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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 KJM-KJN
JOHN ARMSTRONG, et al., *Plaintiffs*, v. EDMUND G. BROWN, JR., et al., *Defendants*.	Case No. C94-2307 CW

NOTICE OF FILING OF RECEIVER'S THIRTY-SECOND TRI-ANNUAL REPORT

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

Dated: June 1, 2016

FUTTERMAN DUPREE
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By:/s/ Martin H. Dodd
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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

Thirty-second Tri-Annual Report of the Federal Receiver For January 1–April 30, 2016

June 1, 2016

California Correctional Health Care Receivership

Vision:

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

Mission:

Reduce avoidable morbidity and mortality and protect public health by providing patients timely access to safe, effective and efficient medical care, and integrate the delivery of medical care with mental health, dental and disability programs.

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Section 1: Executive Summary and Reporting Requirement

A. Reporting Requirements and Reporting Format

This is the thirty-second report filed by the Receivership, and the twenty-sixth submitted by Receiver J. Clark Kelso.

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

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

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

Judge Thelton Henderson issued an order on March 27, 2014, entitled *Order Re: Receiver's Tri-Annual Report* wherein he directs the Receiver to discuss in each Tri-Annual Report the level of care being delivered at California Health Care Facility (CHCF); difficulties with recruiting and retaining medical staff statewide; sustainability of the reforms the Receiver has achieved and plans to achieve; updates on the development of an independent system for evaluating the quality of care; and the degree, if any, to which custodial interference with the delivery of care remains a problem.

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

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

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

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

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

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

B. Progress during this Reporting Period

Progress towards improving the quality of health care in California's prisons continues for the reporting period of January 1 through April 30, 2016, and includes the following:

Electronic Health Records System

In response to information received from the pilot institutions (Folsom State Prison [FSP]/Folsom Women's Facility, California Institution for Women [CIW] and Central California Women's Facility [CCWF]), modifications are being made to the Electronic Health Records System (EHRS), especially in the area of Pharmacy. Deployment to the remaining institutions will be delayed to give the Project Team and programs a chance to resolve those identified areas needing improvement. For more information on EHRS efforts, refer to page seven.

Office of the Inspector General – Cycle 4

The Office of the Inspector General's (OIG's) Cycle 4 Medical Inspections commenced during the week of January 26, 2015. As of the closing of this reporting period, 27 medical inspections have been conducted. During this reporting period, medical inspections were completed at the following CDCR institutions: Ironwood State Prison (ISP), Avenal State Prison (ASP); San Quentin State Prison; CIW; California Substance Abuse Treatment Facility (SATF); California Medical Facility (CMF); Calipatria State Prison (CAL); California State Prison, Corcoran (COR); Salinas Valley State Prison (SVSP); California State Prison, Los Angeles County (LAC); and, Pleasant Valley State Prison (PVSP). Final reports which contain the overall ratings for all sites inspected during this reporting period are pending completion by the OIG.

The Receiver delegated to CDCR authority for the medical operations at FSP on July 13, 2015; Correctional Training Facility (CTF) on March 9, 2016; and Chuckawalla Valley State Prison (CVSP) on May 18, 2016. Institution performance continues to be monitored to ensure sustainability. Meet and Confer sessions have been scheduled with internal and external stakeholders to discuss delegation of additional institutions.

Armstrong

Field Operations staff continues to provide feedback with institution leadership to ensure all patients who rely on sign language interpreter (SLI) services are able to effectively communicate with their health care provider during all medical, nursing, dental and mental health appointments and the use of an SLI has been appropriately documented. Chart audits of all health care encounters for every patient requiring sign language as their primary method of communication continued during the review period. The average percentage of health care encounters where an SLI was appropriately used and documented between December 2015 and April 2016 was 77.45 percent. The average percentage of health care encounters where an SLI was appropriately used and documented from the previous reporting period was 58.38 percent. This represents a 19.07 percentage point increase in the court-mandated 100 percent compliance rate.

Health Care Appeals Pilot

A Health Care Appeals Pilot (Pilot) was filed with the Secretary of State on September 1, 2015, promoting a more efficient program to reduce cancellations/rejections; ensure timely clinical triage; increase quality of responses; and reduce redundancy or inconsistencies. Three institutions were identified to participate in the Pilot: CCWF, SATF, and California State Prison, Solano (SOL).

The Pilot focuses on two main changes, as follows:

1) The implementation of the Health Care Appeals Registered Nurse (HCARN) to conduct clinical triage and facilitate early face-to-face clinical intervention, if necessary; and
2) The elimination of one institutional level of review.

As of April 30, 2016, there has been a reduction (32 percent) in the number of health care appeals filed, a reduction (46 percent) in the number of health care appeals screened out, and an increase (32 percent) in the number of appeals resolved at the institutional level (not escalated to headquarters' level). Plans are currently underway to implement the elements of the Pilot statewide.

HCARN intervention has made patient access to care more efficient in the following ways:

- Identification of urgent/emergent clinical issues and appeals; ensuring timely clinical interface, regardless of how the health care appeal itself will be processed.
- Patient education regarding existing plan of care, medications, appointments, etc., and allowing patients to ask questions during the interview process.

- Submitting a CDC 7362, Health Care Services Request Form, on behalf of the patient.
  - Prior to the Pilot, the Health Care Appeals Office (HCAO) was rejecting appeals, sending them back to the patient, and instructing the patient to submit their own CDC 7362 for access to health care staff.
  - Under the Pilot, the HCAO may still reject appeals, but will submit a CDC 7362 on behalf of the patient, ensuring he or she will be seen by health care staff.

Joint Commission

CCHCS first began to consider Joint Commission accreditation for California's prison health care programs early last year, as documented in the Receiver's 27th Tri-Annual Report. Initial efforts included a gap analysis comparing Joint Commission standards against current CDCR policy and practice, identification of standards that might need to be modified or interpreted differently to fit a correctional setting, and mock accreditation surveys at three sites (FSP, Mule Creek State Prison [MCSP], and headquarters).

To achieve accreditation, CDCR institutions will have to meet high standards of quality and safety, and continue meeting them during each three-year accreditation cycle. CDCR institutions would be subject to different accreditation programs depending on the nature of each institution's mission (refer to Table 1).

Table 1: Joint Commission Accreditation Programs Pertinent to CCHCS Programs

Accreditation Program	Focus	Application in the CDCR
Ambulatory Health Care Accreditation	Outpatient primary medical and dental care	All Institutions
Behavioral Health Care Accreditation	Mental health services	Institutions with mental health missions (e.g., not camps)
Nursing Care Center Accreditation	Inpatients beds / other types of specialized nursing care sites	Institutions with Correctional Treatment Centers and Outpatient Housing Units

In February 2016, the Receiver set a target for the first phase of Joint Commission accreditation, which was to pursue Joint Commission accreditation for all appropriate institutions beginning in calendar year 2018. During this reporting period, staff began to develop a roadmap for accreditation, which includes the following:

- Establishing a multi-disciplinary steering committee for the project.
- Meeting with national Joint Commission Accreditation Program Directors to determine which accreditation programs apply to our institutions, different options for the accreditation rollout, and associated accreditation fees.
- Updating the previously completed gap analysis to reflect the most recent version of Joint Commission standards and connecting different program areas with experts in Joint Commission standards to identify necessary policy changes.

- Convening a focus group of staff with prior experience in Joint Commission surveys or different types of accreditation programs/inspections to develop a model for 1) preparing institutions for accreditation, and 2) managing accreditation rollout from a regional and statewide perspective.
- Identifying resources that might be required to achieve accreditation.

In April 2016, CCHCS established an Intranet site on the Quality Management (QM) Portal to make available to CCHCS staff various key accreditation resources, such as copies of the specific standards for each accreditation program and survey guides, available to CCHCS staff.

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

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

In-State Contracting for Community Correctional Facilities

The total Modified Community Correctional Facility (MCCF) patient population as of April 30, 2016, is 3,885 with a budgeted capacity of 4,218.

