FUTTERMAN DUPREE DODD CROLEY MAIER LLP
MARTIN H. DODD (104363)
180 Sansome Street, 17th Floor
San Francisco, California 94104
Telephone: (415) 399-3840
Facsimile: (415) 399-3838
mdodd@fddcm.com

Attorneys for Receiver
J. Clark Kelso

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

AND FOR THE EASTERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al., *Plaintiffs*, v. EDMUND G. BROWN, JR., et al., *Defendants*.	Case No. C01-1351 TEH
RALPH COLEMAN, et al., *Plaintiffs*, v. EDMUND G. BROWN, JR., et al., *Defendants*.	Case No. CIV S-90-0520 LKK JFM P
JOHN ARMSTRONG, et al., *Plaintiffs*, v. EDMUND G. BROWN, JR., et al., *Defendants*.	Case No. C94-2307 CW

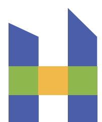
NOTICE OF FILING OF RECEIVER'S TWENTY-FIRST TRI-ANNUAL REPORT

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

Dated: September 14, 2012

FUTTERMAN DUPREE DODD CROLEY MAIER LLP

By: /s/ Martin H. Dodd
Martin H. Dodd
Attorneys for Receiver J. Clark Kelso



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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

Twenty-first Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action For May 1 – August 31, 2012

September 15, 2012

California Correctional Health Care Receivership

Vision:

As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

Mission:

Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates 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**	**1**
2.	**The Receiver's Reporting Requirements**	**3**
3.	**Status and Progress Toward the Turnaround Plan Initiatives**	**4**
GOAL 1	**Ensure Timely Access to Health Care Services**	**4**
Objective 1.1	Screening and Assessment Processes	4
Objective 1.2	Access Staffing and Processes	4
Objective 1.3	Scheduling and Patient-Inmate Tracking System	5
Objective 1.4	Standardized Utilization Management System	5
GOAL 2	**Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services**	**6**
Objective 2.1	Primary Care	6
Objective 2.2	Chronic Care	6
Objective 2.3	Emergency Response	6
Objective 2.4	Specialty Care and Hospitalization	7
GOAL 3	**Recruit, Train and Retain a Professional Quality Medical Care Workforce**	**8**
Objective 3.1	Physicians and Nurses	8
Objective 3.2	Clinical Leadership and Management Structure	8
Objective 3.3	Professional Training Program	8
GOAL 4	**Implement a Quality Assurance and Continuous Improvement Program**	**9**
Objective 4.1	Clinical Quality Measurement and Evaluation Program	9
Objective 4.2	Quality Improvement Programs	12
Objective 4.3	Medical Peer Review and Discipline Process	16
Objective 4.4	Medical Oversight Unit	17
Objective 4.5	Health Care Appeals Process	18

Objective 4.6 Out-of-State, Community Correctional Facilities and Re-entry Oversight........ 18

GOAL 5 Establish Medical Support / Allied Health Infrastructure........ 19

Objective 5.1 Pharmacy........ 19

Objective 5.2 Medical Records........ 21

Objective 5.3 Imaging/Radiology and Laboratory Services........ 21

Objective 5.4 Clinical Information Systems........ 22

Objective 5.5 Telemedicine........ 22

GOAL 6 Provide for Necessary Clinical, Administrative and Housing Facilities........ 23

Objective 6.1 Upgrade Administrative and Clinical Facilities........ 23

Objective 6.2 Expand Administrative, Clinical, and House Facilities........ 23

Objective 6.3 Finish Construction at San Quentin State Prison........ 24

4. Additional Successes Achieved by the Receiver........ 25

A. Office of the Inspector General – Update on the Medical Inspections of California's 33 Adult Prisons........ 25

5. Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented By Institutions Or Individuals........ 26

6. An Accounting of Expenditures for the Reporting Period........ 27

7. Other Matters Deemed Appropriate for Judicial Review........ 28

A. Coordination with Other Lawsuits........ 28

B. Master Contract Waiver Reporting........ 28

C. Consultant Staff Engaged by the Receiver........ 28

8. Conclusion........ 29

Section 1: Executive Summary

In our final Tri-Annual report for 2012, the accomplishments for the period of May 1 through August 31, 2012 are highlighted. Progress continues toward implementing the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights for this reporting period include the following:

- RTPA - Substantial completion of more than 77 percent of the action items. Work on remaining items continues.
- Office of the Inspector General (OIG) Inspections – Continuation of Cycle three inspections with scores improved.
- CCHCS introduced on-demand registries – CCHCS staff have used the on-demand registries to create more than 35,700 customized reports to manage specific patient populations.
- CCHCS provided a number of tools and services to help institutions appropriately place and manage high risk patients. Among them are:
  - Facilitation of patient transfers by a multi-disciplinary workgroup
  - New patient registries
  - Performance monitoring

In the areas of timely access to primary care physicians and timely access to medications, overall the OIG scores showed a modest improvement between Round 2 and Round 3 of the inspections.

The State has now agreed to complete all construction-related improvements. The CHCF in Stockton is on schedule to open next year, and construction at DeWitt has been approved. In addition, CDCR's published plan, *The Future of California Corrections (Blueprint)*, proposed the upgrades of the existing facilities: Healthcare Facility Improvement Program (HCFIP), along with a streamlined legislative approval process allowing oversight to be retained by the Public Works Board (PWB). These changes required legislative support and were approved with the passing of Senate Bill 1022 on June 27, 2012 allowing these projects to follow an approval process similar to other State capital outlay projects. CDCR will submit projects to the Department of Finance (DOF) for approval, with informational letters sent simultaneously to the Joint Legislative Budget Committee (JLBC), and will be scheduled for the soonest PWB meeting available to receive project approval.

Format of the Report

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

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions that are not completed.

2. *Appendices*: In addition to providing metrics, this report also references documents in the Appendices of this report.

3. *Website References*: Whenever possible website references are provided.

RTPA Matrix

In an effort to provide timely and accurate progress reports on the RTPA to the Courts and other vested stakeholders, this format provides an activity status report by enterprise, for statewide applications/programs, and by institution, as appropriate for and in coordination with that operation.

The Enterprise Project Deployment worksheet and the Institution Project Deployment worksheet provide an illustration of the progress made toward each action item outlined in the RTPA and reported in the Tri-Annual Report. The Enterprise Project Deployment worksheet captures projects specifically assigned to the Receiver for broad administrative handling, analysis or testing. The Institution Project Deployment captures the status of all other activity by institution. Reporting will reflect activity that is completed, on schedule, delayed or not progressing, with corresponding dates. The Tri-Annual Report will continue to provide a narrative status report.

Due to the size of the document, the Matrix is included as Appendix 1.

Information Technology Project Matrix

In addition to the RTPA Matrix, a separate chart has been created to specifically illustrate the major technology projects and the deployment of those projects. This document is included as Appendix 2.

Section 2: The Receiver's Reporting Requirements

This is the twenty-first report filed by the Receivership, and the fifteenth submitted by Receiver Clark Kelso.

The Order Appointing Receiver (Appointing Order) filed February 14, 2006 calls for the Receiver to file status reports with the *Plata* court concerning the following issues:

1. All tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion of each task and metric.
2. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.
3. Particular success achieved by the Receiver.
4. An accounting of expenditures for the reporting period.
5. Other matters deemed appropriate for judicial review.

(Reference pages 2-3 of the Appointing Order at http://www.cphcs.ca.gov/docs/court/PlataOrderAppointingReceiver0206.pdf)

In support of the coordination efforts by the three federal courts responsible for the major health care class actions pending against the CDCR, the Receiver files the Tri-Annual Report in three different federal court class action cases: *Armstrong, Coleman, and Plata*.[1] 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_tri.aspx)

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

[1] Coordination efforts previously included the court in *Perez v. Cate*. However, the case was dismissed on August 20, 2012.

Section 3: Status of the Receiver's Turnaround Plan Initiatives

Goal 1: Ensure Timely Access to Health Care Services

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation

This action is completed.

Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons

This action is completed.

Action 1.1.3. By January 2010, begin using the new medical classification system at each reception center prison.

This action is completed.

Action 1.1.4. By January 2011, complete statewide implementation of the medical classification system throughout CDCR institutions.

This action is completed.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on health care access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution.

This action is completed.

Action 1.2.2. By July 2011, the Receiver will have fully implemented Health Care Access Units and developed health care access processes at all CDCR institutions.

This action is completed.

Refer to Appendix 3 for the Executive Summary and Health Care Access Quality Reports for April through July 2012.

Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System

Action 1.3.1. Work with CDCR to accelerate the development of the Strategic Offender Management System with a scheduling and inmate tracking system as one of its first deliverables.

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

Application development is proceeding on several fronts. Updated scheduling systems are in development for medical and dental that will provide enterprise wide solutions. The existing mental health scheduling system is being enhanced. All scheduling systems will access a newly developed shared calendar which displays combined appointments from all disciplines. These solutions make use of a new source of data, the Health Care Operational Data Store, which provides near real-time patient-inmate data from Strategic Offender Management System (SOMS). Once completed, the combined solution will provide all scheduling systems with SOMS patient-inmate location data and integrate with SOMS for ducating of patient-inmate appointments.

Recent accomplishments include:

1. Functional requirements documents are nearing completion for all disciplines
2. Enhancements are done and being tested for the mental health solution
3. Development is in process for medical and beginning for the dental solution
4. Human resources to support development, database work, and testing have been brought on board

Thus far the project is working well within the budget of existing contracts. Development and testing is projected to run until fourth quarter 2012, with deployment to take place in first quarter 2013.

Objective 1.4. Establish a Standardized Utilization Management System

Action 1.4.1. By May 2010, open long-term care unit.

This action is completed.

Action 1.4.2. By October 2010, establish a centralized UM System.

This action is completed.

Goal 2: Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services

Objective 2.1. Redesign and Standardize Access and Medical Processes for Primary Care

Action 2.1.1. By July 2009, complete the redesign of sick call processes, forms, and staffing models.

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

The Episodic Care Policy and Procedure was put on hold as of January 20, 2012. However, as CCHCS moves forward with, and integrates a primary care model with our medical classification system, we are reassessing the need to establish a specific policy to address episodic care. Until a definitive decision is made, the draft policy will remain “on hold.” The Prison Law Office (PLO) was notified of this decision.

Action 2.1.2. By July 2010, implement the new system in all institutions.

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

Upon approval of the Policy and Procedure, the implementation team will begin a phased rollout at seven institutions. Full implementation at all institutions will follow.

Objective 2.2. Improve Chronic Care System to Support Proactive, Planned Care

Action 2.2.1. By April 2009, complete a comprehensive, one-year Chronic Care Initiative to assess and remediate systemic weaknesses in how chronic care is delivered.

This action is completed.

Objective 2.3. Improve Emergency Response to Reduce Avoidable Morbidity and Mortality

Action 2.3.1. Immediately finalize, adopt and communicate an Emergency Medical Response System policy to all institutions.

This action is completed.

Action 2.3.2. By July 2009, develop and implement certification standards for all clinical staff and training programs for all clinical and custody staff.

This action is completed.

Action 2.3.3. By January 2009, inventory, assess and standardize equipment to support emergency medical response.

This action is completed.

Objective 2.4. Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality

Action 2.4.1. By June 2009, establish standard utilization management and care management processes and policies applicable to referrals to specialty care and hospitals.

This action is completed.

Action 2.4.2. By October 2010, establish on a statewide basis approved contracts with specialty care providers and hospitals.

This action is completed.

Action 2.4.3. By November 2009, ensure specialty care and hospital providers' invoices are processed in a timely manner.

This action is completed.

Goal 3: Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1 Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

For details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for April through July 2012. These reports are included as Appendix 4.

Action 3.1.1. By January 2010, fill ninety percent of nursing positions.
This action is completed.

Action 3.1.2. By January 2010, fill ninety percent of physician positions.
This action is completed.

Objective 3.2 Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2010, establish and staff new executive leadership positions.
Action 3.2.2. By March 2010, establish and staff regional leadership structure.
These actions are completed.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2010, establish statewide organizational orientation for all new health care hires.
This action is completed.

Action 3.3.2. By January 2009, win accreditation for CDCR as a Continuing Medical Education provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education.
The action is completed.

Goal 4: Implement Quality Improvement Programs

Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program

Action 4.1.1. By July 2011, establish sustainable quality measurement, evaluation and patient safety programs.

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

Patient Safety Program

Please see "Statewide Improvement Initiative – Patient Safety Program" under Action 4.2.1.

Developing a Care Team Dashboard

During this reporting period, CCHCS continued to release the monthly Health Care Services Dashboard for public view. Issued monthly since September 2010, the Health Care Services Dashboard consolidates strategic performance information across all clinical program areas into a single report. The primary goal of the Dashboard is to provide CCHCS staff with information that can be used to improve the health care delivery system and patient-inmate outcomes.

To support improvement efforts, the Dashboard presents data on more than 100 performance measures at different reporting levels – aggregate data to assess progress statewide, and institution-level data to determine a particular institution's achievements over time. To make performance measure data as actionable as possible at the local levels, several institutions have been using the patient-inmate registries to reproduce Dashboard metrics at the provider or care team level. At the request of institutions statewide, CCHCS is now working to make as many performance measures as possible available at the individual provider or care team level.

During this reporting period, CCHCS developed a new Dashboard function that allows institution managers to review non-formulary prescribing practices at the individual provider level. In addition, Quality Management (QM) Section staff began converting the measures in the "Prevention / Disease Management" domain of the Dashboard into an on-demand, care team level report. These are the preliminary steps to creating a prototype of a "Care Team Dashboard" – a report with all the measures found in the Dashboard, but reported for a specific team.

A Care Team Dashboard will offer valuable feedback to providers at the point of care, where CCHCS has the greatest capacity for impact on patient-inmate outcomes, and will help managers to identify the care teams who have establish effective mechanisms for delivering timely, cost-effective, evidence-based care, which should be spread to other parts of the institution. If CCHCS is able to update care team-level reports at least monthly, they will also provide important information about the impact of individual clinic initiatives to improve health care processes.

A sample of an on-demand, care team-level report can be found in Appendix 5.

Data Validation

For data to be useful in decision-making, it needs to be reliable. For this reason, the Joint Commission and other authorities in performance management and improvement endorse strategies to prevent inaccuracy in data reporting, including data validation and inter-rater reliability testing. In 2012, CCHCS targeted several self-reported access measures for validation as part of ongoing efforts to improve the quality of data commonly used by health care staff to make management decisions.

Initial validation efforts targeted three medication access measures that had shown a large degree of variation statewide and in month-to-month trending, a red flag for data reliability. During the validation process, Compliance Unit staff review the same patient-inmate charts that the institution used for reporting and compare their results to the institution results to identify areas of congruence and discrepancy. The institution is notified of the validation findings. If there are low levels of agreement between the validator results and the institution's findings, the institution is responsible for taking one or more of several recommended steps to improve data reliability. CCHCS also offers one-on-one training to institution staff that are responsible for medication access reporting to clarify misunderstandings about the reporting requirements and provide a thorough orientation to the reporting tool.

CCHCS employs a rigorous validation process for all patient-inmate registries released to institution staff, which includes independent data analysis by multiple analysts to ensure that the chosen methodology yields the same results, validation of individual patient-inmate findings ("spot-check"), and working with institution staff to validate findings for the patient-inmate population at specific institutions, among other strategies. During this reporting period, CCHCS designed a series of tests to check the reliability of databases used for registries and performance reports. These database tests screen for anomalies in pharmacy, laboratory, and claims data to ensure that data base errors (such as using multiple spellings for the same drug name) do not result in inaccurate data.

Patient-Inmate Registries

For more than a year CCHCS has produced registries, or lists of patient-inmates, with certain chronic conditions or with those who are eligible for preventive services, such as cancer screening. Within these patient-inmate registries, those who may not have received services per CCHCS guidelines or who show abnormal laboratory findings are highlighted, prompting care teams to take action to meet patient-inmate needs.

In May 2012, CCHCS introduced on-demand registries – registries that are updated continuously with the most recent information available from centralized clinical databases, which can be accessed at any time by a care team member. The registries are designed to produce lists of patient-inmates in accordance with an institution or care team's particular needs; for example, patient-inmates can be sorted by risk level, assigned care team, chronic condition, or "red flag" status. In less than four months, CCHCS staff had used the on-demand registries to create more than 35,700 customized reports to manage specific patient-inmate populations.

During this reporting period, CCHCS staff released the Patient Panel Registry, which lists all patient-inmates housed at a particular institution and each patient-inmate's assigned care team. Each patient-inmate's risk level is also specified, allowing for easy identification of the highest-risk patient-inmates. Patient-inmates who have recently transferred to the panel are marked with an asterisk and highlighted in bold. This type of registry is critical for patient-inmate tracking in the California prison system, where more than six out of every ten patient-inmates have moved at least once in the past six months. Many of these patient-inmate moves involve a transfer to another care team. When care teams are aware of changes in panel enrollment, care team members are able to facilitate transfers to prevent gaps in care, particularly important in the care of high risk patient-inmates.

