; reported percentages reflect the most recent audit month results or six month trend, depending on view.	
MENTAL HEALTH SERVICES DELIVERY SYSTEM							
Contact Intervals	High: >90% Moderate:75%-90% Low: <75%	X	X			Percentage adherence with Mental Health Services Delivery System (MHSDS) areas, as measured by weekly contact events for inmate-patients in the MHSDS (including initial and routine Interdisciplinary Treatment Team (IDTT), psychiatrist, and primary clinician (PC) contact). Aggregated percentage adherence represents adherence to each contact type timeframe for each care program and housing placement. Reported percentages reflect the most recent month or six month trend, depending on view.	Mental Health Tracking System
Interdisciplinary Treatment Team (IDTT)				X	X	Percentage adherence to IDTT routine contact event timeframes. Reported percentages reflect the most recent month or six month trend, depending on view.	
Primary Clinician (PC) Contact				X	X	Percentage adherence to PC routine contact event timeframes. Reported percentages reflect the most recent month or six month trend, depending on view.	
Psychiatrist Contact				X	X	Percentage adherence to Psychiatrist contact event timeframes. Reported percentages reflect most recent month or six month trend, depending on view.	
Mental Health Referrals		X	X			Percentage adherence to timeframes for referral entry into MHSDS, as defined by the MHSDS Program Guide. Reported percentages reflect the most recent month or six month trend, depending on view.	
Level of Care Referrals		X	X			Percentage adherence to MHSDS Level of Care timeframes for Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient Program (EOP), and Mental Health Crisis Beds (MHCB), as defined by the MHSDS Program Guide. Reported percentages reflect the most recent month or six month trend, depending on view.	
Mental Health Referrals					X	Percentage adherence to mental health referral timeframes. Reported percentages reflect the most recent month or six month trend, depending on view.	
Level of Care Referrals				X		Percentage adherence to Level of Care Referral (routine, urgent, emergent) timeframes. Reported percentages reflect the most recent month or six month trend, depending on view.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
PREVENTION/DISEASE MANAGEMENT							
EFFECTIVENESS OF HEALTH CARE—COMMUNITY COMPARISON (NATIONAL MEDICAID, OR, IF UNAVAILABLE, NATIONAL COMMERCIAL OR VETERAN'S ADMINISTRATION)							
DIABETES							
Appropriate Diabetes Care	High: >75th Community Percentile Moderate:25th-75th Community Percentile Low: <25th Community Percentile	X				Composite percentage of diabetic inmate-patients continuously incarcerated for at least six months whose: most recent HbA1c was under control; LDL-C was under control; blood pressure was under control; and who received an annual eye exam, as defined below. Reported percentages reflect a comparison of the two most recent quarters.	Reference Laboratory Databases/ Guardian Pharmacy Database/Inmate Locator/Access Measure Audit Tool
Hemoglobin A1c Controlled (< 8%)			X	X	X	Percentage of diabetic inmate-patients continuously incarcerated for at least six months who received a Hemoglobin A1c (blood sugar) test within the preceding six months with a value less than eight percent. To achieve more precise comparability with other health systems, reported percentages reflect the percentage of diabetics with a HbA1c test value less than eight percent of those who were tested. Reported percentages reflect the most recent quarter or a comparison of the two most recent quarters, depending on view.	Reference Laboratory Databases/ Guardian Pharmacy Database/Inmate Locator
LDL-C Controlled (<100 mg/dL)			X	X	X	Percentage of diabetic inmate-patients continuously incarcerated for at least six months who received an low-density lipoprotein ("bad" cholesterol) test within the preceding 12 months with a value less than 100 mg/dL. To achieve more precise comparability with other health systems, reported percentages reflect the percentage of diabetics with an LDL-C test value less than 100 mg/dL of those who were tested. Reported percentages reflect the most recent quarter or a comparison of the two most recent quarters, depending on view.	