The Contract Beds Unit (CBU) within the Division of Adult Institutions (DAI) has finalized the In-State Vendor contract amendments previously implemented as recommended by CCHCS. Each MCCF has managed to consistently, with some challenges, employ a full-time physician. Effective February 29, 2016, Delano MCCF successfully met the staffing requirement by hiring a full-time physician.

Utilizing the newly developed medical inspection compliance audit tool, CCHCS conducted three Health Care Monitoring Audits at Central Valley MCCF, Desert View MCCF, and Delano MCCF. Audit findings for Central Valley MCCF and Desert View MCCF were rated as Inadequate and findings for Delano MCCF are pending.

Based on the inability to retain a permanent full time physician, two facilities, Desert View MCCF and Delano MCCF, were closed to new admissions for approximately one month by CBU until a physician could be hired.

Out-of-State Contract Facilities

In CDCR's continued efforts to reduce the California Out-of-State Correctional Facilities population by returning patients to a CDCR institution or MCCF within California, a second facility was closed. The Florence Correctional Center (FCC) in Arizona was officially closed in January 2016. The remaining two out-of-state facilities include Tallahatchie County Correctional Facility (TCCF) in Mississippi, and La Palma Correctional Center in Arizona. From January 8, 2016 to April 30, 2016, the California Out-of-State Correctional Facilities

population was reduced by 333 patients, for a total population of 4,927, with a budgeted patient capacity of 5,828.

Health Care Monitoring Audit reports were completed for TCCF which was rated as Inadequate and FCC, which was rated Adequate. TCCF was closed to intake for approximately two months as a result of receiving an Inadequate rating on the on-site audit.

Transportation Vehicles

Previous Tri-Annual Reports have documented the difficulties CDCR has experienced in the process of ensuring that each institution has adequate health care transport vehicles, as agreed to when this responsibility was delegated to them in late 2012. CDCR continues to work towards establishing a cohesive procurement plan that addresses the replacement of health care transport vehicles within the confines of their Vehicle Fleet Assessment Plan.

Following the October 2012 delegation of oversight and procurement of all health care vehicles to CDCR, CCHCS identified 13 Emergency Response Vehicles (ERV) and one electric cart ERV, five para-transit mini-buses, and one 22-passenger para-transit bus that required replacement. Over the past several years, the majority of these identified vehicles were systematically replaced. The ERVs were purchased with Fiscal Year (FY) 2013–14 funds, all 13 have been received and are in service, and the electric cart ERV has a delivery date of May 2016. CDCR and CCHCS took delivery of three of the five mini para-transit buses that were purchased with FY 2014–15 funds; however, the remaining two mini-buses have structural design issues and are awaiting Department of General Services inspection approval. CDCR and CCHCS are anticipating delivery of the 22 passenger para-transit bus in the third quarter of 2016.

In the last Tri-Annual Report, it was documented that prior to the transition for oversight of the procurement process to the Assistant Deputy Director, Office of Business Services staff processed a FY 2014–15 procurement order for 185 new vehicles, of which 22 (11 percent) were designated for health care services. Following the transition, the total number of vehicles purchased was increased to 255 in FY 2014–15. Out of the total of 255 vehicles, 62 (24 percent) vehicles were designated for health care transport vehicles. DAI has received all 62 vehicles and all received vehicles have been retrofitted with security modifications. There are three vehicles in the final process of telecommunication installation and are expected to be in service in May 2016.

During the last reporting period, it was reported that after receiving the results of a statewide vehicle survey, DAI submitted proposed procurement orders for 251 vehicles for FY 2015–16. Of the proposed purchase orders, 217 (86 percent) were identified as health care vehicles. However, based upon available funding and re-evaluating departmental priorities, the actual purchase orders submitted by CDCR/DAI totaled 180 vehicles for FY 2015–16. Of the purchase orders submitted, 150 (83 percent) have been identified as health care vehicles. CDCR/DAI have projected a delivery date of these vehicles in the second quarter of 2017.

Section 2: Status and Progress Concerning Remaining Statewide Gaps

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

A. Availability and Usability of Health Information

As reported in the Thirty-First Tri-Annual Report, Cerner Corporation was selected to provide a commercial "off-the-shelf" EHRS for CCHCS. This system will provide CCHCS and CDCR demonstrable and sustained benefits to patient safety, quality and efficiency of care, and staff efficiencies and satisfaction. The EHRS project is part of a larger organizational transformation project entitled ECHOS – Electronic Correctional Healthcare Operational System. The project is presently in the pilot implementation phase.

During this reporting period, challenges to efficient and effective use of the solution most notably related to Pharmacy operations were identified. As a result, CCHCS has deferred any further rollout while these issues are addressed. The EHRS project team continues to address other technical, workflow and training revisions identified at our pilot institutions. Train-the-trainer training for the next participants was conducted and EHRS team members have continued engaging Change Ambassadors from the field and headquarters to provide solution demonstrations (e.g., effective communication, medication administration and scheduling) to the respective next wave institutions and staff.

As part of the Governor's May Revision to the Governor's proposed budget for 2016–17, CCHCS and CDCR requested funding for the integration of an electronic dental record solution into the EHRS. Funding was also requested for additional support for the EHRS project, as a result of the experience gained through piloting the solution at the three institutions and headquarters. The funding is awaiting action by the Legislature.

Overall, the EHRS project is 52 percent complete, and implementation of the EHRS at the next wave of institutions will occur during this year. Complete EHRS deployment is estimated to be complete by December 2017.

B. Scheduling and Access to Care

To mitigate potential risk to patients and ensure that the organization's current high performance in access continues under the new EHRS, CCHCS has initiated a third phase to the Scheduling Process Improvement (SPI) Initiative begun in 2014, which will:

- Work with EHRS institutions to refine key workflows that impact scheduling.

- Package and disseminate standardized workflows to institutions statewide.
- Redefine the scheduling infrastructure introduced in SPI Phase 2 for an EHRS environment.
- Provide institutions with reports similar to those previously available under MedSATS and Mental Health Tracking System (MHTS).
- Introduce new monitoring tools, such as the EHRS Diagnostic Report and Huddle Report, to assist institutions in identifying and addressing potential risks to patients, correcting inaccurate or incomplete orders and scheduling data, and monitoring scheduling process reliability and efficiency.

CCHCS has established an SPI Phase 3 Workgroup to manage this initiative; it reports to the statewide Complete Care Oversight Team.

Progress toward the goals listed above continues as follows:

Standardizing Scheduling Practices. During this reporting period, SPI support staff studied scheduling-related workflows implemented at the three EHRS pilot institutions through on-site observation and focus group sessions with subject matter experts at headquarters. A large part of this effort entailed mapping how schedulable orders work in actual application, including staff roles and responsibilities and the way scheduling information is transmitted and stored for viewing by health care staff. This analysis is ongoing, and important both for determining where scheduling processes need to be standardized and for designing decision support tools and reports.

During this reporting period, the SPI Workgroup identified gaps in scheduling data due to the inappropriate use of order types and resulting appointments. In EHRS, the process for establishing an appointment has two parts. First, a clinician must enter an order type, selecting from a pre-populated list. Once an order is entered into the system and transmitted to the scheduler's queue of pending orders, the scheduler sets a date for the appointment to occur.

Analysis of pilot institution scheduling data indicates that providers use a wide range of orders for the same type of appointment. This is problematic for tracking purposes and decision support. For example, if a provider uses an episodic care appointment type for a patient requiring follow-up after returning from a higher level of care, a number of problems may occur, as follows:

- Schedulers may get confused about which compliance date applies;
- Automated reports may not flag appointments correctly when they are nearing the compliance due date;
- The appointment may not be placed in the appropriate category for Dashboard reporting and other types of access monitoring; and,
- Ultimately, the patient may not be seen within timeframes appropriate to his or her situation.