CCHCS also completed field-testing for a new Mental Health Registry, which will be released in autumn of 2012. The Mental Health Registry and associated subregistries offer a number of data points that mental health clinicians can use to monitor and manage patient-inmates with mental illness, including required diagnostic tests to detect potentially dangerous side effects of psychotropic agents. The Mental Health Registry helps to prevent redundant ordering of laboratory studies by medical and mental health providers seeing the same patient-inmate, contributing to operational efficiencies and cost savings.

During this reporting period, CCHCS refined a new methodology for identifying patient-inmates with end-stage liver disease, a difficult project because the clinical findings linked to end-stage liver disease may also be attributed to other conditions. For five of the past six years, end-stage liver disease has been the second most common cause of death for California patient-inmates. Information about patient-inmates receiving treatment for hepatitis C is already incorporated into the Chronic Care Master Registry; data regarding patients with end-stage liver disease should be available in fall of 2012.

CCHCS also developed a criteria and methodology for identifying patient-inmates at risk for polypharmacy during this reporting period. Polypharmacy – taking many medications for various health conditions – can result in harmful drug interactions or side effects if the patient-inmate is not monitored closely by the assigned care team. With the new polypharmacy data point on the Chronic Care Master Registry, patient-inmates taking ten or more medications will be flagged for care teams, prompting care teams to both verify that all prescribed medications are actually needed and increase patient-inmate monitoring as appropriate to mitigate risk.

Action 4.1.2. By July 2009, work with the Office of the Inspector General to establish an audit program focused on compliance with Plata requirements.

This action is completed.

<u>Objective 4.2.</u> Establish a Quality Improvement Program

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

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

The QM Program Policies, which are currently being revised, define QM program essential elements, including, but not limited to:

- Statewide and institution-level improvement plans with measurable performance objectives
- Staff at all reporting levels who are informed about improvement plan objectives and understand their role in supporting improvement activities
- A multi-disciplinary QM Committee structure that manages improvement projects and coordinates improvement activities across the major health care programs
- Staff with the skills and tools to isolate the root causes of quality problems, implement program changes and redesign health care processes, and evaluate results
- A reliable measurement system that evaluates progress toward improvement objectives and provides ongoing surveillance of critical health care processes
- A culture that promotes continuous learning and improvement, under which health care staff consider the improvement of health care processes a routine part of their day-to-day work
- A Patient Safety Program that enables the organization to identify and mitigate risk to patient-inmates

This update reflects current efforts to implement these essential program elements.

<u>Statewide Improvement Initiative – Patient Safety Program</u>

In May 2012, CCHCS adopted policies and procedures to establish a statewide Patient Safety Program, which includes:

- Routine program surveillance to identify problematic health care processes, including a statewide system for reporting patient-inmate safety issues, “near misses”, and adverse/sentinel events;
- An annual Patient Safety Plan, which determines priority areas for statewide interventions and performance objectives;
- Statewide and institution-level interventions designed to protect patient-inmates and improve outcomes;

- Regular communication in the form of patient-inmate safety alerts, program reports, and other mechanisms to ensure that all institutions are aware of patient-inmate safety issues;
- Technical assistance, staff development programs, and decision support tools, such as forms, checklists, and flowcharts, to support root cause analysis and process redesign;
- A patient-inmate safety culture that encourages staff to proactively identify and mitigate risk to patient-inmates and emphasizes continuous learning and improvement;
- A triaging process to ensure that patient-inmate safety issues that present immediate danger to patient-inmates and/or staff are resolved quickly and effectively and provide direction to institutions about appropriate follow up;
- A headquarters committee to provide oversight to the statewide Patient Safety Program, review patient-inmate safety data, and take action to prevent poor patient-inmate outcomes; and
- A referral process for adverse or sentinel events that involve blameworthy acts, including criminal activities.

In August 2012, the statewide Patient Safety Committee convened for the first time and discussed potential strategies for rolling out the policies and procedures to the 33 institutions. The Patient Safety Committee will meet frequently in September and October to complete planning for statewide implementation of the new Patient Safety Program, which may include partnership with the Veteran's Health Administration or other entities to develop tools and training for key program elements, such as adverse/sentinel event tracking and root cause analysis.

Statewide Improvement Initiative – High Risk Patient-Inmates

It is a common phenomenon in health systems that a small group of patient-inmates with complex clinical conditions disproportionately drive the use of health care resources. Within CCHCS, eight percent of patient-inmates consume more than half of the organization's pharmaceutical, specialty, community hospital, and emergency services. Community hospital and emergency room costs alone were more than $100 million for CCHCS high risk patient-inmates (which number less than 11,000) from July to December 2011.

Like other health systems, CCHCS needs to effectively manage high risk patient-inmates to prevent the poor outcomes that are common for this group, decrease costs, and establish a health care system that is sustainable even as patient-inmate needs become more complex over time. To support improvements in the monitoring and management of high risk patient-inmates, CCHCS has established a statewide High Risk Initiative, which targets two major aspects of patient-inmate management:

- Appropriate placement: Transfer of high risk patient-inmates to Intermediate Institutions that have been designated for their care.
- Primary care: Ensuring that institutions have sustainable systems in place to ensure that high risk patient-inmates receive critical primary care services, including continuity with

an assigned provider and team, evidence-based care, timely access to clinician, specialty, diagnostic, and medication services, and coordination of services when high risk patient-inmates move from one care setting to another.

During this reporting period, CCHCS provided a number of tools and services to help institutions appropriately place and manage high risk patient-inmates. Among them are:

- Facilitation of patient-inmate transfers by a multi-disciplinary workgroup. For several months now, the Health Care Population Oversight Program and Medical Placement Unit, in collaboration with health care leadership has been working with one Basic Institution at a time to move high risk patient-inmates to Intermediate Institutions, and replace these patient-inmates with others who are classified as medium or low health risk.
- New patient-inmate registries. In May 2012, CCHCS released a new set of patient-inmate registries with enhanced features for managers and health care teams. Care teams can review the risk level of all patient-inmates assigned them using the Patient Panel Registry; clicking on the risk designation of any patient-inmates brings up a comment box that specifies the criteria that caused the patient-inmate to be placed in the risk category. Through the Chronic Care Master Registry, care teams can access a list of patient-inmates with common chronic diseases, their risk level, and other important clinical information, such as abnormal clinical findings or missing services.
- Performance monitoring. CCHCS monitors the percentage of high risk patient-inmates at each Basic Institution and updates this number monthly in the Health Care Services Dashboard. In the Monthly Comparison View of the Dashboard, institutions find a breakdown of the percentage of the total patient-inmate population that falls into each risk category, allowing institutions to easily assess whether the institution's proportion of high risk patient-inmates is appropriate to the institution's health care mission.

CCHCS also produced the first High Risk Patients Performance Report, included in Appendix 6, which evaluates appropriate placement of high risk patient-inmates, and describes how patient-inmates are classified into risk categories, requirements for placement of high risk patient-inmates, and current efforts to move high risk patient-inmates from Basic Institutions to Intermediate Institutions. This report outlines CCHCS statewide performance objectives for placement of high risk patient-inmates, and shows each institution's performance to date.

Statewide Performance Improvement Plan

In 2011, CCHCS established the 2011-2012 Performance Improvement Plan, a document that identifies organization-wide improvement priorities, specific performance objectives, and statewide strategies used to achieve those objectives. Performance Improvement Plan objectives are monitored monthly through the Health Care Services Dashboard.

In August, the headquarters QM Committee initiated the process for reviewing and updating the Performance Improvement Plan. Preliminary steps in this process include reviewing the organization's progress relative to previous performance objectives, analyzing patient-inmate

morbidity and mortality data to identify new opportunities for improvement, and gathering input from stakeholder groups, Chief Executive Officers and health care leadership at institution level, and others. The goal is to have a draft 2013 Performance Improvement Plan by December 2012.

Institution Performance Improvement Work Plans and the CCHCS Primary Care Model

During the last reporting period, CCHCS modified the corrective action process that follows each Office of the Inspector General (OIG) medical inspection to promote a system-wide approach to improvements and full implementation of the primary care model. In the first two rounds of OIG inspections, the Program Compliance Unit worked with institutions to develop a Corrective Action Plan after each inspection, focusing on areas where the institution had less than 75 percent compliance with medical policies. During the third round of OIG inspections, the QM Section will partner with the Program Compliance Unit on post-inspection activities, assisting institutions in establishing a Performance Improvement (PI) Work Plan for the year. PI Work Plans place priority on core processes in the primary care model, such as medication management and timely access to health information, and provide an opportunity to consolidate improvement activities and corrective action plans in one document.

During this reporting period, CCHCS worked with California State Prison, Sacramento (SAC), the first institution to undergo a 3rd round medical inspection, to pilot the strategy institutions would use to develop a PI Work Plan. The process included taking an inventory of current and planned improvement initiatives, reviewing strengths and weaknesses in performance from a variety of data sources, and defining priority areas of improvement, with consideration of the primary care model elements. By working closely with SAC, CCHCS was able to create a standardized PI Work Plan Tool Kit for use by institution staff, which now includes a Primary Care Self-Assessment, and has been testing the Tool Kit with nine other institutions (California Medical Facility (CMF), California Men's Colony, San Quentin State Prison (SQ), Richard J. Donovan Correctional Facility (RJD), Central California Women's Facility, Valley State Prison for Women, Sierra Conservation Center, California Rehabilitation Center (CRC), California Institution for Women).

As part of efforts to support PI Work Plan development, CCHCS staff have compiled sample strategies and tools to help institutions implement different elements of the primary care model. Institutions complete the self-assessment to identify gaps in the delivery system where an element of the primary care model has not yet been fully implemented, and can use the sample strategies and tools, which are derived from successful improvement initiatives implemented at individual institutions, to jump-start local improvement efforts. Any sample strategies used at the institution are incorporated into the PI Work Plan.

Finalized PI Work Plans will be posted on the CCHCS Intranet and provided to the PLO.

Quality Improvement Training and Technical Assistance

Since February of 2012, institutions have been sending staff to the QM Section at headquarters for a two-day orientation on the QM Program, improvement resources, and practical ways to

build quality improvement capacity at the local level. Staff selected to attend this orientation are generally clinical and administrative staff with a dominant role in the local QM system; they may coordinate performance management committees, lead multi-disciplinary improvement teams, serve as a mentor to other staff, train staff in quality improvement techniques, prepare for surveys and inspections, and/or direct performance measurement and validation efforts. By mid-May, Quality Officers covering seven institutions completed the two-day training. During this reporting period, five additional institutions sent staff for training. An abbreviated version of this training has been provided to many Chief Medical Executives as part of a broader orientation program.

CCHCS staff made numerous visits to institutions during this reporting period to help institutions use existing improvement tools, such as the registries, to achieve greater adherence to current standards and guidelines, in the interest of improving overall patient-inmate care and preparing for the 3rd round OIG medical inspection. During this reporting period, the CCHCS provided on-site technical assistance and training at ten institutions, and Webinar training at two others.

CCHCS staff also developed a tool kit with instructions, processes, and forms that institutions can use to analyze quality problems, develop solutions, and apply rapid-cycle improvement to test solutions. In addition, CCHCS began testing a reference guide for institutions with sample solutions and associated tools that have been employed to good effect at different institutions.

Action 4.2.2. By September 2009, establish a Policy Unit responsible for overseeing review, revision, posting and distribution of current policies and procedures.

This action is completed.

Action 4.2.3. By January 2010, implement process improvement programs at all institutions involving trained clinical champions and supported by regional and statewide quality advisors.

This action is combined with Action 4.2.1.

<u>Objective 4.3.</u> Establish Medical Peer Review and Discipline Process to Ensure Quality of Care

Action 4.3.1. By July 2008, working with the State Personnel Board and other departments that provide direct medical services, establish an effective Peer Review and Discipline Process to improve the quality of care.

This action is completed.

<u>Objective 4.4</u>. Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations

Action 4.4.1. By January 2009, fully staff and complete the implementation of a Medical Oversight Unit to control and monitor medical employee investigations.

This action is completed.

Statewide Improvement Initiative – Patient Safety Program

In May 2012, CCHCS adopted policies and procedures to establish a statewide Patient Safety Program, which includes a triaging process to ensure that patient safety issues that present immediate danger to patients and/or staff are resolved quickly and effectively, and a referral process through the investigatory process for adverse or sentinel events that involve blameworthy acts, including criminal activities. In August 2012, the statewide Patient Safety Committee convened and is currently developing an implementation plan for the Patient Safety Program and developing tools and training for key program elements.

Under the new Patient Safety Program, adverse or sentinel health care events previously referred to the Medical Oversight Program (MOP) will now be handled in one of two ways. If the event involves or alleges a "blameworthy act" – defined as a criminal act, a purposefully unsafe act, act involving patient abuse of any kind, or a situation in which an individual takes a substantial and unjustifiable risk that may result in patient harm – that incident is referred to the appropriate investigatory agency for investigation and response. Events not involving a blameworthy act are subject to root cause analysis, a standardized process by which a multi-disciplinary team determines the fundamental reasons that the event occurred, and creates an improvement plan to prevent the event from occurring in the future.

The Patient Safety Program maintains a triaging process similar to what was implemented in the Medical Oversight Program; health care executives at headquarters perform an initial review of the circumstances that led to the adverse health care event immediately after the event occurs, and make appropriate referrals to the appropriate investigatory agency, centralized peer review and root cause analysis processes.

This revolutionary approach to adverse health care events brings CCHCS into alignment with the strategies used by the Joint Commission and other nationally-recognized health care authorities for patient safety. It represents an organizational maturation from the Medical Oversight Program that reflects the referral patterns observed over the last two years and better aligns patient safety issues not resulting in death. A statewide Patient Safety Committee, established under these policies, will provide ongoing oversight to adverse event reviews and monitor for completion of action plans.

For more information about the Patient Safety Program, please refer to Action 4.2.1.

Objective 4.5. Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative

Action 4.5.1. By July 2008, centralize management overall health care patient-inmate appeals, correspondence and habeas corpus petitions.

This action is completed.

Refer to Appendix 7 for health care appeals, and habeas corpus petition activity for May through August 2012.

Action 4.5.2. By August 2008, a task force of stakeholders will have concluded a system-wide analysis of the statewide appeals process and will recommend improvements to the Receiver.

This action is completed.

Objective 4.6. **Establish Out-of-State, Community Correctional Facilities (CCF) and Re-entry Facility Oversight Program**

Action 4.6.1. By July 2008, establish administrative unit responsible for oversight of medical care given to patient-inmates housed in out-of-state, community correctional or re-entry facilities.

This action is completed.

Goal 5: Establish Medical Support / Allied Health Infrastructure

Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program

During this reporting period, implementation of the Pharmacy Services Road Map to Excellence continues to make progress. Progress during this reporting period is detailed below.

Action 5.1.1. Continue developing the drug formulary for the most commonly prescribed medications.

This action is completed.

The CDCR Pharmacy and Therapeutics Committee (P&T) continues its monthly meetings to review utilization trends, to actively manage the formulary, and to review and approve pharmacy policies and procedures. During these meetings, the committee members reviewed monthly reports including the pharmacy dashboard, monthly metrics summary, and medication error reports. The P&T Committee finished the cost-effective analyses with psycho-therapeutic medications. It showed that money is saved by switching to generic Olanzapine, over Abilify. The P&T Committee is actively considering therapeutic equivalent products and generic equivalents in an effort toward cost effective care. The therapeutic switching from one medication to another is always done for the good of the patient-inmate first, hence the notion of cost-effectiveness.

During this three month period, the P&T Committee established an *ad hoc* committee to establish a single formulary for the CHCF Stockton Facility between CCHCS and the California Department of State Hospitals (DSH) psychiatrists. This was accomplished. The DSH psychiatrists agree to adhere to the CCHCS formulary.

Additionally, the P&T Committee established a nutritional subcommittee to deal with many nutritional issues that have impact on pharmacotherapy. The subcommittee has been formed and met for the first time in July 2012 and they have carved out an agenda that will consider clinical issues such as nutritional supplements and vitamin supplementation.

Refer to Appendix 8 for Top Drugs, Top Therapeutic Category Purchases, and Central Fill Pharmacy Service Level for May through August 2012.

Action 5.1.2. By March 2010, improve pharmacy policies and practices at each institution and complete the roll-out of the GuardianRx® system.

This action is completed.

The roll-out of the Guardian Rx® system is completed with 33 out of the 33 pharmacies and the Guardian Rx® system has fully migrated to a more stable health care network. This project is closed.

The P&T Committee continued to actively review and revise pharmacy policies and procedures as needed. The 2012 revisions have started and the first 20 pharmacy policies have been reviewed and are being vetted through the organization's approval processes. The third set of ten pharmacy policies are presently under active review and revision.