Screening or Treatment for Kidney Disease			X	X	X	Percentage of diabetic inmate-patients continuously incarcerated for at least six months who received a microalbumin (abnormal kidney function) test within the preceding 12 months or who were prescribed an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor blocker (ARB) medication for prevention of further kidney damage. Reported percentages reflect the most recent quarter or a comparison of the two most recent quarters, depending on view.	
Blood Pressure Controlled (<130/80)			X	X	X	Percentage of a representative sample of diabetic inmate-patients continuously incarcerated for at least six months whose most recent blood pressure reading within the preceding three months was less than 130/80. Reported percentages reflect data from May through September 2010.	Access Measure Audit Tool
Annual Retinal Examinations			X	X	X	Percentage of a representative sample of diabetic inmate-patients continuously incarcerated for at least six months whose received a dilated retinal (eye) exam within the preceding 12 months. Reported percentages reflect data from May through September 2010.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
PREVENTION/DISEASE MANAGEMENT							
EFFECTIVENESS OF HEALTH CARE—COMMUNITY COMPARISON (NATIONAL MEDICAID, OR, IF UNAVAILABLE, NATIONAL COMMERCIAL OR VETERAN'S ADMINISTRATION)							
OTHER HEALTH CONDITIONS							
Appropriate Asthma Care	High: >75th Community Percentile Moderate:25th-75th Community Percentile Low: <25th Community Percentile	X	X	X	X	Percentage of inmate-patients who were prescribed a short-acting beta agonist (SABA) or an inhaled corticosteroid (ICS) during a six month period among all inmate-patients prescribed two or more asthma medications during the same six month period. Reported percentages reflect the most recent six month period or a comparison of the two most recent six month periods, depending on view.	Guardian Pharmacy Database
Timely Colorectal Cancer Screening		X	X	X	X	Percentage of inmate-patients 50-75 years of age continuously incarcerated for at least six months who received: a fecal occult blood test (FOBT) within the preceding12 months, a sigmoidoscopy within the preceding five years, or a colonoscopy within the preceding 10 years or informed refusal within last year. Colonoscopy and sigmoidoscopy data is available for June 2008 and after. Please note that the current performance data includes patients 50-75 years of age, whereas the community standard includes patients 51-75 years of age. Reported percentages reflect the most recent six month period or a comparison of the two most recent six month periods, depending on view.	Reference Laboratory Databases/ Guardian Pharmacy Database/ Distributed Data Processing System
Timely Breast Cancer Screening		X	X	X	X	Percentage of female inmate-patients 50-75 years of age continuously incarcerated for at least six months who received a mammogram within the preceding two years. Mammography data is available for June 2009 and after. Please note that the current performance data includes patients 50-75 years of age, whereas the community standard includes patients 42-69 years of age. Reported percentages reflect the most recent six month period or a comparison of the two most recent six month periods, depending on view.	
Therapeutic Anticoagulation		X	X	X	X	Percentage of inmate-patients who were prescribed Warfarin anticoagulation therapy and achieved a therapeutic international normalizing ratio (INR) between 2 and 3.5 in the preceding 30 days. Reported percentages reflect the most recent six month period or a comparison of the two most recent six month periods, depending on view.	
BASELINE AND INTERNAL GOALS							
HIV Screening	**Goal: >85% adherence** High: >85% Moderate:75%-85% Low: <75%	X	X	X	X	Percentage of newly arriving inmate-patients who were screened for Human Immunodeficiency Virus (HIV) within the preceding six months. Reported percentages reflect the most recent six month period or a comparison of the two most recent six month periods, depending on view.	Reference Laboratory Databases/ Inmate Locator
Potentially Avoidable Hospitalizations per 1,000 Inmates per Year	**Goal: <2** High : <2 Moderate:2-10 Low: >10	X	X	X	X	Rate of potentially avoidable hospitalizations per 1,000 inmate-patients per year based on the Agency for Healthcare Research and Quality (AHRQ) criteria for the following conditions: cellulitis, pneumonia, diabetes and related complications, asthma, chronic obstructive pulmonary disease (COPD), altered level of consciousness or seizure, and congestive heart failure. Reported rates reflect an annualized rate of the most recent six month period.	Third Party Administrator Claims