To correct this, the SPI Workgroup will create a guide for applying order types, complemented by a standardized set of "order favorites" in EHRS that will steer health care staff toward selecting the correct order type.

SPI Workgroup staff have also found that pilot institutions are not consistently creating orders for walk-in patients or nurse co-consultations with a Primary Care Provider (PCP). Workgroup members are reviewing current workflows related to orders in this area and refining training materials to ensure care team members and scheduling staff are provided clear direction on how to record walk-ins and co-consultations.

Scheduling Tools and Reports. With the rollout of EHRS, pilot institutions lost access to scheduling reports they used to manage everyday operations, such as reports that told scheduling managers which appointments were not yet scheduled, appointments close to their compliance date, and appointments that should have been closed in the system but still showed as open. For much of this reporting period, SPI staff focused on understanding the EHRS scheduling user interface and its data fields and producing scheduling data, which continues to be validated by pilot institution staff in the field.

- MedSATS-Type Management Reports. During this reporting period, SPI staff had developed a new set of operational reports that provided information similar to what was previously found in MedSATS "close to compliance" and aging reports. The intent of these reports is to assist schedulers and clinic managers in assessing and prioritizing queues of pending/unscheduled orders, as well as ensuring that an appointment status is accurately reflected in the system, which is essential for tracking purposes. The new EHRS scheduling reports, which include backlog trends by care team or queue, are expected to be released to pilot institutions in May 2016.

- Scheduling Diagnostic Report. In 2015, as part of the Focus Institutions Learning Collaborative, CCHCS made available to institutions a Scheduling Diagnostic Report, which, among other data, broke down a number of key indicators by care team, including access measure performance, rescheduling and bundling rates, the rate of nursing referrals to the PCP, and productivity data. This report allows clinic managers to identify particular strengths and weaknesses of individual care teams relative to access to care and to provide targeted technical assistance in the areas a team needs it most. With the conversion from MedSATS to EHRS, pilot institutions no longer have access to this report. SPI staff are working to make this information available again for all EHRS institutions.

Scheduling Data Validation. Regardless what scheduling system CCHCS implements, it takes months and regular communication with institutions to obtain reliable scheduling data and an accurate picture of access to care that schedulers and managers can use for day-to-day operational management. It is anticipated that the same will be true for EHRS, as it will take

time to generate correct, usable scheduling data. During the rollout of MedSATS, Dental Scheduling Tracking System, and MHTS, institutions performed self-assessments to evaluate data quality and were provided with external validation reports identifying problem areas. During this reporting period, SPI staff began to flag potential inaccuracies for pilot institutions; this is intended to become a more formal validation effort as more institutions adopt EHRS.

C. Care Management

In summer 2014, CCHCS established the Population Management Care Coordination (PMCC) Committee with two main objectives: create a nursing focused care coordination model and improve health care transfers.

Care Coordination Subgroup

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

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

In summer 2014, the Care Coordination subgroup of the PMCC Committee established the Patient Acuity Tool, adopted from North Carolina Assessment, for use in licensed inpatient units (e.g., Correctional Treatment Centers [CTCs]) to ensure appropriate staffing based on patient acuity level. This tool has been integrated with the Patient Risk Stratification Tool for Population Management to make it more comprehensive and was tested at CHCF in October and November 2015. Development of policy and training for the use of this tool is delayed while we focus on implementing the Complete Care Model (CCM) and the EHRS. It is expected to resume early 2017.

The Care Coordination subgroup has also updated the Medication Management policy and procedures to be reflective of the CCM of health care delivery. Training was provided in December 2015 and the policy and procedures were implemented statewide on January 4, 2016.

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

- Establishing Patient Service Plans which is a tool used for patient management. This tool is the basis for Population Risk Stratification, which will standardize terminology and guide resource utilization in the management of entire patient populations.
- Developing Nursing Care Management policy and procedure, Reference Manual and Operational Guide. Training on Care Management of Complex Care Patients is integrated into the learning sessions for the CCM in 2016.

- Developing, modifying and updating the CCM series of policies and procedures which will incorporate Access to Primary Care, Primary Care Model, Preventive Clinical Services, Outpatient Specialty Services, Physical Therapy, Reception Health Care Policy and Chronic Care Disease Management. The CCM policy, which is the anchor of the series, was implemented in July 2015. The following series of policies and procedures have been completed and are in the 30-day stakeholder review process:
  - Care Teams and Patient Services Procedure
  - Scheduling and Access to Care Procedure
  - Scope of Patient Services Procedure
  - Population and Care Management Procedure
  - Outpatient Housing Unit Policy and Procedure

The following policies were approved and distributed to the field:

- Correctional Treatment Center Policy and Procedure – April 6, 2016
- Patient Care During Pregnancy and Childbirth Policy and Procedure – January 28, 2016

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

Complete Care Model Implementation

A fully implemented team-based primary care model is a top priority for CCHCS. During this reporting period, CCHCS took the following steps in pursuit of this goal:

- Established the CCOT, a statewide steering committee, to further refine the model and manage statewide implementation.
- Kicked off the statewide learning collaborative that will serve as the vehicle for implementing the new model.
- Began to develop an assessment tool to accurately gauge status of CCM implementation at individual institutions as part of evaluating EHRS readiness/adoption.

Complete Care Oversight Team

CCOT was established to manage CCM implementation including, but not limited to the following:

- Providing strategic direction on implementation of the CCM.
- Evaluating performance, design and implement CCM improvement initiatives.
- Communicating progress and coordinating sharing of CCM best practices statewide.
- Developing Learning Session content and other training to orient staff on CCM principles and associated systems and processes.

With representatives from various program areas and regional teams, the CCOT promotes a multidisciplinary and multi-level approach to overseeing organizational implementation of the CCM. Recent CCOT activities include working with regional teams to train executive teams from all institutions and EHRS subject matter experts in the first session of the CCM learning collaborative focusing on Care Team Infrastructure and Population Management. The next training focusing on Scheduling and Access to Care is expected for fall 2016.

Statewide Learning Collaborative

During this reporting period, CCOT and CCHCS regional teams introduced the CCM to the 25 institutions that were not part of the 2015 Focus Institutions Learning Collaborative, continuing to use the learning collaborative model as a rollout strategy as detailed in Figure 1, CCM Learning Collaborative Model, below.

Figure 1: CCM Learning Collaborative Model	
1	**Tools and Training.** Institution leadership teams attend Learning Sessions, where they are trained in Complete Care Model concepts and given guidance and direction about how to operationalize them at the institution. Each Learning Session offers decision support pertaining not only to CCM elements but also to change management strategies, such as implementation plans and checklists, forms, guides, and reports, to support successful implementation.
2	**Group Problem-Solving.** Whenever possible, Learning Sessions include multiple institutions. When one institution identifies a barrier, often another has had to deal with a similar situation and may have a viable solution. Each Learning Session sets aside time for sharing best practices and elevating issues that may be more of a statewide concern than an individual institution problem. For CCM implementation, staff from Focus Institutions are frequently asked to talk about their experiences implementing Complete Care.
3	**Regional Team Support Between Learning Sessions.** After each Learning Session, regional executives, consultants, and quality management staff deploy to the institutions to assist with implementation.
4	**Performance Reports.** Performance objectives are identified for each Learning Session, and performance reports are provided to each institution at least monthly to assess progress toward goals.
5	**Quality Management System.** Learning Sessions emphasize how to use the existing quality management system infrastructure, such as the Performance Improvement Work Plan, quality committees, and the local Quality Management Support Unit, to implement and manage Complete Care Model improvement projects.