In January 2012, the central pharmacy launched a simple clinical monitoring service for patient-inmates on anticoagulation therapy. By combining the data stream and the laboratory values into a virtual clinical decision support system, we were able to use clinical rules to alert clinicians that there may be an urgent clinical situation that may require attention. This monitoring system for anticoagulation is fully deployed to all 33 facilities. We are in the process of designing the second clinical alert, which will provide information to the prescriber for evaluating drug interaction for patients going onto protease inhibitor therapy for HCV disease.

Action 5.1.3. By May 2010, establish a central-fill pharmacy.
This action is completed.

The present plan is to support the facilities by dispensing and delivering Keep-on-Person (KOP) prescriptions to the supported facilities. By the end of July 2012, the central pharmacy dispensed and delivered KOP prescriptions to 27 prison pharmacies throughout the state.

The plan is to still complete the first phase of the central pharmacy dispensing support by the close of 2012. The central pharmacy will start a new support feature for the pharmacies in the prisons. This is to provide prepackaged drug cards to the local pharmacies so they can use these cards for on-site dispensing. The central pharmacy provides pre-packaged drugs today; the only difference is that the patient-inmate-specific labeling will be provided by the local pharmacy instead of the central pharmacy. By doing so, the central pharmacy can continue to mitigate the waste in local dispensing within plastic bags and to reduce the amount of standing inventory within the local pharmacies. There is also some reduction in staffing through an economy-of-effort.

The central pharmacy has implemented a centralized order entry service since January 2011. The concept was instituted to establish mutual support from the central pharmacy located in Sacramento to assist the institution pharmacies that had to depend on unreliable and expensive registry labor. Today, this small service has grown to support 20 institutions' pharmacies. Since this centralized order entry team is more efficient, the service is also able to provide support for the pharmacies that require assistance due to unplanned events, such as power outages at the local prison. The service is also providing support for planned absences, such as providing vacation coverage. This service has provided mutual support from a single centralized location for the entire pharmacy services.

<u>Objective 5.2.</u> Establish Standardized Health Records Practice

Action 5.2.1. By November 2009, create a roadmap for achieving an effective management system that ensures standardized health records practice in all institutions.

This action has been completed.

<u>Objective 5.3.</u> Establish Effective Imaging/Radiology and Laboratory Services

Action 5.3.1. By August 2008, decide upon strategy to improve medical records, radiology and laboratory services after receiving recommendations from consultants.

This action is ongoing. Progress during the reporting period is as follows:

<u>Imaging/Radiology Services</u>

The replacement of priority Medical Imaging equipment is complete. All institutions now have digital imaging capabilities and printing medical images on laser film. This has allowed the removal of dark rooms and chemical film processors in the institutions.

As of August 2012, 11 institutions are in the construction process for new mobile pads for 18 wheel trailers with medical imaging scanners for on-site services; 21 institutions have completed mobile pads that meet the August 2011 revised guidelines. The mobile pad improvement project will improve the workflow of the specialty modalities Magnetic Resonance Imaging and Computerized Tomography with Ultrasound services assigned dedicated rooms. The completion of the network connection to the Fuji Radiology Information System and Picture Archiving and Communication System (RIS/PACS) will reduce dramatically the turnaround time from days to hours.

Three clinical information systems have been procured to support the workflow of Imaging Services, one for Dental Services and two for Medical Imaging Services. The Medicor mini Picture Archiving and Communication System for Dental Services is projected to begin implementation in the fall of 2012. The RIS/PACS for Medical Imaging Services is projected to begin implementation in early fall of 2012.

In March 2012, a statewide radiology group was contracted through the Prison Health Care Provider Network. This new radiology group will be responsible for providing interpretation services for all on-site and mobile exams, and their services will begin in conjunction with the RIS/PACS implementation. In addition, they are performing all Radiology Supervisor and Operator duties and as of August 2012 they have surveyed 31 institutions. The remaining institutions are projected to be completed by October 2012.

Major Accomplishments This Reporting Period:

- PowerScribe software has been procured for the transcription component of the RIS/PACS.
- RIS/PACS servicer and data build for paperless workflow projected to be completed by fall 2012.

- Radiology group has been contracted with for statewide interpretation and Radiology Supervisor and Operator services and 31 institutions have been surveyed.
- Design and configuration of the network, as well as necessary network drops, nearly completed.
- The mobile pad project has a majority of sites completed or in progress with estimated available for use by fall of 2012.

Laboratory Services
The vacant Chief of Laboratory Services position has been filled as of July 2012. Information gathering about the laboratory system, types of equipment, practices, policies and procedures among the institutions has been launched, to include site visits and introductory meetings with the personnel and management team of the institutions. Laboratory Services has initiated a study to determine the level of appropriateness, based on the level of acuity and patient-inmate population served, of diagnostic laboratory services and the implementation of enterprise wide laboratory information system that would enhance patient-inmate care and reduce duplicate testing at the institutions. This study has focused on the ten institutions that operate in-house clinical laboratories among all of CDCR. Efforts to standardize glucose and sexual transmitted disease (syphilis) screening tests performed at the in-house labs are underway. A formal Laboratory Services recommendation will be provided by 2013.

Laboratory Services has been managing the personnel security level for the use of Quest's laboratory information system. Submission of test requisitions to Quest electronically has increased to about 92 percent as of June 2012. Although the target is 100 percent, the rate has varied each week depending on Quest IT server status, on-line access, barcode printer and workstation status. Paper requisitions serve as a back-up to electronic requisitioning and due to limited staff when heavy workloads are submitted to Quest, the paper route was chosen to complete the processes.

Laboratory Services coordinated efforts to customize several clinical laboratory test panels at Quest is still pending due to the barriers of the different test codes existence between northern and southern California within the Quest system; Quest is working to remedy this.

Objective 5.4. Establish Clinical Information Systems

Action 5.4.1. By September 2009, establish a clinical data repository available to all institutions as the foundation for all other health information technology systems.

This action is completed.

Objective 5.5. Expand and Improve Telemedicine Capabilities

Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure.

This action is completed.

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

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

The State has now agreed to complete all construction-related improvements. The CHCF in Stockton is on schedule to open next year, and construction at DeWitt has been approved. In addition, CDCR's published plan, *The Future of California Corrections (Blueprint)*, proposed the upgrades of the existing facilities: HCFIP (with the exception of CRC, which is scheduled for closure), along with a streamlined legislative approval process allowing oversight to be retained by the PWB. These changes required legislative support and were approved with the passing of Senate Bill 1022 on June 27, 2012 allowing these projects to follow an approval process similar to other State capital outlay projects. CDCR will submit projects to the DOF for approval, with informational letters sent simultaneously to the JLBC, and will be scheduled for the soonest PWB meeting available to receive project approval. The estimated cost of these upgrades, including medication distribution, is approximately $725 million.

Action 6.1.1. By January 2010, completed assessment and planning for upgraded administrative and clinical facilities at each of CDCR's thirty-three institutions.

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

The JLBC received the required notifications and CMF, California State Prison, Solano upgrades, and Statewide Medication Distribution projects are scheduled for approval at the PWB meeting in September 2012 and the Pooled Money Investment Board (PMIB) meeting in October 2012. Submission of subsequent projects will be scheduled following approval of the first three projects.

Action 6.1.2. By January 2012, complete construction of upgraded administrative and clinical facilities at each of CDCR's thirty-three institutions.

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

The design, bid, and construction phases for projects at each of the 33 institutions will begin once PWB project approvals and PMIB loan approvals have been obtained. The typical project duration is three to four years from loan approval.

Objective 6.2. Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs.

The Receiver and CDCR developed a bed plan in January 2011 that provided medical and mental health facilities for the projected patient-inmate population through 2013. The approved plan envisioned one new facility with 1,722 beds and the use of three former Division of Juvenile Justice (DJJ) facilities, which would be converted to accommodate patient-inmates with medical and mental health conditions. Since then, the JLBC has denied approval of the DJJ Heman G. Stark (Stark) and DJJ Estrella Correctional Facility (Estrella) projects. In CDCR's

Blueprint, which takes into account the projected patient-inmate population reductions resulting from the AB 109 realignment, they have now included the previously pended renovation of DeWitt Nelson Youth Correctional Facility (DeWitt) that will add 1,133 beds, of which 953 will be health care beds. This facility is immediately adjacent to the CHCF in Stockton.

Action 6.2.1. Complete pre-planning activities on all sites as quickly as possible.
This action item is ongoing. Progress during this reporting period is as follows:

The PMIB loan approval was obtained in May 2012 and the contract with Hensel Phelps Construction Company was approved in June 2012 for the DeWitt project. The Notice to Proceed was issued on July 3, 2012. Stark and Estrella are not supported by CDCR or included in their Blueprint.

Action 6.2.2. By February 2009, begin construction at first site.
This action item is ongoing. Progress during this reporting period is as follows:

CHCF is on schedule for construction to be completed in August 2013 with full occupancy by December 2013. Since the groundbreaking eight months ago, 48 of 49 buildings are standing and enclosed with interior work in progress. There are 1,400 trade workers onsite daily. Hensel Phelps/Granite Joint Venture (JV) is 60 percent complete with Design-Build Package #1, which includes the guard towers, central plant, and warehouse. Clark/McCarthy JV is 49 percent complete with Design-Build Package #2, which includes the housing units, treatment facilities, main kitchen, and all other support facilities.

Action 6.2.3. By July 2013, complete execution of phased construction program.
This action item is ongoing. Progress during this reporting period is as follows:

Construction for DeWitt is expected to be completed in March 2014. There is no plan by CDCR to proceed with Stark or Estrella.

<u>Objective 6.3.</u> Complete Construction at San Quentin State Prison

Action 6.3.1. By December 2008, complete all construction except for the Central Health Services Facility.
This action is completed.

Action 6.3.2. By April 2010, complete construction of the Central Health Services Facility.
This action is completed.

Section 4: Additional Successes Achieved by the Receiver

A. Office of the Inspector General – Update on the Medical Inspections of California's 33 Adult Prisons

To evaluate and monitor the progress of medical care delivery to patient-inmates at each prison, the Receiver requested that the California OIG conduct an objective, clinically appropriate, and metric-oriented medical inspection program. To fulfill this request, the Inspector General assigns a score to each prison based on multiple metrics to derive an overall rating of zero to 100 percent. Although only the federal court may determine whether a constitutional standard for medical care has been met, the Receiver's scoring criteria for adherence to medical policies and procedures establish the minimum score for moderate adherence to that standard to be 75 percent. Scores below 75 percent denote low adherence, while those above 85 percent reflect high adherence.

Using this tool, the Inspector General rated California's 33 adult institutions for the first cycle of inspections (September 2008 – June 2010) at 72.9 percent, on average. High Desert State Prison scored lowest, at 62.4 percent, and Folsom State Prison received the highest score, at 83.2 percent. The Inspector General found that nearly all prisons were not effective in ensuring that patient-inmates receive their medications. In addition, prisons were generally not effective at ensuring that patient-inmates are seen or provided services for routine, urgent, and emergency medical needs according to timelines set by CCHCS policy. However, the Inspector General did find that prisons generally performed well in areas involving duties performed by nurses, and continuity of care.

Second cycle inspections began September 2010 and the OIG completed 33 inspections as of April 30, 2012 and issued 33 final inspection reports. Summary results of these final reports show that four of the 33 institutions achieved a score higher than 85 percent placing them in the category of high adherence and 25 of the 33 institutions achieved a score of 75 percent or higher placing them in the moderate adherence area. California Correctional Center achieved the highest score of 89.5 percent. Of the four institutions scoring less than 75 percent, RJD scored the lowest at 73 percent but improved by 5 percent over their previous score of 68 percent. With 33 finalized inspections reports, the overall statewide average for the second cycle inspections is 78.9 percent which reflects an improvement of seven percent over the first cycle statewide average of 71.9 percent.

The OIG began the third cycle of inspections in February 2012. Based on draft scores for the first few institutions, we anticipate continued improvement in scores throughout the institutions. To date, OIG inspected 18 institutions and provided finalized reports for seven of the 18. All seven institutions achieved a score of 75 percent or higher and four scored at 85 percent or above. Of these finalized reports, SQ scored the highest with 90.4 percent, an 8.9 percent increase from the previous cycle. CMF scored the lowest with 79.1 percent, a 0.1 percent increase from the previous cycle. Based on these finalized inspection reports, the inspection scores increased on average by 5.5 percent to date.

Section 5: Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals

There are no particularly significant problems to highlight for this reporting period.

Section 6: An Accounting of Expenditures for the Reporting Period

A. Expenses

The total net operating and capital expenses of the Office of the Receiver for the year ended June 2012 $2,066,522 and $0.00 respectively. Additionally, all remaining capital projects were transferred from CPR records to CDCR accounting records. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 9.

For the two months ending August 31, 2012 the net operating and capital expenses were $373,850 and $0.00 respectively.

B. Revenues

For the months of May and June 2012, 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 2011/2012 to the CPR from the State of California is $1,625,000.

For the two months July and August 2012, the Receiver requested transfers of $325,000 from the State to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the office of the Receiver.

All funds were received in a timely manner.

Section 7: Other Matters Deemed Appropriate for Judicial Review

A. Coordination with Other Lawsuits

During the reporting period, regular meetings between the four courts, *Plata, Coleman, Perez,* and *Armstrong* (Coordination Group) class actions have continued. Coordination Group meetings were held on May 9th and June 28th. Progress has continued during this reporting period and is captured in meeting minutes. The *Perez* case was dismissed on August 20, 2012 and, thus, *Perez* representatives cease participating in the regular coordination meetings.

B. Master Contract Waiver Reporting

On June 4, 2007, the Court approved the Receiver's Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders issued since that date. The approved project areas, the substitute bidding procedures and the Receiver's corresponding reporting obligations are summarized in the Receiver's Seventh Quarterly Report and are fully articulated in the Court's Orders, and therefore, the Receiver will not reiterate those details here.

As ordered by the Court, included as Appendix 10 is a summary of the contract the Receiver awarded during this reporting period, including a brief description of the contract, the project to which the contract pertains, and the method the Receiver utilized to award the contract (i.e., expedited formal bid, urgent informal bid, sole source).

C. Consultant Staff Engaged by the Receiver

During this reporting period, the Office of the Receiver has not engaged any consultant staff.

Section 8: Conclusion

It is clear that we have made significant progress towards full implementation of the Turnaround Plan of Action and towards our ultimate goal of providing a constitutionally adequate level of medical care within California's adult prisons. With the scores reported by the OIG showing consistent improvement, the number of clearly avoidable deaths remaining at a consistently low rate, and the progress being made by the State in reducing overcrowding, we are now in a position to start the process of ending the Receivership, the transition from day-to-day management by the Receiver back to day-to-day management by the State and, ultimately, the conclusion of the case. The meet-and-confer ordered by the Court helped set the stage for this transition, which we believe will begin in earnest during the next reporting period.