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
RECEIVED TIMELY HEALTH CARE							
Episodic Care by RN (with Symptoms)	**Goal: >85% adherence** High: >85% Moderate:75%-85% Low: <75%	X	X	X	X	Percentage of inmate-patients who submitted a medical Health Care Service Request form indicating symptoms who were seen face-to-face by a nurse within one business day. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Access Measure Audit Tool
Primary Care Provider Episodic Care (Routine)		X	X	X	X	Percentage of inmate-patients who received a routine appointment with a primary care provider within 14 calendar days of a nurse referral. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Provider Chronic Care Visit		X	X	X	X	Percentage of inmate-patients enrolled in the chronic care program who received an evaluation by a primary care provider as frequently as ordered but no more than 180 calendar days after their previous evaluation. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Specialist Evaluation (High Priority)		X	X	X	X	Percentage of inmate-patients evaluated by a specialist within 14 calendar days of approval of a high priority referral. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Specialist Evaluation (Routine)		X	X	X	X	Percentage of inmate-patients evaluated by a specialist within 90 calendar days of approval of a routine referral. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Provider Follow-Up (Routine and High Priority)		X				Percentage of inmate-patients who received a follow-up by a primary care provider within three business days of returning from a high priority specialty appointment or within 14 calendar days of returning from a routine specialty appointment. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Provider Follow-Up (High Priority Specialty)			X	X	X	Percentage of inmate-patients who received a follow-up by a primary care provider within three business days after returning from a high priority specialty appointment. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Provider Follow-Up (Routine Specialty)			X	X	X	Percentage of inmate-patients who received follow-up by a primary care provider within 14 calendar days after a routine specialty appointment. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Provider Follow-Up (Return from Higher Level of Care)		X	X	X	X	Percentage of inmate-patients returning from a higher level of community care (a community hospital or emergency department) who received an evaluation by their primary care provider within five calendar days of return to the institution. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
RECEIVED TIMELY HEALTH CARE							
Medication	**Goal: >85% adherence** High: >85% Moderate:75%-85% Low: <75%	X	X	X		Composite percentage of the percentage of inmate-patients who received appropriate medications as defined below. Reported percentages reflect the most recent month and/ or a trend of the most recent six month period, depending on view.	Access Measure Audit Tool
Chronic Care					X	Percentage of inmate-patients enrolled in the chronic care program who received all prescribed chronic care medications in the last 90 calendar days. Reported percentages reflect the most recent month and a trend of the most recent six month period.	
Return from Higher Level of Care					X	Percentage of inmate-patients returning from higher level of community care (a community hospital or emergency department) who received all prescribed medications within one business day. Reported percentages reflect the most recent month and a trend of the most recent six month period.	
New Arrivals and/or Intra-system Transfers					X	Percentage of newly arriving or intra-system transfer inmate-patients who received all medications previously prescribed within specified policy timeframes (one calendar day for newly arriving inmate-patients and one business day for intra-system transfers). Reported percentages reflect the most recent month and a trend of the most recent six month period.	
Health Care Appointment Missed Due to Custody	**Not Benchmarked**	X	X		X	Percentage of all scheduled health care appointments missed due to custody factors. Reported percentages reflect the most recent month and a trend of the most recent six month period.	Health Care Access Report