During this reporting period, all CDCR institutions had received training and more than 30 available tools, which were also posted on a new CCM Intranet site accessible through a link on the QM Portal. Learning Session 1 emphasized putting infrastructure and processes in place to achieve stable primary care teams and routine population management. Objectives included, but were not limited to the following:

- Care Team Infrastructure
  - Form teams and establish panels.
  - Align care team members' schedules.
  - Co-locate team members where possible.
- Huddles
  - Hold huddles every clinic day with all core team members in attendance at least 95 percent of the time.
  - Cover required topics, using data from the Automated Huddle Report, among other sources.
- Population Management Working Session
  - Hold two sessions per month per team.
  - Core members in attendance.
  - Chief Medical Executive and Chief Nurse Executive facilitate.
  - Review population health performance trends.
  - Take action pursuant to guidelines to provide necessary services to individual patients.
  - Discuss new patients, clinically complex patients.
- Quality Management System
  - Use system to monitor and address CCM performance.

In February, March, and April 2016, regional teams visited institutions to provide on-site support as they implemented care team and population management infrastructure and processes, bridging the gap between expectations set by organizational leadership and how institution staff at all levels implement changes on the ground. Regional team assistance took many forms, including kick-off conferences to emphasize the importance of the project to institution staff; special training sessions tailored to staff with specific roles and responsibilities; clarification of the new standards; hands-on technical assistance as institution established care team back-up systems or redefined patient panels; helping institutions put processes in place to collect data for daily huddles; modeling how to conduct Population Management Working Sessions; mentorship of the leadership team and other institution staff as they manage the project locally; and observing huddles, working sessions, and providing feedback.

While on-site assisting institutions, regional teams also continuously evaluated institution progress toward CCM objectives, using standardized reporting tools. By the end of the reporting period, regional teams were able to report CCM trends relative to a range of infrastructure, process, and outcome measures.

CCM Assessment Tool – EHRS Readiness/Adoption Initiative

In October 2015, the new EHRS was implemented at three pilot institutions: CCWF, CIW, and FSP. Although each institution went through extensive system training and other proactive activities to prepare for the rollout, many of the health care staff had difficulties with the cut-over to the new system. The resulting work-around sometimes undermined core elements of the CCM, such as coordination across disciplines or team communication. To ensure that the remaining institutions use a sustainable approach to implement the EHRS system, remaining true to the CCM, CCOT formed an EHRS Readiness/Adoption Workgroup consisting of staff, clinical leadership and executives from headquarters, pilot institutions and regions.

The EHRS Readiness/Adoption Workgroup's goal is to establish a core set of measures that will help develop a strategy to fully prepare and assess readiness at remaining institutions before the EHRS implementation. The workgroup has gathered EHRS preparation tools, information, and feedback from pilot institutions and program areas to develop a set metrics that determine:

- Organizational Readiness: Specific criteria or process efficiencies that must be met by the organization before it can deploy EHRS, such as that core CCM infrastructure elements are in place.
- Rollout Placement: Factors that will influence an institution's "place in line" during the phased approach to implement the EHRS across all remaining institutions.
- Institution Readiness: Specific criteria or process efficiencies that must be met by an institution before it can deploy EHRS.
- Institution Adoption**:** Staff are able to demonstrate effective and efficient use of the EHRS in their day-to-day work, and surveillance data indicates that local system performance and patient outcomes are at or above baseline.

Workgroup members will be prioritizing the metrics and provide a recommended core set of metrics to CCOT.

Transfer Subgroup

In fall 2014, the Transfer subgroup of the PMCC Committee has bolstered the Medical Hold process, in which clinicians have the ability to hold patients at their institution until they are medically safe to be transferred to another institution. This ability prevents inappropriate transfers that could cause health care concerns for the patients. The ability to place a medical hold on a patient is now available electronically on the Medical Classification Chrono (MCC) application. This application automatically transfers the MCC 128-C3 information to the Strategic Offenders Management System (SOMS) simultaneously. Custody staff check the medical hold attribute in the MCC 128-C3 and place a hold as required. The subgroup has completed statewide education to both clinical and custody staff. CCHCS has provisioned Registered Nurse (RN) staff statewide on the ability to place a temporary medical hold on a patient to prevent inappropriate and unsafe transfers.

The Transfer subgroup has also updated the Health Care Transfer policy and procedure, which is currently in the executive level review. Several new tools were developed and are included in the draft procedure, including an automated Patient Summary sheet, which will also be an essential tool for care management, and a transfer check-list.

D. Health Care Infrastructure at Facilities

Clinical facility upgrades through the Health Care Facility Improvement Program (HCFIP) projects are progressing. Preliminary plans for all 32 projects have been approved by the State Public Works Board. During this reporting period, three projects (California Correctional Center, High Desert State Prison [HDSP], and PVSP) received Department of Finance (DOF) approval to award construction contracts. To date, of the 32 HCFIP projects, the State Fire Marshal (SFM) has approved working drawings for 27 projects, and DOF has approved the award of construction contracts for all 18 general contractor projects and Notices to Proceed have been issued. Working drawings for the last five projects (CAL; California State Prison, Centinela [CEN]; CVSP; ISP; and Pelican Bay State Prison) are being finalized. Upon completion, the drawings will be submitted to the SFM for approval and to the DOF for approval to proceed with construction.

Construction of the first HCFIP project at ASP was completed in February 2016 while construction activities progress at most of the other institutions. Construction of the first standalone Administrative Segregation Unit (ASU) Primary Care Clinic at LAC was completed in January 2016 and the first patient was seen on March 8, 2016. As for the Statewide Medication Distribution projects, construction at four of the 22 institutions was completed during this reporting period. HDSP and ISP were completed in March 2016, and CAL and CEN were completed in April 2016.

Schedule delays continue to occur based on, but not limited to, SFM design review, actual Notice to Proceed dates, on-site construction conditions, and efforts to safeguard operational continuity of care plans and the necessary swing space. The revised schedules reflect completion of construction and occupancy by early 2018.

Section 3: Quality Assurance and Continuous Improvement Program

Review of Performance Improvement Plan 2013–15 Performance Objectives – CCHCS Performance Report

As part of the transition to a new organization-wide Performance Improvement Plan (PIP) for 2016–18, the Quality Management Committee (QMC) commissioned a status report on the previous improvement plan, which covered 2013–15, in part to inform goal-setting and make decisions about which measures would remain front-and-center on the Dashboard over the next two years. In March 2016, the Statewide QMC shared the results of the progress review, releasing the 2015 CCHCS Performance Report, which evaluates progress in priority focus areas from the enterprise-wide PIP 2013–15, as well as lessons learned and recommendations for future improvement projects and activities. The full report is provided in *Appendix 1*, 2015 CCHCS Performance Report.

The 2015 CCHCS Performance Report highlights four major findings:

1. CCHCS is at goal or close to goal in most measures. Statewide performance exceeds goal or is close to goal in 33 of the 34 aggregate performance measures tracked monthly in the Health Care Services Dashboard.
2. CCHCS is performing better than it has before and better than some community health care organizations in some measures. Twelve of the PIP 2013–15 performance measures use Effective Data and Information Set methodology to allow for comparison with other health care organizations nationwide. CCHCS surpasses the 75th percentile of national health plans in ten of the 12 population health measures. The rate of 30-day readmission for community hospitalizations in the California prison system is half that of the rate reported by commercial and Medi-Cal health plans. This is important not only for patient outcomes but for fiscal accountability. The better the CDCR is at controlling chronic illness, the better value realized for California taxpayers, as CDCR avoids costly hospital stays and other resource use.
3. CCHCS is becoming more successful at making improvements. Recently introduced Dashboard metrics show more accelerated improvement in performance after less than a year. In just 11 months, for example, end-stage liver disease performance increased from 63 percent adherence to statewide guidelines to 87 percent. Adherence to diagnostic monitoring guidelines went from 81 percent to 91 percent. Performance on the new polypharmacy review measure improved 52 percent in a six-month period, from 19 percent to 71 percent.
4. CCHCS still shows a lot of variation in performance across measures. Performance across institutions and within a single institution over time varies significantly.

The report recommends continuing to build upon success through the current three-phase implementation of the quality management system: enhancing the measurement system to encompass more elements of the CCM, ensuring resources are in place to support the CCM and high-risk program areas, and making sustainability strategies a routine part of health

program implementation.