TABLE OF APPENDICES

1 Receiver's Turnaround Plan of Action Matrix

2 CCHCS Information Technology Project Matrix

3 Executive Summary & Health Care Access Quality Reports – April through July 2012

4 Human Resources Recruitment and Retention Reports – April through July 2012

5 Sample of An On-demand, Care Team-level Report

6 High Risk Patients Performance Report

7 Health Care Appeals and Habeas Corpus Petition Activity – May through August 2012

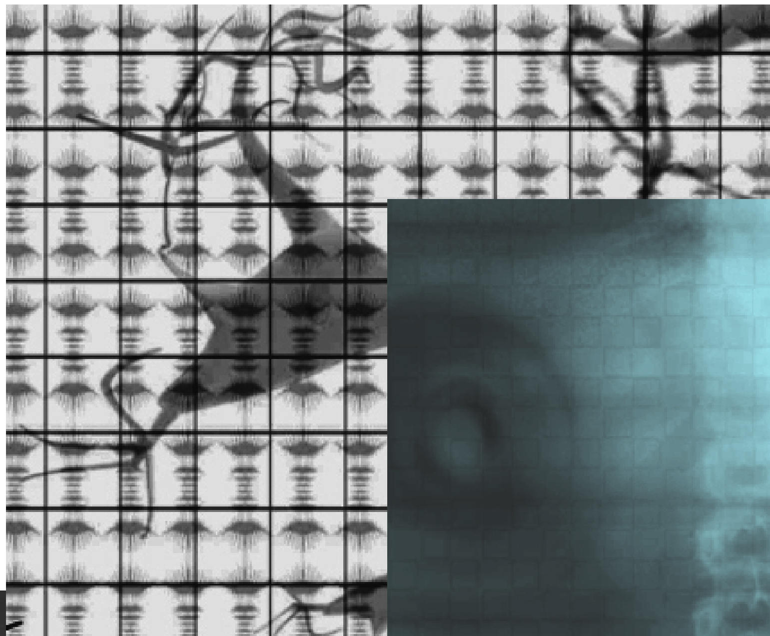
8 Top Drugs, Top Therapeutic Category Purchases, and Central Fill Pharmacy Service Level – May through August 2012

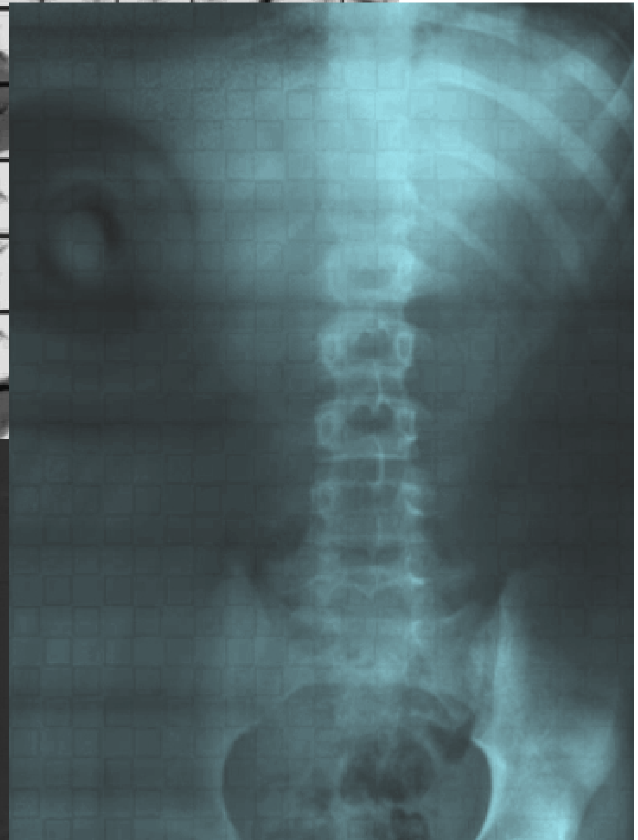
9 CPR Financial Statements – May through August 2012

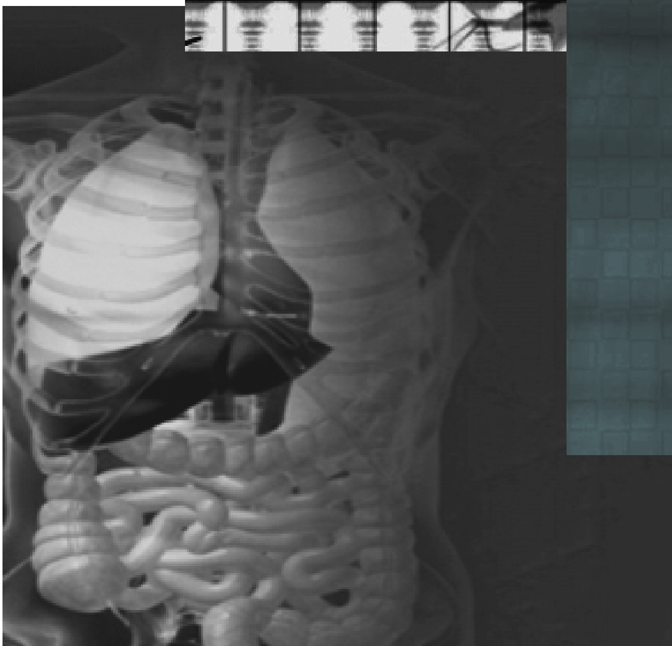
10 Master Contract Waiver

High Risk Patient Performance Report

Appropriate Placement in the CCHCS Primary Care Environment







California Correctional Health Care Services
Quality Management Section
P.O. Box 4038
Sacramento, CA 95812
August 2012

Table of Contents

Introduction 1

Classification and Placement of High Risk Patients 2

Characteristics of High Risk Patients 5

Findings 6

Recommendations 7

Appendix 12

Methodology 13

Memo to the Field – Centralized Automated Risk Classification System 15

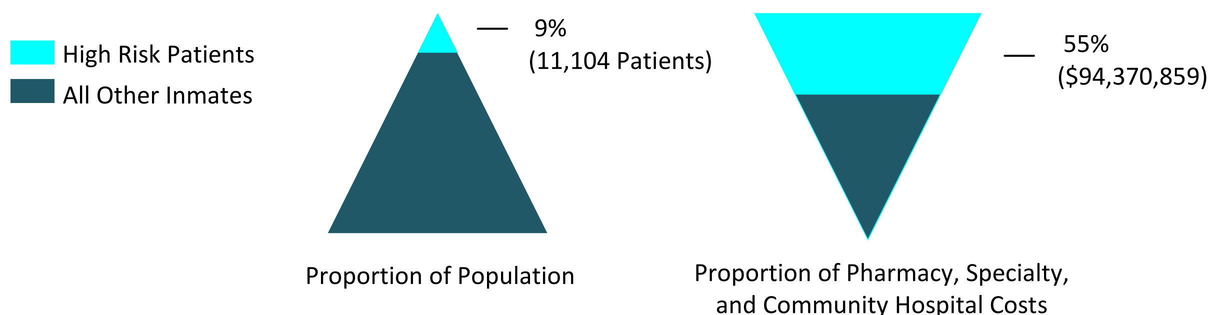
This report is the first of a series of reports to evaluate the care provided to high risk patients, and focuses specifically on appropriate placement of high risk patients. Subsequent reports will assess other important performance factors, such as access, continuity, coordination, quality, utilization, and cost of care. Beyond performance data, this report discusses characteristics of high risk patients, as well as specific recommendations which institution managers and care teams should consider to improve outcomes for this population.

Introduction

In health systems, a small subset of patients disproportionately contributes to health-related risk and cost, a concept commonly referred to as the "Pareto principle." Within the California prison system, a small group of patients diagnosed with complex clinical conditions, referred to as high risk patients[1], disproportionately consume the use of health care resources. Within California's prison system, nine percent of the patient population who are considered high risk utilizes more than half of the organization's pharmaceutical, specialty, community hospital, and emergency costs. See Figure 1.

Therefore, even small improvements in the way CCHCS staff place and manage high risk patients have the potential of both improving health outcomes and greatly reducing avoidable costs for this population.

Figure 1. High Risk Patients: Proportion of Total Population vs. Proportion of Pharmacy, Specialty, and Community Hospital Cost [2] between October 2011 and March 2012.



[1] For the purposes of this report, "high risk" refers to a subset of patients identified as high risk per the Clinical Risk Classification System.
[2] Pharmacy, specialty, and contract hospital services. Pharmacy costs do not include human resources costs for staff who process medications, such as pharmacy technicians; specialty and contract hospital costs include third party off-site medical claims and exclude on-site registry and specialty services expenses.

In its annual Performance Improvement Plan for 2011-2012, California Correctional Health Care Services (CCHCS) focuses on improving care for high risk patients as a major statewide initiative. The High Risk Initiative promotes placement of high risk patients at institutions best resourced for their care, access to a consistent interdisciplinary care teams, and enhanced care coordination and care management for this population. Under the High Risk Initiative, CCHCS will:

- Assist institutions in appropriately placing high risk patients,
- Provide institutions and care teams with decision support, such as continuously updated patient registries, to help health care staff identify and manage high risk patients, and
- Redesign core health care processes that focus on this patient population.

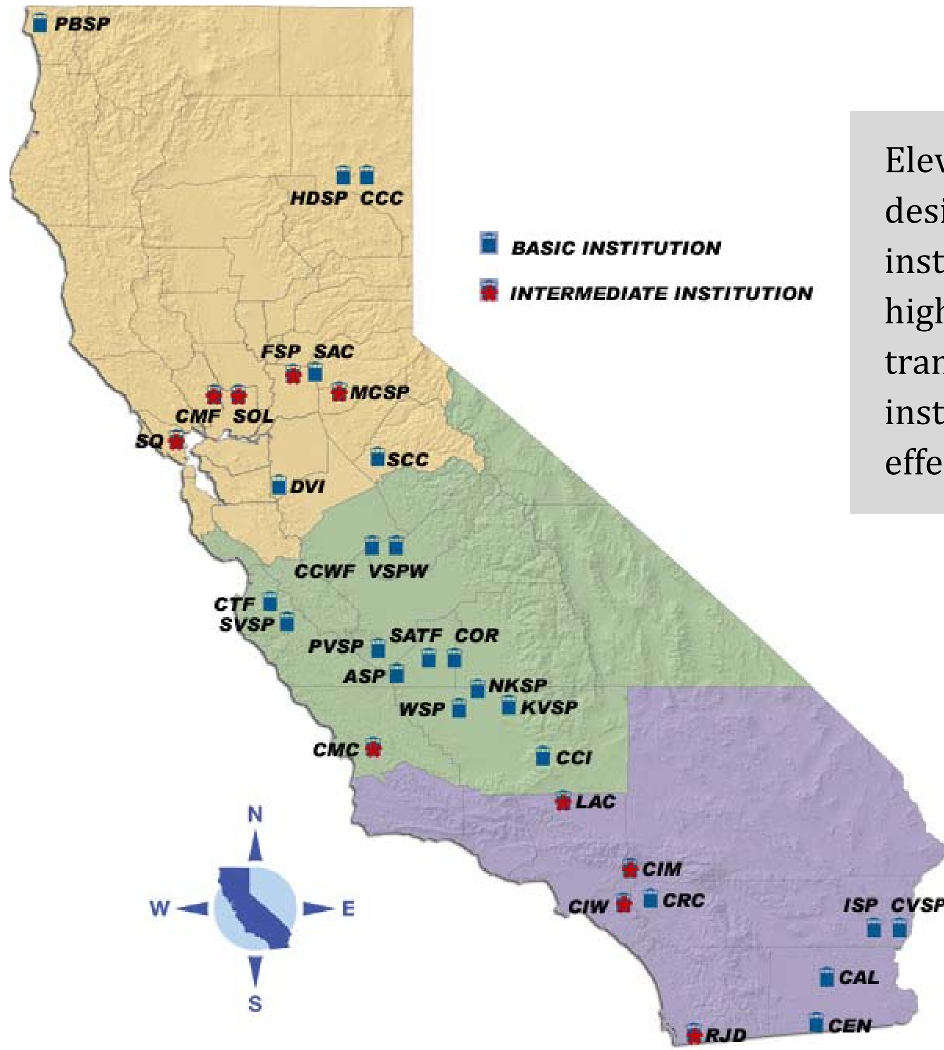
Over the next 18 months, CCHCS will closely monitor placement of high risk patients and implementation of critical Primary Care Elements, with results published monthly in the Health Care Services Dashboard.

Classification and Placement of High Risk Patients

Since November 2010, CCHCS staff have used the Medical Classification System (MCS) as a standardized method for determining each inmate's risk level. Under the MCS, patients are assigned one of three risk categories: High Risk, Medium Risk, and Low Risk. Please see Table 1 for a description of the factors associated with each risk level.

Upon entry into the prison system, health care staff assess each inmate to determine his or her health risk, and this information is used to match patients with prisons that will meet their health care needs in the most efficient and cost-effective manner. Per policy, most high risk patients should be transferred to an Intermediate Institution, which are predominantly located in urban areas close to tertiary care centers and specialty care providers, for the most cost-effective care. High risk patients will also be housed at the new California Health Care Facility (CHCF) in Stockton. Figure 2 shows Intermediate and Basic Institutions and their location in California.

Figure 2. Intermediate and Basic Institutions in the California Prison System



Eleven institutions have been designated as "intermediate" institutions; per policy, most high risk patients should be transferred to an intermediate institution for the most cost-effective care.

When the MCS policy was first implemented, the medical risk classification process was primarily paper-based. Institution health care staff were expected to assign patients a medical risk category based on information collected at health screenings and from available medical records, and record this information in a Medical Classification Chrono. In 2012, CCHCS applied widely-accepted and evidence-based predictive models to establish an automated system for identification and classification of an inmate's health risk. Inmate risk levels are now determined using information from centralized laboratory, pharmacy, claims, and other databases, as well as clinical judgment. Please see Table 1 for a description of the factors associated with each risk level.

Table 1. Automated Classification System Risk Levels and Summary of Associated Criteria

Risk Level	*Summary of Associated Criteria*
High Risk	Patients who trigger one or more criteria, including: medications indicating High Risk medical condition, frequent hospitalizations, high risk specialty services, abnormal labs, high risk diagnosis or procedures, and age.
Medium Risk	Patients with one or more chronic illness (including mental health and permanent disability).
Low Risk	Patients who are otherwise healthy or identified as having well-controlled asthma or diabetes, and asymptomatic HCV patients.

CCHCS clinical staff now have access to a Patient Panel Registry which lists each patient at a given institution and their current risk level. Updated continuously, this patient registry provides clinicians and administrators with the information they need to identify and appropriately place high risk patients, ensuring the most efficient use of health care resources.

CCHCS Correction Services, in collaboration with health care leadership and Classification staff in the California Department of Corrections and Rehabilitation, has begun to reassign high risk patients now housed at Basic Institutions to Intermediate Institutions (and, in turn, move lower risk patients to Basic Institutions). In July 2012, CCHCS provided each institution with a list of patients determined to be high risk by the Automated Risk Classification System and required institutions to verify risk status of these patients within 30 days. The finalized high risk list for each institution becomes the basis for inmate transfers. Please see the Appendix (page 15) for the statewide memorandum that describes this initiative.

Characteristics of High Risk Patients

As would be expected, high risk patients are at greater risk for poor health outcomes than the average inmate (the selection methodology is described later in this report). Nearly half of the general inmate population is free of chronic disease, while all high risk patients have been diagnosed with either a serious medical condition and/or multiple chronic conditions. A number of other factors distinguish the over 11,100 high risk patients in the California prison system from the overall inmate population:

- They are older than the average inmate. The median age of California inmates is 38 years; for high risk inmates, the median age is more than 10 years older – 53 years of age (see Table 2).

- High risk patients are likely to remain under the Department's jurisdiction. Thirty-five percent (35%) of high risk patients will serve life sentences[3] compared to twenty-three percent (23%) of the general population.

- One out of every three high risk patients are enrolled in the Mental Health Program. Thirty-seven percent (37%) of high risk patients have been diagnosed with mental health conditions, a prevalence forty percent higher than what is found in the general population.

- Care management is complicated by frequent inmate movement. Between July 2011 and June 2012, CDCR inmates transferred an average of 4 times from one cell bed to another, from one institution to another, between health care settings, or in and out of the prison system. Even at the local level, movements within an institution can result in reassignment to a new health care team, and a lapse in care may result if the transition is not carefully coordinated.

- While a transition in care may not have a significant impact on healthier inmates, gaps in clinician services, medications, or diagnostic studies that may occur could result in adverse outcomes for high risk patients.

[3] Includes life without parole.

Table 2. Offender Characteristics of High Risk Patients

	Number of Inmates	Median Age	Life Sentence	Serious Medical Condition	Mental Health Condition
General Population	113,405	38	23%	52%	25%
High Risk	11,104	53	35%	100%	37%

Although high risk patients comprise about nine percent (9%) of the total population, they drive over half of all expenditures for community hospitalizations, emergency department visits, specialty consultations, and medications. For the six months between October 2011 and March 2012, the costs for community hospital and emergency department visits, specialty consults and medications for the entire inmate population was approximately $171 million; costs for high risk patients accounted for $94 million[4] (55%) of this amount.

Of the 9,661 hospitalizations that occurred in between April 2011 and March 2012, over 44% (4,270) involved High Risk patients. Additionally, a subset of **potentially avoidable hospitalizations** for high risk patients averaged about $17,000 in community hospital costs per admission, for a total of nearly $25 million.

Findings

2011-2012 Performance Improvement Plan Objective:

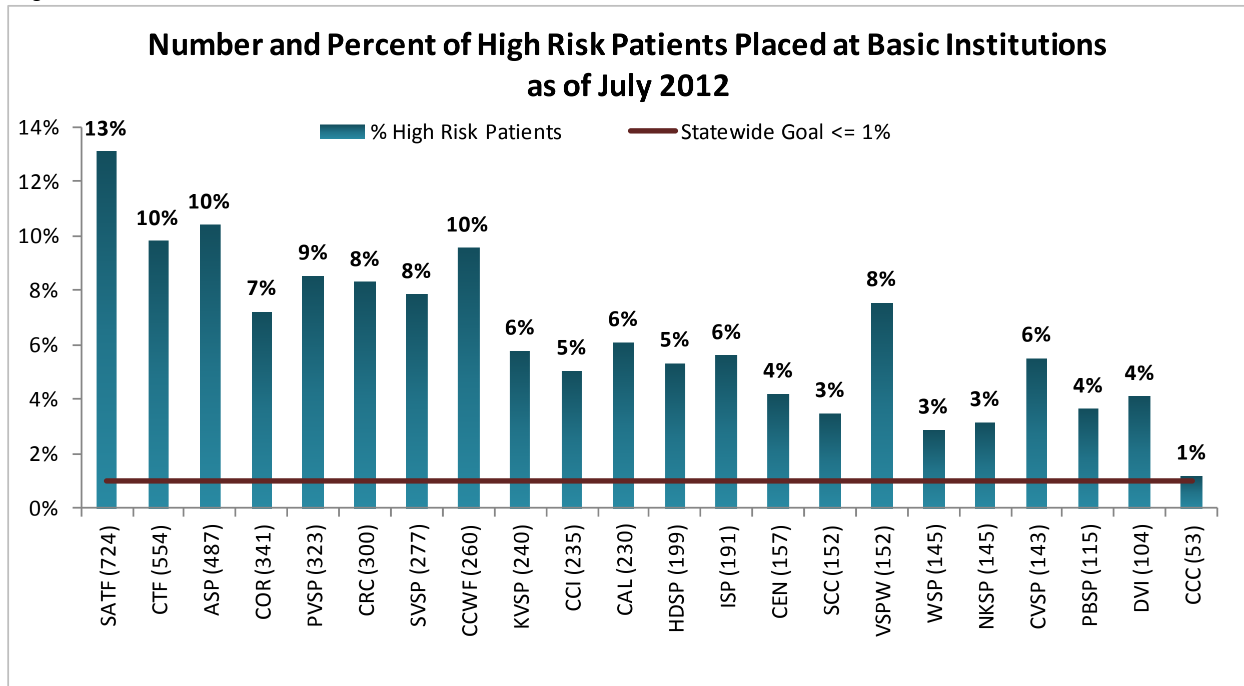
By December 31, 2012, greater than 75% of high risk patients will be housed at Intermediate Institutions or CHCF.