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
UTILIZATION MANAGEMENT							
SPECIALTY SERVICES							
Specialty Care Referrals per 1,000 Inmates	**Goal: <75** High: <75 Moderate:75-85 Low: >85	X	X	X	X	Average number of referrals for specialist consultation referrals submitted and approved per 1,000 inmate-patients per month. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	InterQual (Utilization Management Statewide Report/ Statewide Population Report
Specialty Appointments by Telemedicine	**Goal: >30%** High: >30% Moderate:25%-30% Low: <25%	X				Percentage of non-psychiatric specialist visits appropriate for telemedicine (i.e., non-procedural evaluation, management, or consultation) delivered via telemedicine services. Reported numbers reflect the most recent month and a trend of the most recent six month period.	Third Party Administrator
Actual Specialty Services Cost per Inmate per Month	**Not Benchmarked**		X	X	X	Dollar cost of all non-psychiatric specialty services per inmate per month. Reported numbers reflect the most recent month and a trend of the most recent six month period.	Third Party Administrator
COMMUNITY EMERGENCY DEPARTMENT AND HOSPITAL SERVICES							
Average Number of Bed Days per 1,000 Inmates per Year	**Goal: <500** High: <500 Moderate:500-650 Low: >650	X	X	X	X	Average number of days spent occupying a clinic bed or community hospital bed per 1,000 inmates per year. Reported numbers reflect the most recent month and a trend of the most recent six month period.	Census and Discharge Data Information System (Utilization Management Statewide Report)/ Statewide Population Report/ Third Party Administrator
Administrative Bed Days per 1,000 Inmates per Year	**Goal: <2** High: <2 Moderate:2-10 Low: >10	X	X	X	X	Average number of potentially avoidable days spent occupying a community hospital bed (e.g., due to unavailability of Correctional Treatment Center beds) per 1,000 inmate-patients per year. Reported numbers reflect the most recent month and a trend of the most recent six month period.	
Actual Emergency Department Cost per Inmate per Month	**Not Benchmarked**		X	X	X	Dollar cost of emergency department visits per 1,000 inmates per month. Reported costs reflect the most recent month and a trend of the most recent six month period.	Census and Discharge Data Information System/Statewide Population Report/ Third Party Administrator
Actual Inpatient Cost per Inmate per Month			X	X	X	Dollar cost of inpatient treatment services per 1,000 inmates per month. Reported costs reflect the most recent month and a trend of the most recent six month period.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
UTILIZATION MANAGEMENT							
MEDICATION SERVICES							
Non-Formulary Usage (Composite)	**Not Benchmarked**	X	X	X	X	Percentage of all prescriptions filled that are not on the formulary. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Guardian Pharmacy Database/ Statewide Population Report
Non-Formulary (Non-Mental Health)	**Goal: <3%** High: <3% Moderate:3%-5% Low: >5%			X	X	Percentage of all non-mental health prescriptions filled that are not on the formulary. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Non-Formulary (Mental Health)				X	X	Percentage of all mental health prescriptions filled that are not on the formulary. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Prescriptions per Inmate per Month (Composite)		X	X	X	X	Average number of prescriptions dispensed per inmate per month. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Prescriptions per Inmate per Month (Non-Mental Health)				X	X	Average number of non-mental health prescriptions dispensed per inmate per month. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Prescriptions per Inmate per Month (Mental Health)				X	X	Average number of mental health prescriptions dispensed per inmate per month. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Cost of Prescriptions per Inmate per Month (Composite)				X	X	Dollar cost of all prescriptions per inmate per month. Reported costs reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Cost of Prescriptions per Inmate per Month (Non-Mental Health)				X	X	Dollar cost of all non-mental health prescriptions per inmate per month. Reported costs reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Cost of Prescriptions per Inmate per Month (Mental Health)				X	X	Dollar cost of all mental health prescriptions per inmate per month. Reported costs reflect the most recent month and/or a trend of the most recent six month period, depending on view.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
TURNOVER/WORKLOAD							
TURNOVER							
Turnover Rate	**Goal: <10%** High: <10% Moderate:10%-20% Low: >20%	X	X	X		Percentage of voluntary staff separations from state employment displayed in the following categories: Primary Care Physicians (PCP), Nursing, Pharmacy, Dental, Psychiatrist, and Primary Mental Health Clinician. Reported rates reflect the most recent month.	Receiver's Turnaround Plan of Action Monthly Report
WORKLOAD							
Patient Encounters per Provider	**Not Benchmarked**	X	X	X	X	Average number of inmate-patients seen per Primary Care Provider (PCP) per normalized eight hour day. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Provider Productivity Tool
Prescriptions per Pharmacist		X	X	X	X	Average number of prescriptions filled per Pharmacist per normalized eight hour day. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Guardian Pharmacy Database
Prescriptions per Pharmacist Technician		X	X	X	X	Average number of prescriptions dispensed per Pharmacist Technician per normalized eight hour day. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Appeals Processed per Analyst		X	X	X	X	Average number of patient health care appeals processed per analyst per normalized eight hour day. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Health Care Appeals Report
Patient Encounters per Primary Mental Health Clinician		X	X	X	X	Average number of inmate-patients seen per assigned primary mental health clinician (psychologist or social worker) per normalized eight hour day. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Mental Health Tracking System
Patient Encounters per Psychiatrist		X	X	X	X	Average number of inmate-patients seen per Psychiatrist per normalized eight hour day. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	
Dental Assessment Tracking Evaluation Scores—Mainline		X	X	X	X	The Dental Assessment Tracking Evaluation Scores (DATES) - Mainline is an assessment of the degree to which CDCR dentists perform procedures during treatment appointments at mainline institutions. Reported scores reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Dental Assessment Tracking Evaluation Scores (DATES)
Dental Assessment Tracking Evaluation Scores—Reception Center		X	X	X	X	The Dental Assessment Tracking Evaluation Scores (DATES) - Reception Center (RC) is an assessment of the degree to which CDCR dentists perform procedures during treatment appointments at RC institutions. Reported scores reflect the most recent month and/or a trend of the most recent six month period, depending on view.	