Release of Health Care Services Dashboard 4.2

During this reporting period, CCHCS initiated efforts to integrate EHRS data into the Health Care Services Dashboard. With the integration of the EHRS fields, views of the Dashboard for FSP, CIW and CCWF rendered blank over the past several months will soon be restored.

To factor EHRS information into more than 200 Dashboard measures and submeasures, CCHCS staff spent months sifting through hundreds of thousands of fields in the new EHRS database to find those pertinent to CCHCS' performance metrics and package those fields in a way that makes them easily accessible to informatics staff. Integrating EHRS into the Dashboard meant redefining more than 200 performance measure methodologies and modifying multiple report views, and requiring substantial support by staff at the EHRS pilot institutions, including many hours of validation. "Dashboard 4.2" will include many new features including, but not limited to the following:

- New Medication Management Measures. CCHCS can now track medications from prescription to receipt by the patient without having to conduct chart audits. A set of new EHRS medication access metrics can now be seen with a drill-down view that divides performance data into transfer status, medication type, discipline, and other categories.
- Streamlined Medication Administration Process Improvement Project (MAPIP) Measures for Non-EHRS Institutions. MAPIP reporting for the Dashboard has been streamlined to ten submeasures, a reduction from 14 measures previously.
- Fewer Health Information Management Measures for EHRS Institutions. Once an institution implements EHRS, certain Health Information Management metrics will no longer apply, such as targeted timeframes for dictated documents. Others will remain: CCHCS will continue to monitor timeliness of specialty reports, community hospital and Department of State Hospitals (DSH) records, and internally-generated dental documentation at EHRS institutions post-rollout.
- Significant Changes to Methodologies in the Five Highest Impact Areas. The five Dashboard Domains (Scheduling and Access to Care, Continuity of Clinicians and Services, Medication Management, Workload per Day, and Health Information Management) most impacted by EHRS implementation show major methodology changes in nearly all measures. Because data entry practices could influence CCHCS' ability to accurately collect and report performance, EHRS institutions are urged to educate staff about the new methodologies.
- New EHRS and Non-EHRS Glossary Specifications. The Dashboard Glossary includes a specification for each measure, providing detailed information about the performance measure methodology, such as how the numerator and denominator is defined, exclusion criteria, data sources, and benchmarking.

- Glossary Now Includes Condition Specifications. Condition specifications provide lists of diagnoses, diagnostic findings, medications, claims, and other data points that CCHCS uses to categorize patients as having a certain disease.

From this point forward, as institutions rollout the EHRS locally, their Dashboard data will convert automatically to EHRS and there will be no gaps in performance reporting.

Process Improvement Techniques – Lean Six Sigma

As reported in the Thirty-First Tri-Annual Report, during FY 2015–16 CCHCS received budget authority to provide staff with Lean Six Sigma training in an effort to identify, analyze and resolve quality problems in a sustainable way throughout the organization. During this reporting period, CCHCS issued a request for proposals to secure a vendor for the training program and have continued to address logistical details such as procuring statistical analysis software for the first wave of Green Belt training classes. The first wave of training is expected to begin later this year.

Pending establishment of its own internal training program, CCHCS continues to participate in the Governor's Lean Six Sigma Initiative, as coordinated by the Government Operations Agency and the Governor's Office of Business and Economic Development. This six-month training program offers small groups of CCHCS staff intensive training and coaching in applying Lean Six Sigma principles to identified problem areas. Three CCHCS projects were accepted and completed in the 2015 round of training and two additional CCHCS projects were accepted and are expected to be completed in the next six months.

Process Improvement Techniques – Updated Root Cause Analysis Tool Kit

In 2013, CCHCS introduced a Root Cause Analysis (RCA) Tool Kit and statewide training as part of the new Patient Safety Program implementation. The RCA Tool Kit outlined a step-by-step procedure for performing an RCA. This is a multi-disciplinary approach to studying health care incidents retrospectively to prevent likelihood of recurrence and is required under current policy for all adverse/sentinels events. To ensure a standardized approach to RCAs statewide, institutions are required to use the RCA Tool Kit when evaluating any health care incident deemed an adverse/sentinel event.

With repeated application over the past two years, CCHCS has learned a great deal about what is and is not effective about the RCA process and its associated tools. Institution best practices have emerged and have been incorporated into the RCA Tool Kit, resulting in the following:

- A streamlined RCA process that simplifies and consolidates major steps.
- Updated RCA related documents to ensure completeness of RCA Reports.
- Development of an RCA Facilitator's Guide and specialized training for facilitators.

During the next reporting period, CCHCS will provide an overview to the field of the updated RCA process, as well as more intensive training for staff designated as RCA Facilitators.

Performance Evaluation and Improvement Tools – Registry Upgrades

In January 2016, CCHCS introduced a series of new tools and upgrades to existing tools to support individual patient and patient population management including the following:

- Updated Clinical Risk Classification criteria.
- Upgraded Patient Risk Profile with several additional levels of clinical detail.
- Enhanced Patient Summary that includes links to additional patient level information related to medications, clinical risk and registry alerts.
- Changes to Master Registry fields and flags.

Registry upgrades included integration of both EHRS and International Classification of Diseases 10 data into patient registries, the Patient Summary, and other tools.

Patient Safety Priority – Medication Process Improvement Initiatives

As discussed in the prior report, the Statewide Patient Safety Committee established a Medication Process Improvement Initiative to identify, prioritize, and address systemic medication process vulnerabilities. It has chartered two workgroups to date, one on polypharmacy and one pertaining to insulin errors, to develop tools, resources, training, and best practices to improve patient safety in medication-related processes. During this reporting period, CCHCS also contracted with experts in Lean Six Sigma to evaluate medication processes and related patient safety issues at EHRS pilot institutions, provide recommendations for improvement, and assist in efforts to improve patient safety and efficiency.

Patient Safety Initiative – Medication Administration and EHRS Pilot Institutions

In January 2016, CCHCS issued a request for proposals for Lean Six Sigma consulting services to assess and provide recommendations and completing an improvement initiative project as it related to standardizing medication management workflows using the EHRS, including but not limited to medication reconciliation, ordering, dispensing/processing and administration processes in both the institution and Central Fill Pharmacy settings.

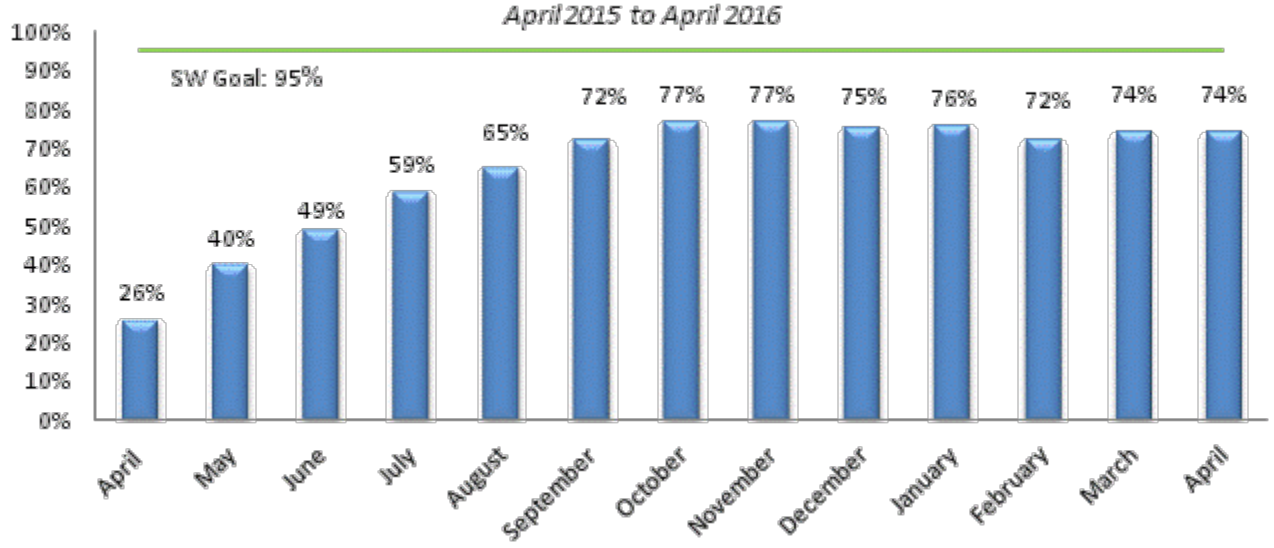
An assessment was conducted at CCWF and FSP, and the consultants found 48 EHRS risk elements during their assessment of which 13 findings were so significant that the consultants recommended the EHRS rollout be held back until remedies were in place to mitigate the risks. In early March 2016, the consultants presented their findings and recommendation to executive leadership and were asked to work on an improvement project relating to one of the 13 critical risks that were identified. As a part of the request for proposal, the consultants are currently focusing on improving the FSP utilization by institutions to meet increased demand with no additional resources. A report is expected in June 2016.