As of July 2012, fifty percent (50%) of high risk patients are located in Basic Institutions. Meeting the statewide objective to house seventy-five percent (75%) of high risk patients at Intermediate Institutions by the end of the year means moving roughly 2,750 high risk patients from Basic Institutions to Intermediate Institutions over the course of the next seven months. See Figure 3 and Appendix Table A-1.

The twenty-two Basic Institutions still house half of the high risk patient population. Most of those high risk patients are housed at seven of the 22 Basic Institutions: SATF, CTF, ASP, COR, PVSP, CRC, and SVSP. Among the four Basic Institutions with the most high risk patients (SATF, CTF, ASP, COR), at least one in every ten inmates falls into the high risk category. See Figure 3.

[4] A lag in billing receipt may result in figures lower than annualized figures reported elsewhere.

Figure 3.



* Figures shown in Figure 3 may under represent high risk patients, specifically those who have entered the CA correctional system within the last 6-12 months, as data may not yet be available to adequately classify them.

Recommendations

<u>Statewide High Risk Initiative - Placement</u>

For several months now, CCHCS and CDCR staff has been working together to move high risk patients to Intermediate Institutions, and replace these patients with others at medium or low health risk.

- <u>Basic Institutions</u> can support this statewide initiative by working closely with The Medical Placement Unit and custody classification staff to facilitate movement of high risk patients to other institutions, making it a priority to complete these transfers.
- <u>Intermediate Institutions</u> can support the statewide initiative to appropriately place high risk patients by ensuring that high risk patients newly transferred to the institution are promptly assigned to a care team, are scheduled for timely evaluation with the assigned primary care provider, and receive medications and diagnostic services as required.

In addition to the statewide initiative to appropriately place high risk patients, CCHCS has developed specific tools and strategies to assist institutions in properly placing and managing high risk patients.

Tools and Strategies for Appropriate Placement: New Patient Registries

In May 2012, CCHCS released a new set of patient registries with enhanced features for managers and health care teams. These new registries:

- Are updated continuously, as soon as pharmacy, laboratory, inmate movement, and other relevant data become available.
- Can be easily customized to show a specific health care team's assigned patients, patients with a particular condition, patients flagged for abnormal laboratory results, among other options.
- Identify new patients who have transferred to the patient panel within the past 30 days.
- Provide more information than has been offered before, including each patient's risk level.

Care teams can review the risk level of all patient assigned them using the Patient Panel Registry. Through the Chronic Care Master Registry, care teams can access a list of patients with common chronic diseases, their risk level, and other important clinical information, such as abnormal clinical findings or missing services. Viewers can click on the risk designation of any registry patient, bringing up a comment box that specifies the criteria that caused the patient to be placed in the risk category. See Figure 4.

CCHCS recommends that institutions use registries to:

- Identify high risk patients, verify that the risk level is appropriate, and support efforts to transfer high risk patients to an Intermediate Institution or CHCF.
- Identify patients who have recently transferred to their current care team and ensure that these patients are evaluated by the assigned Primary Care Provider within appropriate timeframes based on clinical need and policy requirements.
- Follow up on "flags" that appear for High Risk patients on the Chronic Care Master Registry. The flag may indicate that a recommended service has not been provided, or may highlight an abnormal result.

Figure 4: View of Chronic Care Master Registry, with Risk Criteria comment box

Home > QM > Registries > rg_Master | Home | My Subscriptions | Help

Institution: ASP | Care Team: AD SEG Clinic, Other, Yard A C | View Report

Risk Group: High Risk 1, High Risk 2, Mediu | Select Conditions: MH Level of Care, Asthma, Chr

Show Alerts Only: True / False | Choose Alerts: Show All

1 of 78 | 100% | Find | Next

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Avenal State Prison (ASP)
Master Registry - Chronic Conditions
Patient Count: 3167

Risk_Criteria - Window...
CDCR #: | Risk Level: HIGH 1

Medical High Risk Factors
MULTIPLE HOSPITALIZATIONS
SENSITIVE MED COND (IBD)

Identification & Housing					Risk Gr							elected Chronic Conditions							
CDCR#	Last Name	DOB	Cell Bed	Care Team or Yard	Clinical Risk	MH High						betes (A1C)	HCV	HIV (CD4)	HLP (LDL)	HTN & Other CV	Seizure	Warfarin (INR)	ADA/ DPP
				Yard A Clinic	MED							5.3			58	ACE	Depako		
				Yard A Clinic	HIGH 1							5.8	Ab+			Multi-3	Dilant		DNM
				Yard C	MED							5.2			103	Multi-3	Dilant		
					MED			7	CCCMS	2.0 :0	ADJ	5.6	Ab+Vl-		128	Multi-3			
				Other	HIGH 1			6			OPI	5.7			41	Multi-3		4.6	DPO
				Yard A Clinic	MED			6	CCCMS		ADJ	9.2			47	Multi-4			Multi-2
				Yard B Clinic	MED			6	CCCMS		ADJ	8.5	Ab+VL+		99	Multi-2			
				Yard B Clinic	MED			6	CCCMS		OPI		Ab+VL+		114	Ca-Blkr	Dilant		
				Yard C Clinic	MED			6	CCCMS	0.3 :1		6.9			92	Multi-3			DNM
				Yard C Clinic	HIGH 1			6	CCCMS		OPI		Ab+VL+			Diureti		2.7	DNM
				Yard C Clinic	MED			6	CCCMS		ADJ	5.7	Ab+Vl-		52	Multi-2			
				Yard C Clinic	MED			6	CCCMS		OPI ADJ	5.6			100	Multi-3			Multi-2
				Yard C Clinic	MED			6	CCCMS			5.6	Ab+Vl-		112	ACE			DNM
				Yard C Clinic	MED			6	CCCMS		ADJ	7.8			135	Multi-3			DNM
				Yard D Clinic	HIGH 1	2		6	CCCMS			8.1	Ab+VL+		39	Multi-5			DNM

Click here to access the new patient registries: Master Chronic Care Registry

To ensure optimal use of the new registries:

- Provide all care team members with access to registries. All clinicians and many administrative staff already have access to these registries; please contact Ryan Jones at Ryan.Jones@cdcr.ca.gov if a team member needs access but has not been granted it.
- Ensure that care teams at your institution know how to use the new patient registries. Designate a group of staff well-versed in registry features to mentor other staff.
- Ensure that staff know where to find the User's Manual, which describes registry features. Click here for the User's Manual: Registry User's Guide

Performance Monitoring

CCHCS monitors the percentage of high risk patients at each Basic Institution and updates this number monthly in the Health Care Services Dashboard. In the Monthly Comparison View of the Dashboard, institutions find a breakdown of the percentage of the total patient population that falls into each risk category allowing institutions to easily assess whether the institution is meeting the statewide performance goal of less than or equal to one percent of the patient population. All institutions' percentages are posted, allowing for comparison across facilities. See Figure 5.

Figure 5: Percentage of Patients in Each Risk Category, Per Institution, as Found in the Health Care Services Dashboard Monthly Comparison View

http://intranet/cphcs/hc/medical/primarycare/QI/Das...

DASHBOARD MONTHLY COMPARISON - April 2012

INSTITUTION AND POPULATION CHARACTERISTICS	ASP	CAL	CCC	CCI	CCWF	CEN	CIM	CIW	CMC	CMF	COR	CRC
High Risk Priority 1	[illegible]%	1%	0%	1%	4%	1%	4%	2%	4%	14%	2%	2%
High Risk Priority 2	[illegible]%	5%	1%	4%	6%	3%	9%	6%	10%	20%	6%	6%
Medium Risk	[illegible]4%	31%	23%	54%	51%	30%	51%	47%	50%	53%	55%	50%
Low Risk	[illegible]4%	63%	76%	41%	39%	66%	35%	45%	36%	13%	37%	42%
Enhanced Outpatient Program-Mental Health	14	-	-	14	46	-	56	67	613	507	238	-
Patients with Diability (ADA)	451	101	38	138	213	101	400	78	291	768	275	144
Licensed Outpatient Beds	28	18	24	32	39	15	160	37	37	293	99	10
Inmates ≥ 50 years old	1,436	331	365	658	470	407	1,257	235	1,565	980	685	690
Women/Men Institutions	M	M	M	M	W	M	M	W	M	M	M	M
Total Population	5,222	4,001	4,836	4,728	2,852	3,715	5,256	1,637	5,540	2,413	4,504	3,950

INSTITUTION AND POPULATION CHARACTERISTICS	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP
High Risk Priority 1	3%	2%	1%	1%	2%	1%	1%	3%	4%	1%	1%	2%
High Risk Priority 2	7%	5%	3%	4%	3%	4%	4%	6%	10%	3%	3%	6%
Medium Risk	52%	35%	39%	51%	43%	36%	54%	61%	64%	37%	43%	64%
Low Risk	38%	58%	57%	44%	52%	60%	40%	30%	22%	59%	54%	28%
Enhanced Outpatient Program-Mental Health	10	-	15	-	14	-	92	378	507	55	198	7
Patients with Diability (ADA)	270	118	113	110	260	82	208	184	200	115	59	443
Licensed Outpatient Beds	22	14	29	-	35	15	22	18	12	16	20	17
Inmates ≥ 50 years old	1,766	583	279	484	358	510	296	544	853	507	270	841
Women/Men Institutions	M	M	M	M	M	M	M	M	M	M	M	M
Total Population	5,713	2,723	2,597	2,928	3,786	3,509	4,174	3,894	3,065	4,714	3,091	3,734

For each institution, the monthly Institution Scorecard shows a count of high risk patients, and provides a 6-month trend line to show whether this number is increasing (as would be expected for Intermediate Institutions) or decreasing (as would be expected for Basic Institutions) over time. See Figure 6.

Figure 6. Count of high risk patients housed at the institution

MAJOR COSTS PER INMATE PER MONTH

BOR	FY 10/11	YTD 11/12	Statewide (excluding HQ)
edical Staff	$60.96	$63.71	$79.39
rsing Staff	$205.00	$215.39	$327.36
armacy Staff	$16.43	$14.74	$26.95
ntal Clinical Staff	$75.47	$70.67	$70.70
ental Health Clinical Staff	$57.82	$62.55	$146.19
nical Support Staff	$9.80	$9.57	$18.46
min. Support Staff	$70.89	$75.63	$93.17
N LABOR			
spital	$146.82	$113.44	$91.00
nergency Department	$7.47	$5.94	$4.11
ecialty	$30.07	$30.78	$30.24
edications	$79.34	$75.05	$102.57
agnostics	$57.91	$15.25	$21.17

MODERATE ADHERENCE | LOW ADHERENCE

WORKLOAD PER DAY

	6 Month Trend	Feb. 2012	Statewide
Patient Encounters per PCP		11	12
Patient Encounters per Primary Mental Health Clinician		8	7
Patient Encounters per Psychiatrist		13	10
Prescriptions Per Pharmacist		227	121

OTHER TRENDS

	6 Month Trend	Most Recent	Statewide
High Risk Patients		600	10,754
Mental Health High Utilizers*		2	9
Appeals Received*		38	36
Health Care Appts. Missed due to Cusdody		0.0%	1.9%
Prison Population Capacity		183%	155%
Cell Bed Changes		40%	53%
Average Document Scan Time (in days)		2.6	3.8

*Per 1,000 inmates

Please click here to access the Health Care Services Dashboard: Dashboard

At Basic Institutions, review the percentage of high risk patients at the institution during the institution's regularly-scheduled Quality Management Committee meeting or other appropriate performance management committee meeting. Track this measure as the institution makes efforts to exchange high risk patients for medium and low risk patients to ensure that the percentage of high risk patients decreases over time. Consider tracking other metrics for high risk patients, such as whether these patients were seen within 14 days of assignment to a new care team, and whether these patients received diagnostic services, medications, and specialty consultations per policy and guidelines. Institutions may wish to use a tracer methodology, which assesses the effectiveness of health care processes by following the care provided to an individual patient, to review services provided to high risk patients.

Click here for more information on the tracer methodology: Joint Commission Tracer Methodology

---

In summary, High Risk Patients represent a small proportion of the inmate population, but disproportionately carry the burden of health risk and consume the majority of non-labor costs. Although the High Risk patients should be housed at Intermediate Institutions best resourced to provide cost-effective care, only 50% are currently housed within these institutions. As described in this Report, there are a several tools and strategies that headquarter and institution staff should use to ensure appropriate placement and clinical management of this patient population.

Please share this performance report with institution staff and discuss in a variety of forums including the Quality Management Committee, program subcommittees, and supervisors' and care team meetings focusing on how best to implement the tools and strategies currently available to optimally place and clinically manage High Risk patients.

Appendix

Table A-1. Number and Prevalence of High Risk Patients July 2012

Mission Average	Institutions	Number of High Risk Patients	Total Inmate Population	Prevalence of High Risk Patients
WOMEN 9%	CCWF	260	2724	10%
	CIW	129	1515	9%
	VSPW	152	2011	8%
RC BASIC 3%	DVI	104	2535	4%
	NKSP	145	4616	3%
	WSP	145	5052	3%
RC INTERM 14%	CIM	841	4940	17%
	LAC	396	3961	10%
	RJD	523	3285	16%
	SQ	454	3665	12%
BASIC 7%	ASP	487	4684	10%
	CAL	230	3785	6%
	CCC	53	4479	1%
	CCI	235	4669	5%
	CEN	157	3742	4%
	COR	341	4720	7%
	CRC	300	3620	8%
	CTF	554	5654	10%
	CVSP	143	2596	6%
	HDSP	199	3737	5%
	ISP	191	3405	6%
	KVSP	240	4156	6%
	PBSP	115	3159	4%
	PVSP	323	3790	9%
	SATF	724	5539	13%
	SCC	152	4369	3%
	SVSP	277	3535	8%
INTERMEDIATE 16%	CMC	844	5383	16%
	CMF	857	2357	36%
	FSP	149	2863	5%
	MCSP	469	3058	15%
	SAC	302	2684	11%
	SOL	613	4221	15%
	Statewide	11104	124509	9%

Methodology

To produce the performance data used in this report, CCHCS first established criteria for identifying High Risk patients. A team of clinicians and analysts developed the criteria used to identify High Risk patients based upon requirements in the Medical Classification policy and procedure, evidence in the medical literature and existing predictive models, and clinical experience (see Table A-2 on page 21). The criteria for classification of High Risk rely upon pharmacy, laboratory, third-party claims and referral data as indicators of chronic, sensitive or high-risk conditions.

For the purposes of this report, a "High Risk" patient generally refers to those who have multiple acute or chronic conditions (or ambulatory care sensitive conditions) that require extended medical or rehabilitative treatments. CCHCS data provide guidance with regard to diseases that contribute most to illness, death, avoidable hospitalizations and increased costs. Patients were considered High Risk when they met one or more of the specified criteria.

The percentage of High Risk patients by institution was computed by dividing the number of High Risk patients at each institution by the prison population at the time of the analysis times 100.

Criteria and Data Sources

The classification criteria are based on pharmacy, laboratory, third-party claims and referral data as indicators of chronic, sensitive or high-risk conditions.[5] Data sources included:

- Third Party Administrator (TPA) Claims — Emergency Department, Hospitalizations and Specialty Provider Billing (includes diagnosis and procedure coding).
- Census and Discharge Data Information System (CADDIS) — CCHCS Bed Management (identifies community hospital admissions).
- InterQual — CCHCS Specialty Referral criteria.
- Guardian Pharmacy — Pharmacy data.
- Quest Diagnostics — Laboratory reports.

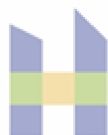
[5] This method has been applied in other research. See, for example, Fishman P, Goodman M, Hornbrook M, Meenan R, Bachman D, and O'Keefe Rosetti M. Risk adjustment using automated ambulatory pharmacy data: The Rx Risk model. Med Care 2003; 41:84-99.