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Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
EXPENDITURES							
HEALTH CARE EXPENDITURES FISCAL YEAR 2009/2010 PER INMATE PER MONTH							
Total	Not Benchmarked	X				The per inmate per month sum of all fiscal year expenses for all health care program areas listed below. Reported expenditures reflect the most recent month.	Business Information System (BIS)
Direct Medical		X			X	The per inmate per month sum of all fiscal year expenses for direct medical care, including Personal Services, Contract Services, Operating Expenses, Pharmaceuticals, and Medical Supplies. Reported expenditures reflect the most recent month.	
Clinical Support		X				The per inmate per month sum of all fiscal year expenses for clinical support, including Personal Services and Operating Expenses. Reported expenditures reflect the most recent month.	
Dental		X			X	The per inmate per month sum of all fiscal year expenses for dental program services, including Personal Services, Contract Services, Operating Expenses, Pharmaceuticals, and Distributed Administration/Special Line Item. Reported expenditures reflect the most recent month.	
Mental Health		X			X	The per inmate per month sum of all fiscal year expenses for mental health program services, including Personal Services, Contract Services, Operating Expenses, Pharmaceuticals, and Distributed Administration/Special Line Item. Reported expenditures reflect the most recent month.	
Pharmacy		X			X	The per inmate per month sum of all fiscal year expenses for pharmacy services, including Personal Services, Contract Services, Operating Expenses, Pharmaceuticals, and Distributed Administration/Special Line Item. Reported expenditures reflect the most recent month.	
Headquarters		X				The per inmate per month sum of all fiscal year expenses for headquarters operations, including Personal Services, Information Technology (IT), Facility Operations/Leasing and One Time Administration Costs. Reported expenditures reflect the most recent month.	
Actual Cost per Inmate per Month		X				The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for the program areas listed below. Reported costs reflect the most recent month.	Management Information Retrieval System (MIRS)
Actual Provider Cost per Inmate per Month			X	X	X	The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for medical primary care providers. Reported scores reflect the most recent month.	
Actual Nursing Cost per Inmate per Month			X	X	X	The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for nursing services. Reported costs reflect the most recent month.	
Actual Pharmacy Cost per Inmate per Month			X	X	X	The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for pharmacy services. Reported costs reflect the most recent month.	
Actual Dental Cost per Inmate per Month			X	X	X	The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for dental services. Reported costs reflect the most recent month.	
Actual Primary Mental Health Clinician Cost per Inmate per Month			X	X	X	The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for primary mental health clinician services. Reported costs reflect the most recent month.	
Actual Psychiatrist Cost per Inmate per Month			X	X	X	The per inmate per month cost of salaries/wages, retirement, benefits, temporary help, registry, and overtime for psychiatrist services. Reported costs reflect the most recent month.	