Patient Safety Initiative – Polypharmacy

In 2014, the Statewide Patient Safety Committee, in conjunction with the Pharmacy and Therapeutics Committee, formed a multi-disciplinary workgroup to evaluate and provide institutional support and resources to help manage patients on multiple medications (polypharmacy). During this reporting period, resources provided under this initiative which include a Polypharmacy Registry; sample local operating procedure; CDCR 7540, Polypharmacy Review Documentation; and continuing education were released in January 2015.

This initiative introduced a performance goal that care teams provide a polypharmacy review for all patients on ten or more medications at least annually, adopted as part of the statewide PIP 2016–18. Although CCHCS has not yet met the statewide goal, since initial implementation in April 2015 there has been a 50 percent increase in polypharmacy reviews over the course of the past year. Baseline performance in this measure started at 26 percent statewide and by fall 2015, institutions had achieved 77 percent adherence to the polypharmacy review requirement, but performance has remained steady at 72 percent to 75 percent since that time. Figure 2 illustrates statewide trends in polypharmacy reviews from April 2015 to April 2016.

Figure 2: Percentage of CCHCS Patients on 10 or More Medications Who Received a Polypharmacy Review within the Past 12 Months
April 2015 to April 2016



In December 2015, the Polypharmacy Registry was redesigned and can now be found under a more comprehensive Medication Registry with more critical medication management information for care teams, including alerts to medication allergies, details about current prescriptions and laboratory results. The CCHCS Patient Safety Committee continues to monitor progress in this initiative monthly, and results are posted in the Dashboard under the Population Health Management domain.

Patient Safety Initiative – Insulin

In July 2015, the Statewide Patient Safety Committee established an improvement initiative focused on preventing insulin-related medication errors, promoting the following three interventions designed to reduce the risk of errors:

1. A new color-coded tray system to differentiate between the different types of insulin during administration.
2. "Do Not Disturb" signs to reduce interruptions/distractions during insulin administration.
3. Patient Education to teach patients about insulin administration errors and encourage their participation in verifying that they are receiving the appropriate type and amount of insulin.

CCHCS piloted the insulin program at MCSP, and then introduced the initiative statewide in October 2015. In total, 32 institutions elected to take part in the initiative. As of April 2016, 31 of those institutions have received their insulin packages. In March 2016, participating institutions were solicited for feedback and comments regarding improvements or challenges as a result of implementation. In general, feedback reported is positive. With a reduction in interruptions, many institutions report decreased times in insulin lines. Patient education and decision support provided under this initiative appears to have increased nurse and patient interaction, with patients engaged in helping to ensure proper insulin type and dosage. The most notable challenge relates to the color-coding system and possible confusion with the manufacturer's color-coded insulin labels. The Statewide Patient Safety Committee will be addressing the feedback provided during the next reporting period.

Section 4: Receiver's Delegation of Authority

Receivership Transition Plan

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

During this reporting period, the Receiver delegated authority, after meet and confer sessions with both parties, for CTF on March 9, 2016, and CVSP on May 19, 2016. This brings the total number of delegated institutions to three.

Previously, the Receiver had delegated authority for the medical operations at FSP to CDCR on July 13, 2015. FSP's performance continues to be monitored on a monthly basis to ensure sustainability while under CDCR control.

Access Quality Report

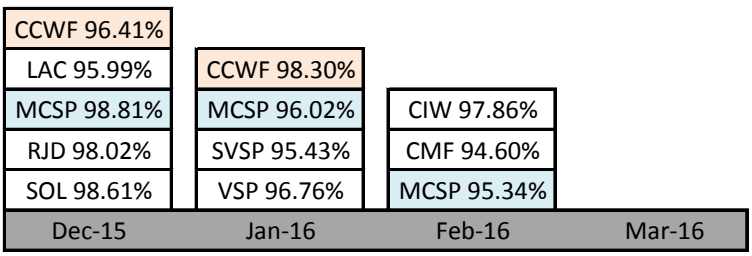
Field Operations staff continue to receive the required monthly Access Quality Report (AQR) data from institutions and publish the monthly statewide AQR. Refer to *Appendix 2* for the Executive Summary and Health Care Access Quality Report for December 2015 through March 2016. Field Operations staff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

Custody Access to Care Success Rate

During this reporting period, statewide AQRs were published for the months of December 2015 and January through March 2016. The average custody *Access to Care Success Rate* for this period was 99.42 percent, above the Receiver's benchmark of 99 percent. This represents an increase of 0.51 percentage points as compared to the Thirty-First Tri-Annual reporting period, which included data from August through November 2015.

Refer to Figure 3 for a summary, by month, of the number of institutions failing to attain the 99 percent benchmark established in the delegation. The primary reason an institution fell below the benchmark is attributed to an increase in the number of ducats not completed due to a modified program which resulted in the cancellation and rescheduling of health care appointments at the affected institutions. Notably, none of the institutions fell below the benchmark for the month of March 2016.

Figure 3: Institutions Failing to Attain the 99.00% Standard for the Custody Access to Care Success Rate



For institutions failing to attain the benchmark, 18 Corrective Action Plans were required from November 2015 through February 2016.

Operations Monitoring Audits

During the reporting period, Field Operations staff conducted 14 Health Care Access Unit (HCAU) Operations Monitoring Audits: a Round III Six-Month Limited Review at SOL due to a failure of Component 5 (the last audit of Round III), 12 Round IV Annual Audits at various institutions, and a Round IV Six-Month Limited Review at Sierra Conservation Center due to a failure of Component 4. In addition, an HCAU Preliminary Operations Review was conducted at CHCF.

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

During the reporting period, Field Operations staff published the results of 13 audits: one Round III Six Month Limited Review, and 12 Round IV Annual Audits. Of these 13 audits, ten were referred for a division and regional level of review. The findings of these audits are outlined Figure 4, Round III Six-Month Limited Review or Re-Audit, and Figure 5, Round IV Annual Audits, below.

Figure 4: Round III Six-Month Limited Review or Re-Audit

Institution	Type of 6-Month Review	Result/Division and Regional Review
California State Prison, Solano	Limited Review, 1 Component	Component #5 improved from 70.4% to 83.8%. Referred.[1]

Figure 5: Round IV Annual Audits

Institution	Audit Result	Division and Regional Review
Pelican Bay State Prison	Overall score improved from RIII 85.5% to RIV 94.4%.	Referred. [2]
California Medical Facility	Overall score improved from RIII 90.1% to RIV 92.3%.	Referred. [3]
Deuel Vocational Institution	Overall score improved from RIII 88.5% to RIV 94.9%.	Referred. [4]
California State Prison, Corcoran	Overall score improved from RIII 94.4% to RIV 95.2%.	Referred. [5]
Chuckawalla Valley State Prison	Overall score improved from RIII 94.9% to RIV 95.3%.	Referred.[6]

[1] Indicated by a failure to accurately report data on the institution's AQR; specifically, the number of off-site specialty care vehicle transports, the number of patients transported offsite for specialty care services, the number of health care related vehicle transports, and the number of health care access redirect staff hours.