- Mental Health Tracking System (MHTS.net) — Patients enrolled in the Mental Health Program.
- Disability Effective Communications Tracking System (DECS) — Information on disabilities.
- Distributed Data Processing System (DDPS) — Information on inmate placement.

Sensitive Medical Conditions

These were identified using a list of medications that are associated with important diagnoses such as ALS, cancer, hemophilia, HIV, organ transplant or HCV treatment and that, if the medications were missed, could result in serious health effects.

Memo to the Field – Centralized Automated Risk Classification System



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	July 25, 2012
To:	Chief Executive Officers Chief Medical Executives Deputy Medical Executives
Subject:	CENTRALIZED AUTOMATED RISK CLASSIFICATION SYSTEM

Effective immediately, this memorandum supersedes the California Correctional Health Care Services (CCHCS) Centralized Automated Risk Classification System memorandum dated May 16, 2012 (attached). After further analysis related to the implementation of the May 16, 2012 memorandum, the following actions are to occur upon the receipt of this memorandum and attachments.

The attached Centralized Automated Risk Classification System list contains High Risk (HR) Inmate – Patients (IPs) currently housed at your institution that have been identified as requiring transfer to an appropriate intermediate-level medical care institution. Please review the attached list to ensure the IP's current California Department of Corrections and Rehabilitation (CDCR) Medical Classification Chrono (128 C-3) reflects the IP's Medical Risk: High Risk status. If the CDCR 128 C-3 does not reflect HR, the institution primary care provider (PCP) staff is required to complete one or more of the following actions within **30 days of receipt of the IP list**:

- The PCP staff will complete a new CDCR 128 C-3 that documents the inmate's current medical classification factors, including the Medical Risk: HR factor. A copy of the completed CDCR 128 C-3 will be routed to the institution Classification and Parole Representative who will utilize the CDCR 128 C-3 as a trigger to initiate a classification action.
- If the institution PCP disagrees with the IP's HR designation, the provider shall discuss the case with the Chief Physician and Surgeon and the Chief Medical Executive (CME).
- If the CME believes the IP is medium or low risk, he/she will case conference with their designated Deputy Medical Executive (DME) and Douglas C. Peterson, DME to come to a consensus on the IP's medical risk status.
- If all parties agree the IP is not HR, the IP will be removed from the automated HR list. If a consensus cannot be reached, the IP will retain the HR designation and be transferred to an appropriate intermediate-level medical care institution.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
P.O. Box 4038
Sacramento, CA 95812-4038

MEMORANDUM

- Upon completion of the institution medical review, an updated IP HR list based on the CDCR 128 C-3 will be provided by the institution to the Quality Management Unit and the Medical Classification and Case Records Unit (MCCRU). This updated list will then be provided to CDCR's Population Management Unit to be utilized by classification staff to transfer the identified HR IPs.

Should you have any questions or concerns, please contact Douglas C. Peterson, M.D., Deputy Medical Executive, Activations & Classification – Private Prison Compliance and Monitoring Unit, Corrections Services, at (916) 324-6833; after August 6, 2012, at (916) 691-9574 or via email at Douglas.Peterson@cdcr.ca.gov, or Dennis Gunter, Correctional Counselor III, MCCRU, Field Operations, Corrections Services, at (916) 648-8256 or via email at Dennis.Gunter@cdcr.ca.gov.

Attachments

Original signed by:

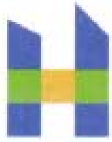
RICHARD KIRKLAND, Chief
Construction Oversight, Field Operations and Activation Management, Correction Services

Original signed by:

STEVEN THARRATT, MD
Statewide Chief Medical Executive

cc: Clark Kelso
David Runnels
Diana Toche
Liana Bailey-Crimmins
Tim Belavich
Jared Goldman
Mitzi Higashidani
Renee Kanan
Evelyn Matteucci
Yulanda Mynhier
Karen Rea
Lance Jensen
Theresa Kimura-Yip
John Dovey
Steven Ritter
Dennis Gunter
Rick Johnson
Ricki Barnett
Elizabeth dos Santos Chen
Alan Frueh
Ellen Greenman
Janet Lewis
Janet Mohle-Boetani
Douglas Peterson
John Zweifler

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
P.O. Box 4038
Sacramento, CA 95812-4038



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	May 16, 2012
To:	Chief Executive Officers Chief Medical Executives
From:	Richard Kirkland, Chief of Construction Oversight, Field Operations, and Activation Management Steven Tharratt, Statewide Chief Medical Executive
Subject:	Centralized Automated Risk Classification System

In November 2010, California Correctional Health Care Services (CCHCS) established the Medical Classification System (MCS) to ensure appropriate placement and management of California's prison inmates. Under the MCS, patients are assigned a number of medical classification factors, including a medical risk category. Patients are routed to the facilities best situated to manage individual health care needs, and primary care teams can use medical risk categories to determine which patients will receive more intensive care coordination and case management services. Satisfaction of Turnaround Plan of Action Goal 1.4, which calls for appropriate identification and housing of long-term care patients, depends upon a fully implemented MCS.

A standardized, reliable medical risk categorization system is important for both improving patient outcomes and reducing costs. In correctional healthcare environments and the non-correctional health care settings, a small subset of patients is at higher risk for poor health outcomes and disproportionately drives health care costs. Placing as many high risk patients as possible at Intermediate institutions brings these patients to urban areas close to tertiary care centers and specialty care providers, which is expected to improve cost effectiveness, operational efficiencies and quality of care. As a result, CCHCS has set the following goal for placement of high risk patients:

By December 31, 2013, greater than 90% of High Risk patients will be housed at an Intermediate institution or California Health Care Facility (CHCF).

With initial implementation of the MCS policy, institution health care staff was expected to assign patients a medical risk category based on information collected at health screenings and available in medical records, and document this information on a Medical Classification Chrono (128-C3). CCHCS now has the technical capacity to determine patient risk from centralized electronic data sources. Applying widely-accepted and evidence-based predictive models,

MEMORANDUM

CCHCS has developed standardized criteria for each medical risk category. Under the new automated system, risk stratification will become consistent across all institutions, and inmate risk levels will be regularly updated with the most recent pharmacy, laboratory, hospitalization, and specialty services data as well as other data sources. Please see Attachment 1 for a description of the risk categories and associated risk factors.

Stratification and Placement of High Risk Patients

The new automated medical risk stratification system can support clinicians in accurately determining the risk of patients assigned to them in several ways. The new system:

- Makes important clinical data readily available to clinicians and care teams promoting proactive planned care for those patients with complex chronic conditions.
- Reduces the workload involved in updating the "Medical Risk" item on the Medical Classification Chronos as patients move from one risk level to another – the system performs this function on a continuous basis, ensuring that clinicians have the most updated risk status for each patient.
- Provides standardized criteria for medical risk determinations, bringing greater consistency to the medical risk stratification process.

The automated system also helps to prevent inefficiencies in patient transfers. Right now, when a high risk patient is transferred to an Intermediate facility, that patient should be exchanged with a medium or low risk patient. With the continuously updated information in the automated system, there should be fewer circumstances in which a high risk patient is moved from a Basic facility, only to be replaced by another high risk patient. In addition, the automated system will support efficient use of the new licensed inpatient beds under construction in Stockton and other locations.

The Health Care Placement Oversight Program (HCPOP), in collaboration with health care leadership, already has begun to reassign high risk patients to Intermediate institutions and, in turn, move lower risk patients to Basic institutions using the automated system. **During this transfer process, the sending institutions' staff does not have to review or revise existing Medical Classification Chronos that have been completed for individual patients.**

However, to be consistent with CCHCS policies and good patient care, **Intermediate institutions receiving high risk patients, shall ensure that the primary care physician (PCP) assigned to manage the high risk patient evaluates this patient as soon as possible but no later than fourteen (14) days after arrival to the Intermediate institution. During the initial evaluation**

MEMORANDUM

with the PCP, the patient's Medical Classification Chrono shall be reviewed and if necessary revised to ensure that the Chrono reflects the appropriate risk designation.

Risk Stratification Reports

Effective this month, CCHCS will make available patient registries that provide each patient's medical risk category, updated on a continuous basis with the most recent centralized data. Specifically, under the column "Clinical Risk" on the CCHCS Master Registry, institutions will find the most current risk stratification of each patient listed. If a care team member wishes to know the criteria used to determine that particular patient's risk stratification, he or she can click on the words "High" or "Med" and a pop-up window will appear with a description of the criteria (see image below). Patient registries can be sorted so that only a care team's assigned patients are shown.

Patients who have been added to the patient panel within the past 30 days are marked with an asterisk (*) and shown in **bold font**. As high risk patients are transferred to Intermediate facilities, primary care teams will have the means to quickly identify these patients and schedule the patient to be seen.

Click here to view the Master Registry

Identification & Housing					Risk Group			Selected Chro					
CDCR#	Last Name	DOB	Cell Bed	Care Team or Yard	Clinical Risk	MH High Util	Avoid Hosp	Cond Count	MH LOC	Asthma (SABA-ICS)	Chronic Pain	Diabetes (HgA1C)	H
			A 130	Yard A Clinic	MED							6.3	
			C 320	Yard C Clinic	MED							5.2	
			D 410	Yard D Clinic	MED							5.6	Ab+
			A 130	Yard A Clinic	HIGH 1							5.3	Ab
			B 210	Yard B Clinic	MED							8.5	Ab+
			C 320	Yard C Clinic	MED							5.7	Ab+
			D 410	Yard D Clinic	HIGH 2							9.2	
			A 120	Yard A Clinic	HIGH 1								Ab+
			A 120	Yard A Clinic	HIGH 2							6.2	
			A 120	Yard A Clinic	MED							9.0	
			A 120	Yard A Clinic	HIGH 2							7.2	
			B 210	Yard B Clinic	MED								Ab+

Risk Criteria - Windows...

CDCR #:

Risk Level: HIGH 1

Medical High Risk Factors
MULTIPLE HOSPITALIZATIONS
SENSITIVE MEDICAL CONDITION

On May 30th and June 5th, CCHCS will offer training on various aspects of the automated risk stratification system and its application at the institution. The training is open to all providers, but will be especially important for reception center providers who will need to assign classification to new patients entering our system.

MEMORANDUM

Clinical Risk Classification System Training

May 30th from 7:30AM-8:30AM

- OR -

June 5th from 3:00PM-4:00PM

To reach the webinar, please do the following:

Connect to audio via the phone:
Dial In = (877) 214-6371
Participant Code = 145230

Connect to video via the Internet:
www.webmeeting.att.com
Meeting Number = 8772146371
Participant Code = 145230

It is the expectation that no later than May 22, 2012, the institution's Chief Medical Executive and Chief Physician and Surgeon ensure that every medical provider at the institution has received a copy of this memorandum, and that the contents have been discussed with the provider staff as well as with the Quality Management Committee members.

We appreciate your feedback on the statewide effort to standardize the medical classification process and ensure appropriate placement and management of our patient population. Please send any comments or questions about this medical classification process to Dr. Doug Peterson at Douglas.Peterson@cdcr.ca.gov.

CC: Clark Kelso
David Runnels
Diana Toche
Liana Bailey-Crimmins
Tim Belavich
Brenda Epperly-Ellis
Jared Goldman
Mitzi Higashidani
Renee Kanan
Evelyn Matteucci
Yulanda Mynhier
Karen Rea
John Dovey
Steve Ritter
Dennis Gunter
Rick Johnson
Ricki Barnett
Elizabeth dos Santos Chen
Alan Frueh
Ellen Greenman
Janet Lewis
Janet Mohle-Boetani
Douglas Peterson
John Zwiefler

Attachment I
Appendix Table A-2

High Risk - Priority 1

Patients who are Clinically Complex -- triggering at least **2 flags** from the selection criteria found in the table below

High Risk - Priority 2

Patients who are Near Clinically Complex -- triggering only **1 flag** from the selection criteria found in the table below

Flag	Description	Data Source	Timeframe
Sensitive Medical Condition	Medications associated with important diagnoses which, if not taken, may lead to a serious adverse event (e.g. immunosuppressants, chemotherapy Rx)	Guardian	6 months
High hospital, ED, Specialty Care and Pharmacy Costs	Patients whose care in the past 6 months has a cost of more than $100,000	Guardian, TPA Claims	6 months
Multiple Hospitalizations*	2 or more inpatient admissions	CADDIS	12 months
Multiple Emergency Department Visits*	3 or more emergency department visits	TPA Claims	12 months
High Risk Specialty Consulations	2 or more appointments to 'high risk' specialist(s) (e.g., oncologist, vascular surgeon)	TPA Claims	6 months
Significant Abnormal Labs	1 or more abnormal lab value that suggests poor control of a chronic condition or serious medical condition (most recent)	Quest	All - Most Recent or Any
Age	65 years of age or older	DDPS	Current Age
Specific High-Risk Diagnoses/Procedures	1 or more ICD-9 codes from ED visit, hospitalization or specialist visit, suggesting serious condition (e.g., cancer, SLE, dementia)	TPA Claims	All

*A patient with a point for 2 or more inpatient hospital admissions cannot receive a second point for 3 or more ED visits (and vice versa)

Medium Risk

Patients with at least 1 chronic condition who do not meet any selection criteria for Clinical High Risk Priority 1 or Priority 2
Excluded from the Medium Risk group are patients with only 1 chronic condition and identified as well-managed asthma or well-managed diabetes (consistent with the Medical Classification System Policy)

Flag	Description	Data Source	Timeframe
1 or More Chronic Conditions	1 or more chronic illnesses, based upon prescribed medications, laboratory tests, or MHTS enrollment (Includes MH High Utilization and Permanent ADA)	Guardian, Quest, MHTS	6 months

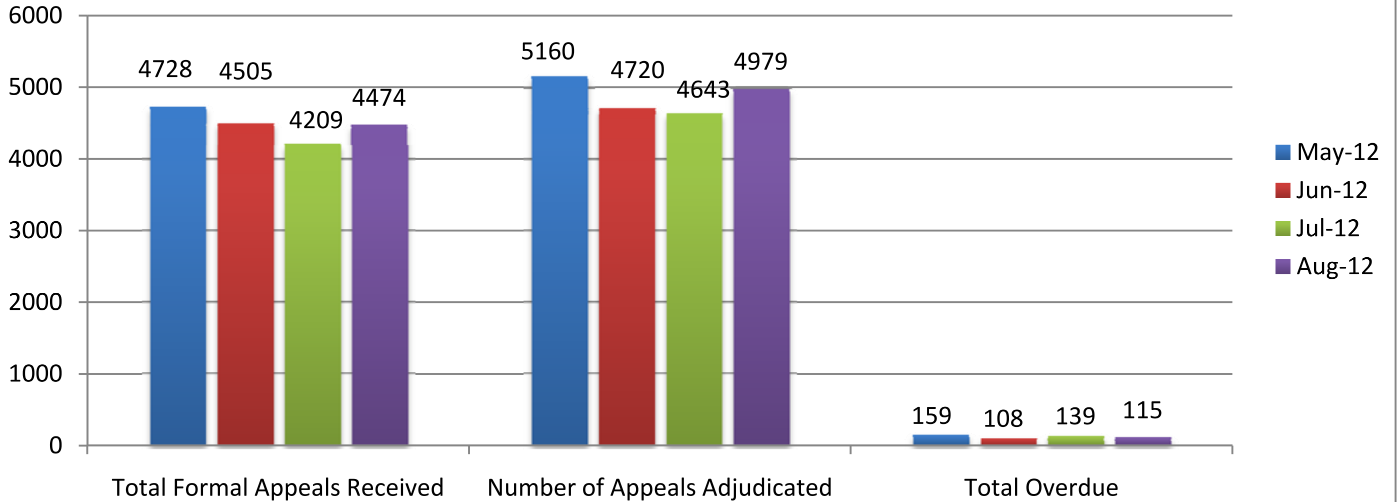
Low Risk

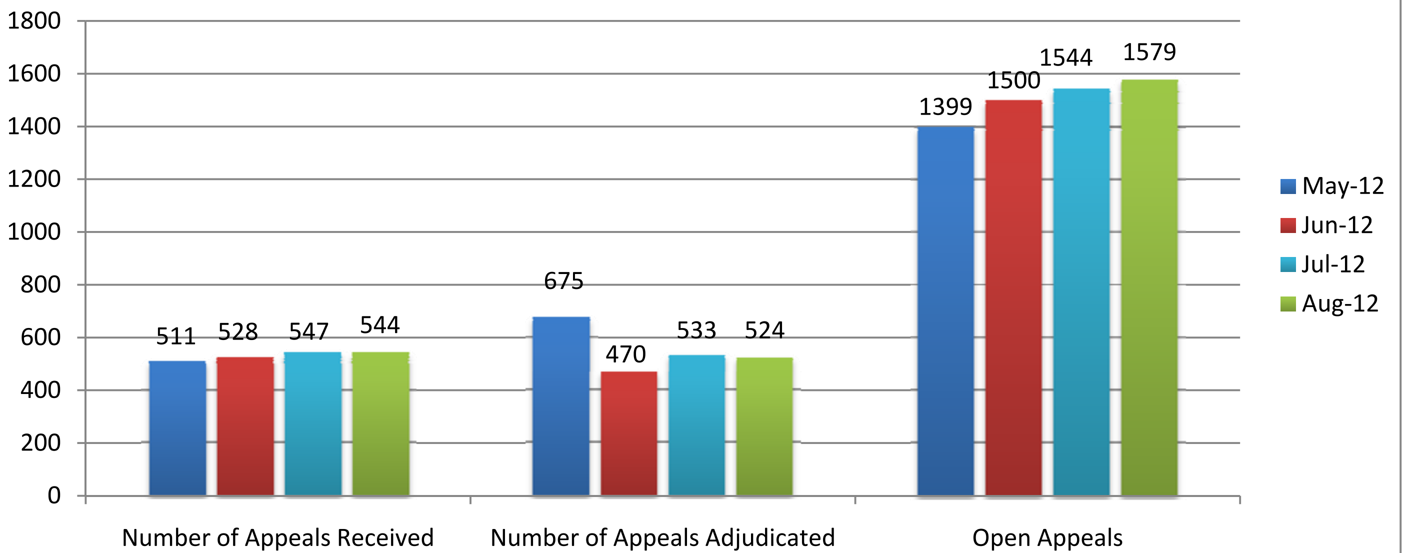
All patients who do not meet the selection criteria for the High Risk Priority 1, Priority 2, or Medium Risk categories