California Correctional Health Care Services Dashboard

GLOSSARY

RETURN TO DASHBOARD

Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
EXPENDITURES							
POSITION AUTHORIZATION AND USAGE							
Position Categories	Not Benchmarked	X				*Provider*— Receiver's Medical Executive, Chief Medical Officer, Chief Physician & Surgeon (P&S), Physician and Surgeon, Physician Assistant and Nurse Practitioner *Nursing*—Receiver's Nurse Executive, Supervising Registered Nurse, Registered Nurse, Licensed Vocational Nurse, Certified Nursing Assistant, Psychiatric Technician *Pharmacy*—Pharmacist, Pharmacy Services Manager and Pharmacy Tech *Dental*—Supervising Dentist, Dentist and Dental Assistant *Primary Mental Health Clinician*—Psychologist, Social Worker, or Psychiatrist	Position Management Report
Provider, Nursing, Pharmacy, Dental, Primary Mental Health Clinician, and Psychiatrist FTE		X				*Full Time Equivalents (FTE)*—Measures one full calendar year of state employee paid employment, or the equivalent of 2,088 hours (the number of average available work hours in a year). A staff month is equivalent to 174 hours (the average available work hours in a month). *Authority*— Ongoing positions approved in the budget of the preceding year (excepting positions abolished because of continued, extended vacancy). Details about authorized positions by classification can be found in the Salaries and Wages Supplement for state organizations. *Filled Positions*— The monthly FTE for filled position hours. *Overtime FTE (OT FTE)* —The monthly FTE overtime hours. *Registry FTE*—The monthly FTE for contract labor hours. Reported scores reflect the most recent month.	
Actual Staff per 1,000 Inmates				X	X	Number of current FTE staff per 1,000 inmates for each provider category (as described above). Reported numbers reflect the most recent month and a trend of the most recent six month period.	
Budgeted Staff per 1,000 Inmates				X	X	Number of FTE staff positions budgeted per 1,000 inmates for each provider category. Reported numbers reflect the most recent month and a trend of the most recent six month period.	
Percentage Vacant				X	X	Percentage of FTE staff positions that are currently vacant for each provider category. Reported percentages reflect the most recent month and a trend of the most recent six month period.	
Variance between Actual/Budgeted				X	X	Percentage difference between the number of budgeted FTE positions and the number of actual staff positions for each provider category. Reported percentages reflect the most recent month and a trend of the most recent six month period.	
Cost per Inmate per Month				X	X	Dollar cost per inmate per month of health care staffing for each provider category. Reported costs reflect the most recent month and a trend of the most recent six month period.	MIRS Report
Percentage Overtime				X	X	Percentage of per inmate per month cost identified as overtime staffing for each provider category. Reported percentages reflect the most recent month and a trend of the most recent six month period.	
Percentage Registry				X	X	Percentage of per inmate per month cost identified as registry staffing for each provider category. Reported percentages reflect the most recent month and a trend of the most recent six month period.	