[2] Indicated by (a) custody staff failing to conduct and document Mental Health Crisis Bed (MHCB) post-discharge welfare checks, (b) custody staff failing to ensure patients who are referred to a MHCB unit are transported within mandated timelines, and (c) custody staff not documenting nursing rounds in restricted housing.

[3] Indicated by (a) the institution does not always distribute medication from locations consistent with the most current policy and expectations set forth by CCHCS and CDCR, (b) not all HCAU custody staff knowing where and how to access the Inmate Medical Services Policy and Procedure and local operating procedures, (c) the HCAU Associate Warden or designee not consistently attending Quality Management Committee meetings, (d) custody staff not documenting nursing rounds in locked units, (e) failing to accurately report data on the institution's AQR; specifically, the number of daily mental health ducats not completed due to custody related outcomes from HCAU custody tracking sheets, the total number of daily specialty/diagnostic ducats, add-on appointments, ducat refusals, and ducats completed from the HCAU custody tracking sheets, and (f) the failure to utilize the SOMS IPTR-149 Pending Bed Assignments report to notify nursing staff of pending bed moves.

[4] Indicated by (a) custody staff not conducting daily inventories of all suicide cut-down kits, and (b) custody staff failing to document nursing rounds in general population housing units during modified programs/lockdowns.

[5] Indicated by failing to (a) document medication distribution and collection of CDCR Forms 7362, *Health Care Service Request,* in general population housing during modified program/lockdown; (b) document the delivery of priority health care ducats to patients; (c) document welfare checks conducted by custody staff for patients returned from an MHCB; (d) return CDCR Forms 7243, *Physician Request for Services*, from off-site medical appointments by custody staff; and (e) timely place patients in an MHCB.

[6] Indicated by failing to (a) document medication distribution and collection of CDCR Forms 7362 in locked units, (b) document the delivery of priority health care ducats to patients; and (c) notify health care clinic staff of patient bed/cell movement which directly affects the medication distribution point.

Institution	Audit Result	Division and Regional Review
Mule Creek State Prison	Overall score improved from RIII 87.8% to RIV 92.8%.	Referred.[7]
California Correctional Center	Overall score improved from RIII 94.4% to RIV 95.4%.	No referral necessary.
Richard J. Donovan State Prison	Overall score improved from RIII 88.4% to RIV 90.6%.	Referred.[8]
San Quentin State Prison	Overall score improved from RIII 89.4% to RIV 95.5%.	No referral necessary.
Pleasant Valley State Prison	Overall score improved from RIII 87.3% to RIV 91.4%.	Referred.[9]
Central California Women's Facility	Overall score improved from RIII 94.7% to RIV 96.1%.	No referral necessary.
Wasco State Prison	Overall score improved from RIII 96.1% to RIV 98.1%.	Referred.[10]

[7] Indicated by (a) failure to ensure nursing access to segregated housing units for the purpose of medication distribution and collection of CDCR Forms 7362, (b) custody staff not consistently documenting the delivery of all priority health care ducats, and (c) not ensuring patients arrive at appointment the location as needed by provider.

[8] Indicated by (a) failure to ensure custody staff consistently provides nursing staff assigned to the sending facility clinic a copy of the pending bed assignment (IPTR149), (b) custody staff not documenting the delivery of all priority health care ducats to patients, (c) custody staff not ensuring the CDCR Form 7243 is returned from the specialty provider to the Triage and Treatment Area (TTA), (d) not utilizing the HCAU custody tracking sheet to document the outcomes of priority health care ducats, (e) not ensuring all housing units possess a complete suicide cut-down kit, and (f) failing to accurately report the number of daily medical ducat refusals from the HCAU custody tracking sheets.

[9] Indicated by (a) failure to ensure the HCAU Captain or designee consistently attends Quality Management Committee meetings, (b) custody staff not documenting nursing rounds and collection of CDCR Forms 7362 in general population housing units under lockdown/modified program, (c) failing to ensure all officers have successfully completed a course in CPR, (d) failing to ensure patients who are referred for MHCB placement are consistently transferred within 24 hours, (e) staff failing to conduct and document MHCB post-discharge welfare checks, and (f) not accurately reporting on the institution's AQR the number of daily add-on appointments and number of patients escorted or transported to the TTA.

[10] Indicated by failing to (a) document medication distribution and collection of CDCR Forms 7362 in general population housing during modified program/lockdown, and (b) conduct morning "check-in" meeting each day between ASU custody staff and mental health staff.

Section 5: Other Matters Deemed Appropriate for Judicial Review

A. California Health Care Facility – Level of Care Delivered

CHCF's health care leadership remains focused on ensuring the delivery of consistent quality health care services to its patient population. Quality improvement systems have assisted CHCF in making significant gains in meeting this mission, as evidenced by overall improvement in its Institution Health Care Performance ranking. During the reporting period, CHCF remained open to intake for Enhanced Outpatient Program (EOP), Special Outpatient Program (SOP), and DSH admissions, as well as limited intake to its medical CTC and Outpatient Housing Units (OHU). Additional updates related to level of care delivery at CHCF include the following:

<u>Medical Services</u>

- Capacity: 3060; Population: 2211 (at 72 percent Capacity)
  - CENSUS as of April 30, 2016
    - OHU: 435
    - CTC: 327
    - MHCB: 94
    - PWC: 161
    - ASU: 41
    - E-EOP: 417
    - E-SOP: 124
    - E Facility: 270
    - DSH: 342
- CHCF's Performance Improvement Work Plan for 2016 provides critical medical services oversight, particularly measures aimed at the health care transfer process, consistent care teams and population management. The measure that addresses patient-centered, consistent care teams has made significant progress in ensuring consistency of huddles on all yards and population management working sessions. Huddle attendance collectively for CHCF continues on an upward trend as noted by a 90 percent compliance rating for March 2016. The health care transfer process measure additionally has made progress in standardization and coordination of appropriate levels of care and management of the exchange of information for patients being admitted to CHCF. CHCF's Compliance Support Unit additionally conducts a 100 percent audit of new arrivals to the Patient Management Unit. This consists of monitoring continuity of care for new arrivals once they are on their units and validating this care via MedSATs and the electronic Unit Health Record.
- Indicative of CHCF health care leadership's commitment to ensuring the effective delivery of quality health care services, great advances have been made in the filling of provider positions. Since the release of the Pay Differential for CHCF providers, the number of physician candidates alone interested in working at CHCF has increased exponentially. As of April 2016, over 60 physicians have contacted CCHCS' Workforce Development Unit with

interest in employment at CHCF. CHCF's assurance to supporting an expeditious and efficient hiring process for vacant provider positions has resulted in the hire of 14 physicians since September 2015. Of the 41 provider positions at CHCF, 28 are filled with the break-out as follows:

- Physician and Surgeons (P&S): 34 positions, 21 filled, 13 vacant, 9 job offers currently accepted
- Nurse Practitioners: 3 positions, 3 filled
- Physician Assistants: 4 positions, 4 filled

This effort is further reflected in CHCF's overall staffing numbers as follows:

- Current Authorized Positions: 1330.5
- Total of Positions Filled: 1093
- Percent filled: 82 percent

B. Statewide Medical Staff Recruitment and Retention

As of April 2016, 86 percent of the nursing positions have been filled statewide (this percentage is an average of four State nursing classifications). More specifically, 57 percent of institutions (20 institutions) have filled 90 percent or higher of their RN positions. This represents an increase of four institutions with fill rates of 90 percent or higher from the previous report. For institutions with less than 90 percent staffing rates, 23 percent (eight institutions) have filled between 80 and 89 percent of their RN positions. Consequently, 20 percent (seven institutions) of institutions have filled less than 80 percent of their RN positions. The goal of filling 90 percent or higher of the Licensed Vocational Nurse (LVN) positions has been achieved at 66 percent of institutions (23 institutions), whereas 26 percent (nine institutions) have filled between 80 and 89 percent of their LVN positions. Only nine percent of institutions (three institutions) have filled fewer than 80 percent of their LVN positions.