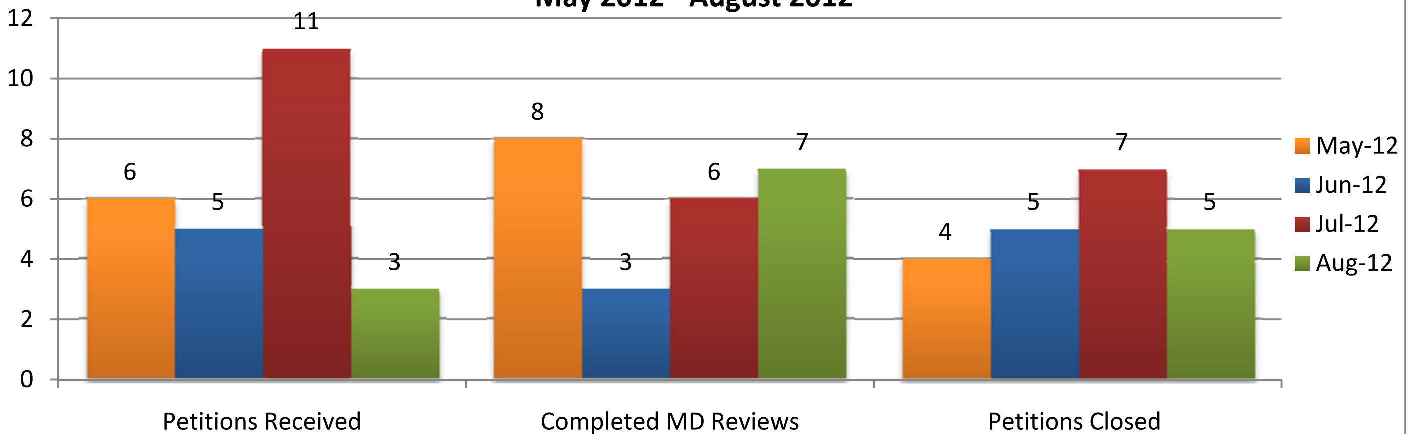
Included are patients identified as well-managed asthma or well-managed diabetes

Flag	Description	Data Source	Timeframe
Healthy Patients Including: Well Managed Asthmatics and Diabetics, and Asymptomatic HCV Patients	Otherwise healthy patients, including: Those who use <= 2 SABA dispenses in 12-months <u>and</u> not on an ICS Those with all HgA1C < 7.7 in 12-months <u>and</u> not on insulin Those who are HCV Ab+ but have a negative viral load (VL-)	Guardian, Quest	12 months

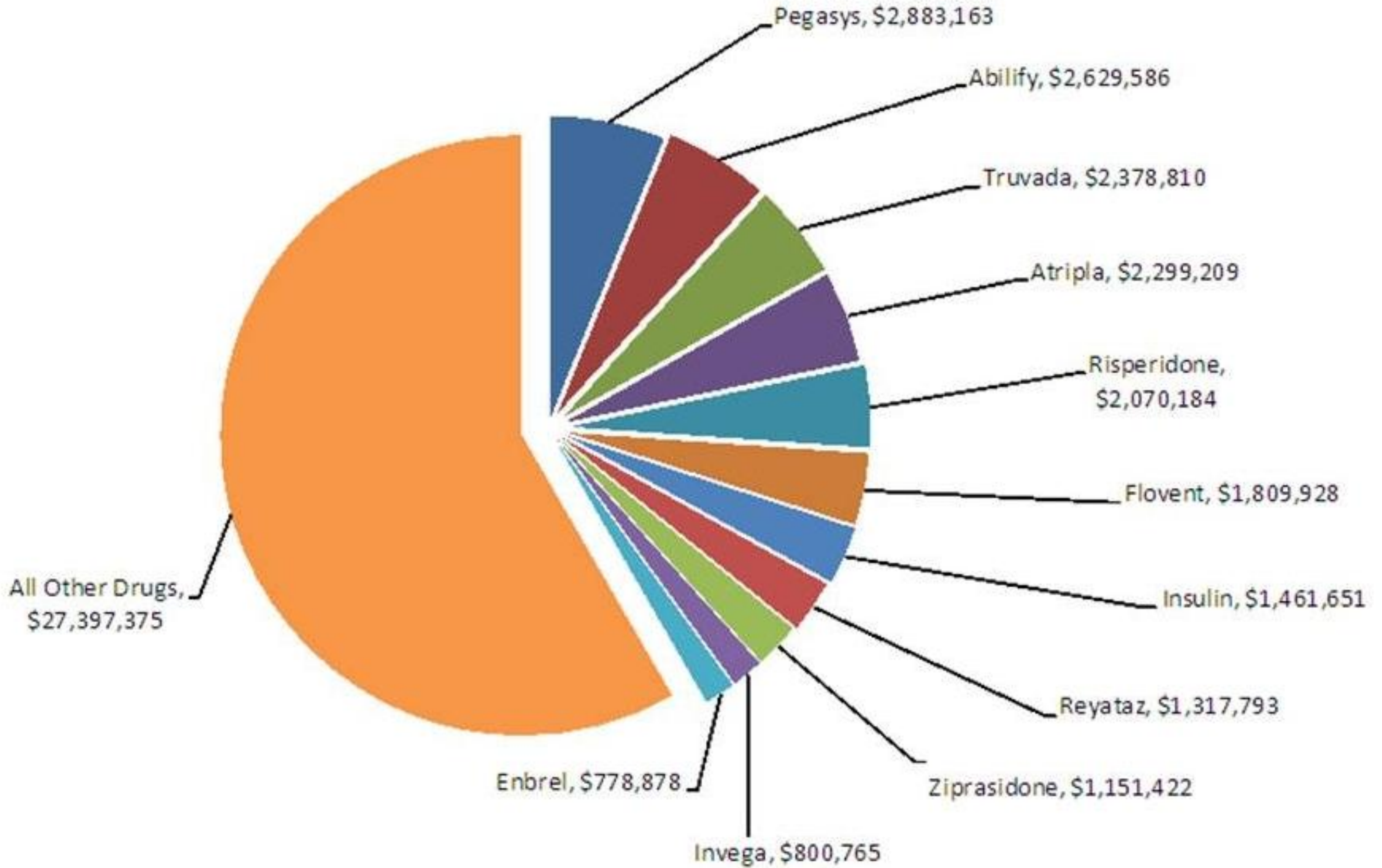
APPENDIX 7


Healthcare Appeals - Institutions (Statewide)
May 2012 - August 2012
6000
5000
4000
3000
2000
1000
0
4728
4505
4209
4474
5160
4720
4643
4979
159
108
139
115
Total Formal Appeals Received
Number of Appeals Adjudicated
Total Overdue
May-12
Jun-12
Jul-12
Aug-12

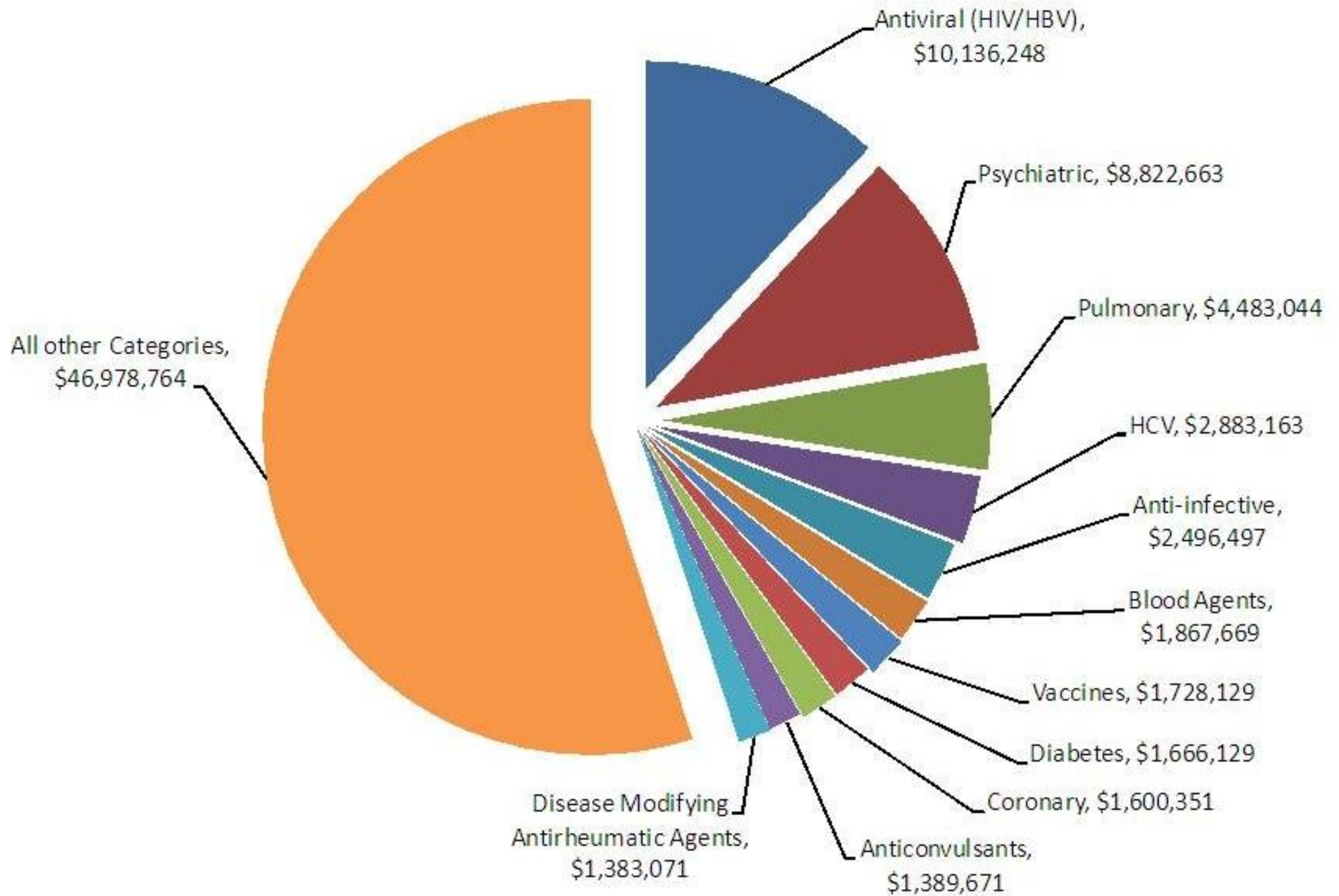

Health Care Appeals - Third Level
May 2012 - August 2012
1800
1600
1400
1200
1000
800
600
400
200
0
511
528
547
544
675
470
533
524
1399
1500
1544
1579
Number of Appeals Received
Number of Appeals Adjudicated
Open Appeals
May-12
Jun-12
Jul-12
Aug-12

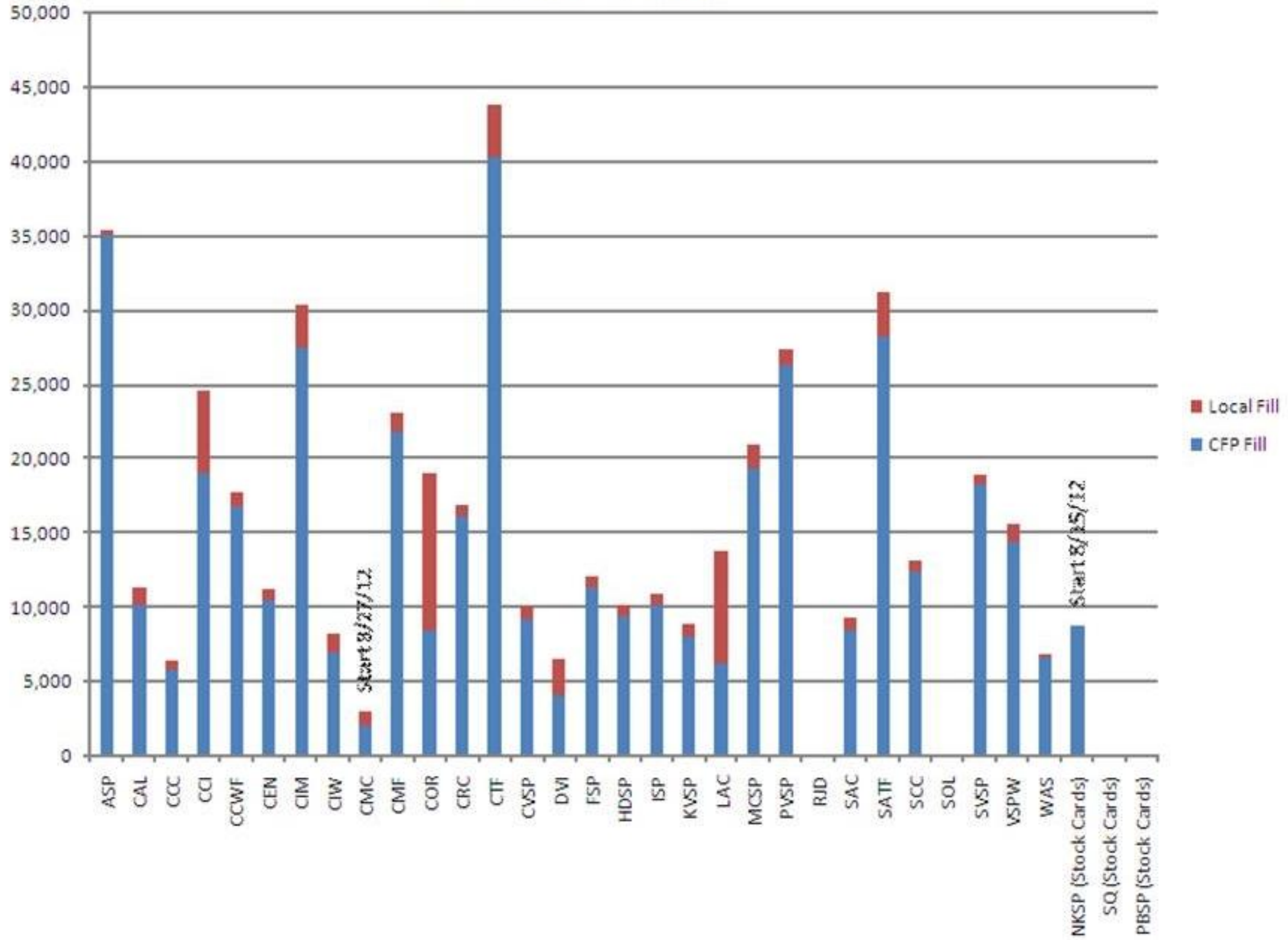

Petitions for Writ of Habeas Corpus
May 2012 - August 2012
12
10
8
6
4
2
0
6
5
11
3
8
3
6
7
4
5
7
5
Petitions Received
Completed MD Reviews
Petitions Closed
May-12
Jun-12
Jul-12
Aug-12

APPENDIX 8


Top Drugs Purchased May Through Aug-2012
Pegasys, $2,883,163
Abilify, $2,629,586
Truvada, $2,378,810
Atripla, $2,299,209
Risperidone, $2,070,184
Flovent, $1,809,928
Insulin, $1,461,651
Reyataz, $1,317,793
Ziprasidone, $1,151,422
Invega, $800,765
Enbrel, $778,878
All Other Drugs, $27,397,375

Top Therapeutic Categories May Through Aug-2012




Central Pharmacy Service Level May Through Aug-2012
(29 Facilities Served)
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Local Fill
CFP Fill
Start 3/27/12
Start 8/15/12
ASP
CAL
CCC
CCI
CCWF
CEN
CIM
CIW
CMC
CMF
COR
CRC
CTF
CVSP
DVI
FSP
HDSP
ISP
KVSP
LAC
MCSP
PVSP
RJD
SAC
SATF
SCC
SOL
SVSP
VSPW
WAS
NKSP (Stock Cards)
SQ (Stock Cards)
PBSP (Stock Cards)

APPENDIX 9

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Discussion and Analysis of Unaudited Financial Statements
For the Period July 1, 2011 through June 30, 2012

The June 30, 2012 financial statements of the California Prison Health Care Receivership Corp (CPR) are presented in compliance with the measurement focus, basis of accounting and financial presentation set forth by the Government Accounting Standards Board (GASB), and include a Statement of Net Assets and General Fund Balance (Balance Sheet) and a Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance (Revenues and Expenses). In lieu of comparing net asset and operating activities to prior period amounts, operating activities are compared to budget.