California Correctional Health Care Services Dashboard

GLOSSARY

RETURN TO DASHBOARD

Measure	Goal	Statewide	Monthly Composite	Trended Composite	Institution Scorecard	Definition	Sources
OTHER PATTERNS AND TRENDS							
Appeals per 1,000 Inmates	Not Benchmarked	X	X	X	X	Average number of appeals received (formal and informal) per 1,000 inmates per month. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Health Care Appeals Report/ Statewide Population Report
Suicide Watch—Monthly Hours		X	X	X	X	Total number of staff hours spent on suicide watch. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Fiscal Suicide Watch Tracking
Prescriptions per Inmate		X	X	X	X	Average number of prescriptions, including refills, dispensed per inmate per month. Reported numbers reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Guardian Pharmacy Database/ Statewide Population Report
Directly Observed & Nurse Administered Prescriptions		X	X	X	X	Percentage of all dispensed prescriptions classified as directly observed or nurse administered. Reported percentages reflect the most recent month and/or a trend of the most recent six month period, depending on view.	Guardian Pharmacy Database
Emergency Department Visits per 1,000 Inmates		X	X	X	X	Average number of community emergency department admissions per 1,000 inmates per month. Six months of data and trend line. Reported rates reflect the most recent month and a trend of the most recent six month period.	Census and Discharge Data Information System/ Statewide Population Report
Hospital Admissions per 1,000 Inmates		X	X	X	X	Average number of community hospital admissions per 1,000 inmates per month. Reported rates reflect the most recent month and a trend of the most recent six month period.	Census and Discharge Data Information System/ Statewide Population Report
Deaths per 100,000 Inmates per Year		X		X		Annual death rate per 100,000 inmates per year in the following categories: non-preventable deaths, possibly preventable deaths, likely preventable deaths, and suicides. Reported rates reflect the most recent month and a trend of the most recent six month period.	Annual Analysis of Inmate Death Reviews/Statewide Population Report

Tell me about….

Benchmarks

Overview The Statewide Health Care Services Dashboard includes multiple measures that are benchmarked – ranked and color-coded to make it easy to see whether California Correctional Health Care Services (CCHCS) has achieved a particular level of performance. This is a common strategy used in dashboards to allow viewers to get an overall sense of organizational performance across multiple categories at a glance.

To arrive at benchmarks for the measures in "Prevention / Disease Management," CCHCS reviews comparative data from other health care organizations, such as Medicaid managed care plans, reported in the Healthcare Effectiveness Data and Information Set (HEDIS), as well as past CCHCS performance. Under HEDIS, the performance of all participating health care organizations on a particular measure is reported by percentile. CCHCS uses these percentiles to set statewide performance standards for prevention and disease management. CCHCS receives a score of "high adherence" when the organization meets or exceeds the 75th percentile of what was reported for Medicaid organizations. Statewide performance is considered at low adherence when it is below the 25th percentile. When Medicaid information is not available, CCHCS executives refer to other community groups, such as commercial health plans or the Department of Veteran's Affairs for comparative data to inform benchmarking.

For some measures, particularly those linked to policy compliance, CCHCS works from internal benchmarks. Measures on the Statewide Health Care Services Dashboard linked to *Plata* policies, such as many of those in the "Received Timely Health Care," carry an 85% objective in order to be coded green color.

All performance benchmarks are set for program improvement purposes, and do not necessarily reflect a determination of community standards of care or constitutional levels of care.

Once performance improvement objectives have been set, a three-part scale is assigned to rank statewide performance:

HIGH ADHERENCE	MODERATE ADHERENCE	LOW ADHERENCE

- more -

Tell me about…Benchmarks / Page 2

"Adherence" refers to compliance with a statewide standard or policy. "High adherence," for example, means that statewide performance meets or exceeds the standard or policy requirement expressed in the performance measure.

There are a number of measures included in the Dashboard that are not benchmarked. These measures, many of which can be found under "Other Patterns/Trends," are not associated with a particular performance objective, but provide useful information that managers can monitor to better understand how well services are functioning and how well resources are being used.

Purpose The color-coded benchmarking system reminds managers at headquarters and institutions of current performance objectives and makes it visually simple for health care staff to assess progress.

Specific Measures All of the measures in the following dashboard categories have an affiliated performance objective and are benchmarked accordingly:

- Medical Program Inspections (OIG)
- Prevention/Disease Management
- Received Timely Health Care
- Utilization Management
- Turnover/Workload (turnover measures only)

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