During this reporting period, hiring-related initiatives for nursing classifications continued where a variety of online job postings were the focus of hiring activities. Nursing vacancies are posted on multiple websites, including, *www.ChangingPrisonHealthCare.org*, *www.SimplyHired.com*, and *www.JuJu.com*. Each job posting typically represents multiple vacancies at an institution. CCHCS staff continue to monitor vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

In general, P&S recruitment efforts continued to focus on "hard-to-fill" institutions during this reporting period. As of April 2016, 85 percent of PCP positions were filled statewide (this percentage is an average of all three State primary care provider classifications). More specifically, 49 percent of institutions (17 institutions) have achieved the goal of filling 90 percent or higher of their P&S positions. Of these 17 institutions, 11 have filled 100 percent of their P&S positions. Additionally, 17 percent of institutions (six institutions) have filled between 80 and 89 percent of their P&S positions, and 34 percent (12 institutions) have filled less than 80 percent of their P&S positions. Of the 12 institutions with lower than 80 percent

fill rates at the time these data points were gathered, the following Table 2 represents current hiring status:

Table 2: Current Hiring Status

Institution	Candidates in Pre/Post Interview Process by Institution	Tentative Offers Accepted	Formal Offers Accepted - Not Started
ASP	0	0	0
CCC	1	0	0
CHCF	3	5	3
CMF	2	2	1
COR	3	0	0
LAC	1	1	0
MCSP	3	2	0
PBSP	2	0	0
SAC	0	0	0
SOL	1	1	0
SVSP	0	1	0
WSP	1	0	0

Workforce Development is continuing with various recruitment strategies to support and improve this trend. Job postings for P&S vacancies continue to be placed online at the CCHCS' recruitment website and other online job boards, and staff continue to recruit at medical conferences. CCHCS' present and future recruitment efforts for nursing and PCP classifications include the following:

Centralized Hiring Efforts – Workforce Development has implemented a centralized hiring program designed to quickly and efficiently fill P&S positions by ushering candidates through the recruiting and hiring process with a principal point of contact from initial application through first date of hire. This program was implemented first at CHCF and was rolled out statewide in January 2016. Since the implementation of this program at CHCF in September 2015, 14 P&S candidates have been hired at CHCF. Additionally, five P&S candidates have been hired at the remaining 34 institutions statewide, with over 40 candidates in the hiring process currently.

Sourcing – With Workforce Development's new staff being hired and trained, the unit is at the first stage of the competitive bid process for vendors to provide the most appropriate platform for our sourcing efforts. Sourcing will allow Workforce Development to access resumes posted on specific websites by health care professionals who are actively seeking employment and to engage directly with them.

Recruitment of Medical Residents – In conjunction with current P&S recruiting efforts, and to proactively provide a pathway for new physicians to view correctional medicine as a viable career option, Workforce Development has expanded its efforts to recruit medical residents. The implementation of a recruitment plan featuring print ads in national career guides, attendance at resident-specific events, and targeted digital marketing in the form of E-Blasts to residents throughout the United States is underway. Additionally, via memoranda released in December 2015, CCHCS has simplified the hiring process for residents who have yet to obtain their internal medicine or family medicine board certifications. With this adjustment, CCHCS can now recruit residents directly out of residency, allowing CCHCS to be more competitive with community hospitals and health systems. As a result of these efforts, CCHCS has four residents prepared to join CCHCS' provider workforce upon their graduation in July.

Visa Sponsorship Program – The Visa Sponsorship program provides opportunities for CCHCS to recruit and hire international clinicians who have been trained in the United States and wish to remain and practice in this country. CCHCS is an exempt employer, which allows the department to provide targeted recruitment to clinician-students who are in the United States on a student visa. Additionally CCHCS also sponsors TN, H-1B, and PERM petitions. This program is currently used in CCHCS' recruiting efforts for psychiatrists and has been utilized for other classifications including P&S, Psychiatrists, Clinical Psychologists, Nurse Practitioners, and Recreation Therapists. To continue and expand this effective program, we have included language promoting visa sponsorship in all advertising for the P&S classification and targeted recruitment of medical residents.

Professional Conferences – CCHCS continues to identify professional health care conferences where CCHCS can have a presence either in-person with an exhibitor booth or remotely through sponsorships and other promotional opportunities. Since the Thirty-first Tri-Annual Report, Workforce Development has attended a total of five 2016 conferences for the P&S classification with three California-located conferences and two out-of-state conferences. Additionally, CCHCS will be attending one out-of-state conference for correctional health care professionals. This tactic allows CCHCS to increase name recognition and brand awareness among both attendees and the health care community. Furthermore, recruitment opportunities at these events are more personal, allowing CCHCS to speak directly to potential candidates.

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

Workforce Development is working directly with programs to provide and implement statewide standards for our health care student rotations in order to improve ease of access to institutional clinics and improve consistency for students and institutional leadership. In

addition, CCHCS is working to increase the number of students/residents rotating through CDCR institutions. Workforce Development is ready to engage with these students after their participation in our health care educational programs is complete to encourage them to apply for civil service full-time employee positions within their fields.

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

Exit Survey – After analyzing the data results from the piloting of the Exit Survey at one of its institutions, CCHCS is readying the survey to be implemented statewide. The survey measures organizational issues most commonly recognized to influence job satisfaction and will allow CCHCS to define areas of improvement to aid in increasing retention of its health care employees.

Military Outreach – Workforce Development has begun actively engaging with Transition Assistance Programs (TAPs) at local military bases in an effort to court clinicians transitioning out of military service and into the private sector. In addition to local outreach, Workforce Development has made contact with the Regional Veterans' Employment Coordinator at the Department of Labor and is working closely with him to develop connections and working relationships with TAPs throughout California and across multiple branches of the military.

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

The advantages of the new Correctional Medicine Fellowship program include, but are not limited, to the following:

- Creating a platform to train and retain physicians who are board certified in Correctional Medicine for the State of California.
- Promoting excellence in Correctional Medicine and improving CCHCS' image, prestige, and position in the community.

- Promoting physician recruitment by attracting young graduates to Correctional Medicine.
- Setting future standards for quality in Correctional Medicine.
- Reducing recruitment costs by hiring at least two fellows per year at a reduced salary.
- Creating future leaders in Correctional Medicine and improving succession planning.
- Creating opportunities for CCHCS' medical executives and primary care providers to have advanced academic exposure and, in turn, boost morale.

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

For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for January through April 2016. These reports are included as *Appendix 3*. Included at the beginning of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: Executive Leadership Filled Percentage and Turnover Rate, Clinical and Nursing Management Filled and Turnover Rate, Primary Care Providers Filled Percentage and Turnover Rate, Nursing Filled Percentage and Turnover Rate, Pharmacy Filled Percentage and Turnover Rate.

C. Coordination with Other Lawsuits

Meetings between the three federal courts, *Plata, Coleman,* and *Armstrong* (Coordination Group) class actions have occurred periodically. However, no Coordination Group meetings were held during this reporting period.

D. Master Contract Waiver Reporting

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

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

E. Consultant Staff Engaged by the Receiver

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

F. Accounting of Expenditures

1. Expenses

The total net operating and capital expenses of the Office of the Receiver for the four-month period from January through April 2016 were $483,925 and $0, respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as *Appendix 4*.

2. Revenues

For the months of January through April 2016, the Receiver requested transfers of $500,000 from the State to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the Office of the Receiver. Total year-to-date funding for the FY 2015–16 to CPR from the State of California is $1,075,000.

All funds were received in a timely manner.