A review of expenses included on the unaudited statement of activities compared to what was budgeted for the twelve months ended June 30, 2012 shows a total difference of $3,932,909 or 65.6 % variance under budget. One line item or activities in the statement account for the majority of the difference.

Professional fees were $4,040,509 or 84.8% under budget. The Legal costs anticipated in the budget have been much less to date than originally considered primarily because of timing with court dates and filings.

Capital assets have decreased $94,226,885 for the twelve months ending June 30, 2012. The primary reason for the decrease was the transfer of all remaining capital projects from CPR records to CDCR accounting records.

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the Twelve months ended
June 30, 2012

	General Fund	Adjustments	Statement of Net Assets
Assets			
Current assets:			
Cash	$77,738	$ -	$ 77,738
Prepaid items	$0	-	-
	77,738	-	77,738
Noncurrent assets:			
Deposits with others	(6,823)	-	(6,823)
Capital assets, net	-	$0	-
Total assets	$ 70,915	-	$ 70,915
Liabilities			
Liabilities:			
Accounts payable	196,118	-	196,118
Accrued salaries and benefits	37,798	-	37,798
Other accrued expenses	61,102		61,102
Compensated absences	0	55,415	55,415
Total liabilities	$ 295,018	$ 55,415	$ 350,433
Fund Balance/Net Assets			
Fund balance:			
Reserved for prepaid items and deposits with others	(6,823)	6,823	-
Unreserved, undesignated	(217,280)	217,280	-
Total fund balance	(224,103)	224,103	-
Total liabilities and fund balance	$ 70,915		
Net assets:			
Invested in capital assets, net of related debt		-	-
Unrestricted		(329,814)	(329,814)
Total net assets		$ (329,814)	$ (329,814)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the Twelve months ended
June 30, 2012

	General Fund	Adjustments	Statement of Activities
Revenues			
Program revenues:			
Operating grants and contributions:			
State of California appropriation to Receivership	$ 1,625,000	-	$ 1,625,000
General revenues:			
Investment earnings	117	-	117
Miscellaneous Income	8,781	-	8,781
Total revenues	1,633,898	-	1,633,898
Expenditures/Expenses:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	1,102,667	-	1,102,667
Legal and professional services	723,611	-	723,611
Travel	27,159	-	27,159
Rents and leases	(15,121)	-	(15,121)
Insurance	18,638	-	18,638
Other	209,567	-	209,567
Depreciation	0	1,170,056	1,170,056
Capital outlay - Fixed Assets	-	93,056,829	93,056,829
Total expenditures/expenses	2,066,522	94,226,885	96,293,407
Change in fund balance	(432,625)	432,625	-
Change in net assets	-	(94,226,885)	(94,659,510)
Fund balance/net assets - July 1, 2011	158,226	94,031,467	94,329,697
Fund balance/net assets - June 30, 2012	$ (274,399)	$ 237,207	$ (329,813)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the Twelve months ended
June 30, 2012

	Final Budget	Actual (Budgetary Basis)	Variance between Final Budget and Actual
Revenues:			
State of California appropriation to Receivership	$5,999,431	$1,625,000	$ (4,374,431)
Investment earnings	$0	$117	117
Miscellaneous Income	-	$8,781	8,781
Total revenues	$5,999,431	$1,633,898	(4,365,533)
Expenditures:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	1,006,248	1,102,667	(96,419)
Legal and professional services	4,764,120	723,611	4,040,509
Travel	36,000	27,159	8,841
Rents and leases	2,539	(15,121)	17,660
Office expenses	18,000	7,635	10,365
Telephone and network	6,780	6,729	51
Insurance	18,000	18,638	(638)
Other	147,744	$195,203	(47,459)
Capital outlay	-	-	-
Total expenditures	5,999,431	2,066,522	3,932,909
Change in fund balance	$ -	(432,625)	$ (432,625)
GAAP basis difference - compensated absences	$0	-	-
Fund balance - July 1, 2011		158,226	
Fund balance - June 30, 2012		$ (274,399)	

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the eleven months ended
May 31, 2012

	General Fund	Adjustments	Statement of Net Assets
Assets			
Current assets:			
Cash	$60,189	$ -	$ 60,189
Prepaid items	$0	-	-
	60,189	-	60,189
Noncurrent assets:			
Deposits with others	(4,355)	-	(4,355)
Capital assets, net	-	$0	-
Total assets	$ 55,834	-	$ 55,834
Liabilities			
Liabilities:			
Accounts payable	75,696	-	75,696
Accrued salaries and benefits	141,741	-	141,741
Other accrued expenses	(36,176)		(36,176)
Compensated absences	0	55,415	55,415
Total liabilities	$ 181,261	$ 55,415	$ 236,676
Fund Balance/Net Assets			
Fund balance:			
Reserved for prepaid items and deposits with others	(4,355)	4,355	-
Unreserved, undesignated -	(121,072)	121,072	-
Total fund balance	(125,427)	125,427	-
Total liabilities and fund balance	$ 55,834		
Net assets:			
Invested in capital assets, net of related debt		-	-
Unrestricted		(286,553)	(286,553)
Total net assets		$ (286,553)	$ (286,553)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the eleven months ended
May 31, 2012

	General Fund	Adjustments	Statement of Activities
Revenues			
Program revenues:			
Operating grants and contributions:			
State of California appropriation to Receivership	$ 1,475,000	-	$ 1,475,000
General revenues:			
Investment earnings	110	-	110
Miscellaneous Income	8,781	-	8,781
Total revenues	1,483,891	-	1,483,891
Expenditures/Expenses:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	1,010,519	-	1,010,519
Legal and professional services	640,270	-	640,270
Travel	23,400	-	23,400
Rents and leases	(15,851)	-	(15,851)
Insurance	17,074	-	17,074
Other	197,842	-	197,842
Depreciation	0	1,170,056	1,170,056
Capital outlay - Fixed Assets	-	93,056,829	93,056,829
Total expenditures/expenses	1,873,255	94,226,885	96,100,140
Change in fund balance	(389,364)	389,364	-
Change in net assets	-	(94,226,885)	(94,616,249)
Fund balance/net assets - July 1, 2011	158,226	94,031,467	94,329,697
Fund balance/net assets - May 31, 2012	$ (231,138)	$ 193,946	$ (286,552)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the eleven months ended
May 31, 2012

	Final Budget	Actual (Budgetary Basis)	Variance between Final Budget and Actual
Revenues:			
State of California appropriation to Receivership	$5,499,690	$1,475,000	$ (4,024,690)
Investment earnings	$0	$110	110
Miscellaneous Income	-	$8,781	8,781
Total revenues	$5,499,690	$1,483,891	(4,015,799)
Expenditures:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	922,394	1,010,519	(88,125)
Legal and professional services	4,367,110	640,270	3,726,840
Travel	33,000	23,400	9,600
Rents and leases	2,539	(15,851)	18,390
Office expenses	16,500	7,212	9,288
Telephone and network	6,215	5,630	585
Insurance	16,500	17,074	(574)
Other	135,432	$185,000	(49,568)
Capital outlay	-	-	-
Total expenditures	5,499,690	1,873,255	3,626,435
Change in fund balance	$ -	(389,364)	$ (389,364)
GAAP basis difference - compensated absences	$0	-	-
Fund balance - July 1, 2011		158,226	
Fund balance - May 31, 2012		$ (231,138)	

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Discussion and Analysis of Unaudited Financial Statements
For the Period July 1, 2012 through August 31, 2012

The August 31, 2012 financial statements of the California Prison Health Care Receivership Corp (CPR) are presented in compliance with the measurement focus, basis of accounting and financial presentation set forth by the Government Accounting Standards Board (GASB), and include a Statement of Net Assets and General Fund Balance (Balance Sheet) and a Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance (Revenues and Expenses). In lieu of comparing net asset and operating activities to prior period amounts, operating activities are compared to budget.

A review of expenses included on the unaudited statement of activities compared to what was budgeted for the two months ended August 31, 2012 shows a total difference of $ 600,914 or 61.6% variance under budget. One line item or activity in the statement account for the majority of the difference.

Professional fees were $612,035 or 77.1% under budget. The Legal costs anticipated in the budget have been much less to date than originally considered primarily because of timing with court dates and filings. We do anticipate legal costs to ramp up to budgeted levels for the fiscal year.

Capital assets have not increased during the first two months of the Fiscal year.

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the two months ended
August 31, 2012

	General Fund	Adjustments	Statement of Net Assets
Assets			
Current assets:			
Cash	($44,999)	$ -	$ (44,999)
Prepaid items	$0	-	-
	(44,999)	-	(44,999)
Noncurrent assets:			
Deposits with others	(5,864)	-	(5,864)
Capital assets, net	-	$0	-
Total assets	$ (50,863)	-	$ (50,863)
Liabilities			
Liabilities:			
Accounts payable	38,370	-	38,370
Accrued salaries and benefits	31,627	-	31,627
Other accrued expenses	96,663		96,663
Compensated absences	0	55,415	55,415
Total liabilities	$ 166,660	$ 55,415	$ 222,075
Fund Balance/Net Assets			
Fund balance:			
Reserved for prepaid items and deposits with others	(5,864)	5,864	-
Unreserved, undesignated -	(211,659)	211,659	-
Total fund balance	(217,523)	217,523	-
Total liabilities and fund balance	$ (50,863)		
Net assets:			
Invested in capital assets, net of related debt		-	-
Unrestricted		(378,648)	(378,648)
Total net assets		$ (378,648)	$ (378,648)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the two months ended
August 31, 2012

	General Fund	Adjustments	Statement of Activities
Revenues			
Program revenues:			
Operating grants and contributions:			
State of California appropriation to Receivership	$ 325,000	-	$ 325,000
General revenues:			
Investment earnings	16	-	16
Miscellaneous Income	0	-	-
Total revenues	325,016	-	325,016
Expenditures/Expenses:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	182,342	-	182,342
Legal and professional services	181,985	-	181,985
Travel	3,983	-	3,983
Insurance	3,128	-	3,128
Other	2,412	-	2,412
Depreciation	0	0	-
Capital outlay - Fixed Assets	-	-	-
Total expenditures/expenses	373,850	-	373,850
Change in fund balance	(48,834)	48,834	-
Change in net assets	-	-	(48,834)
Fund balance/net assets - July 1, 2012	(274,399)	237,207	(329,813)
Fund balance/net assets - August 31, 2012	$ (323,233)	$ 286,041	$ (378,647)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the two months ended
August 31, 2012

	Final Budget	Actual (Budgetary Basis)	Variance between Final Budget and Actual
Revenues:			
State of California appropriation to Receivership	$974,764	$325,000	$ (649,764)
Investment earnings	$0	$16	16
Miscellaneous Income	-	$0	-
Total revenues	$974,764	$325,016	(649,748)
Expenditures:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	167,364	182,342	(14,978)
Legal and professional services	794,020	181,985	612,035
Travel	3,600	3,983	(383)
Office expenses	3,000	554	2,446
Telephone and network	1,430	1,038	392
Insurance	3,000	3,128	(128)
Other	2,350	$820	1,530
Capital outlay	-	-	-
Total expenditures	974,764	373,850	600,914
Change in fund balance	$ -	(48,834)	$ (48,834)
GAAP basis difference - compensated absences	$0	-	-
Fund balance - July 1, 2012		(274,399)	
Fund balance - August 31, 2012		$ (323,233)	

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION

Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the one month ended
July 31, 2012

	General Fund	Adjustments	Statement of Net Assets
Assets			
Current assets:			
Cash	$109,523	$ -	$ 109,523
Prepaid items	$0	-	-
	109,523	-	109,523
Noncurrent assets:			
Deposits with others	(9,251)	-	(9,251)
Capital assets, net	-	$0	-
Total assets	$ 100,272	-	$ 100,272
Liabilities			
Liabilities:			
Accounts payable	235,342	-	235,342
Accrued salaries and benefits	39,649	-	39,649
Other accrued expenses	5,622		5,622
Compensated absences	0	55,415	55,415
Total liabilities	$ 280,613	$ 55,415	$ 336,028
Fund Balance/Net Assets			
Fund balance:			
Reserved for prepaid items and deposits with others	(9,251)	9,251	-
Unreserved, undesignated -	(171,090)	171,090	-
Total fund balance	(180,341)	180,341	-
Total liabilities and fund balance	$ 100,272		
Net assets:			
Invested in capital assets, net of related debt		-	-
Unrestricted		(341,467)	(341,467)
Total net assets		$ (341,467)	$ (341,467)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the one month ended
July 31, 2012

	General Fund	Adjustments	Statement of Activities
Revenues			
Program revenues:			
Operating grants and contributions:			
State of California appropriation to Receivership	$ 175,000	-	$ 175,000
General revenues:			
Investment earnings	8	-	8
Miscellaneous Income	0	-	-
Total revenues	175,008	-	175,008
Expenditures/Expenses:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	91,608	-	91,608
Legal and professional services	90,985	-	90,985
Travel	1,333	-	1,333
Insurance	1,564	-	1,564
Other	1,171	-	1,171
Depreciation	0	0	-
Capital outlay - Fixed Assets	-	-	-
Total expenditures/expenses	186,661	-	186,661
Change in fund balance	(11,653)	11,653	-
Change in net assets	-	-	(11,653)
Fund balance/net assets - July 1, 2012	(274,399)	237,207	(329,813)
Fund balance/net assets - July 31, 2012	$ (286,052)	$ 248,860	$ (341,466)

CALIFORNIA HEALTH CARE RECEIVERSHIP CORPORATION
Statement of Activities and General Fund Revenues, Expenditures and Changes in Fund Balance
For the one month ended
July 31, 2012

	Final Budget	Actual (Budgetary Basis)	Variance between Final Budget and Actual
Revenues:			
State of California appropriation to Receivership	$487,382	$175,000	$ (312,382)
Investment earnings	$0	$8	8
Miscellaneous Income	-	$0	-
Total revenues	$487,382	$175,008	(312,374)
Expenditures:			
Prison health care administration and oversight:			
Current:			
Salaries and benefits	83,682	91,608	(7,926)
Legal and professional services	397,010	90,985	306,025
Travel	1,800	1,333	467
Office expenses	1,500	276	1,224
Telephone and network	715	484	231
Insurance	1,500	1,564	(64)
Other	1,175	$411	764
Capital outlay	-	-	-
Total expenditures	487,382	186,661	300,721
Change in fund balance	$ -	(11,653)	$ (11,653)
GAAP basis difference - compensated absences	$0	-	-
Fund balance - July 1, 2012		(274,399)	
Fund balance - July 31, 2012		$ (286,052)	

APPENDIX 10

Vendor Engaged by the Receiver During this Reporting Period Relating to Services to Assist the Receivership in the Development and Delivery of Constitutional Medical Care Within the California Department of Corrections and Rehabilitation ("CDCR") and its Prisons

During this reporting period, the Receiver has used the substitute contracting process to assist the Office of the Receiver in the development and delivery of constitutional care within CDCR and its prisons. The Receiver has engaged the following vendor for provision of the services noted:

Information Technology

Pharmacy Project

Automated Pharmacy Dispensing Cabinetry

During this reporting period, the Office of the Receiver engaged a contractor, Omnicell, for leasing of automated pharmacy dispensing cabinetry, including all propriety software for the California Health Care Facility (CHCF) – Stockton.

The contractor will: a) deliver and install 50 cabinets; b) train CHCF clinical and nursing staff on the implementation and use of equipment; c) perform maintenance and operation services both on-site and remotely; and d) work with CCHCS and Maxor National Pharmacy Service Corporation to build an Omnicell-Guardian Rx interface. The automated Omnicell pharmacy cabinets will provide institutional medical staff with 24-hour access to medications.

The Office of the Receiver procured this contract via the sole source bidding process, as CCHCS determined that Omnicell was the only vendor providing automated cabinets that meet all of the institutional requirements.