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UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

AND FOR THE NORTHERN 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 THIRTY-FOURTH TRI-ANNUAL REPORT

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PLEASE TAKE NOTICE that the Receiver in *Plata, et al. v. Brown, Jr., et al.*, Case No. C01-1351-THE; *Coleman, et al. v. Brown, Jr., et al.* Case No. CIV-S-90-0520-LKK-JFM-P; and *Armstrong, et al. v. Brown, Jr., et al.*Case No. C94-2307-CW has filed herewith his Thirty-Fourth Tri-Annual Report.

Dated: February 1, 2017

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

Thirty-fourth Tri-Annual Report of the Federal Receiver For September 1–December 31, 2016

February 1, 2017

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-fourth report filed by the Receivership, and the twenty-eighth 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 September 1 through December 31, 2016, and includes the following:

Electronic Health Records System

Electronic Health Records System (EHRS) was successfully implemented at Pelican Bay State Prison (PBSP) and Correctional Training Facility (CTF) in September 2016; California City Correctional Center (CAC) and California Rehabilitation Center (CRC) in October 2016; and California Correctional Center (CCC), Sierra Conservation Center (SCC), and California Correctional Institution (CCI) in November 2016. Planning activities continue for the implementation of the remaining institutions. Statewide implementation of the EHRS is estimated to be completed by October 2017.

Office of the Inspector General – Cycle 4

The Office of the Inspector General's (OIG's) Cycle 4 Medical Inspections commenced during the week of January 26, 2015. As of this reporting period, medical inspections have been conducted at all 35 institutions. Final reports which contain overall ratings are pending completion by the OIG for the following institutions: Substance Abuse Treatment Facility (SATF); Pleasant Valley State Prison (PVSP); Richard J. Donovan Correctional Facility (RJD); Central California Women's Facility (CCWF); California State Prison, Sacramento (SAC); and CHCF.

During this reporting period, the Receiver delegated to CDCR authority for the medical operations at California Institution for Men (CIM) on October 7, 2016, and Avenal State Prison (ASP) on October 19, 2016. Institution performance continues to be monitored to ensure

sustainability. Meet-and-confer meetings have been scheduled with the parties during the next reporting period to discuss the potential delegation of Calipatria State Prison (CAL), California Institution for Women (CIW), and Kern Valley State Prison (KVSP).

Office of the Inspector General – Cycle 5

During this reporting period, the OIG met with CCHCS and internal and external stakeholders to discuss changes to the Cycle 5 Medical Inspection Tool (MIT). The revised case review methodology and sample sizes, draft MIT, and the schedule for the Cycle 5 Medical Inspections, which includes the first 20 inspections, were shared with institutions statewide.

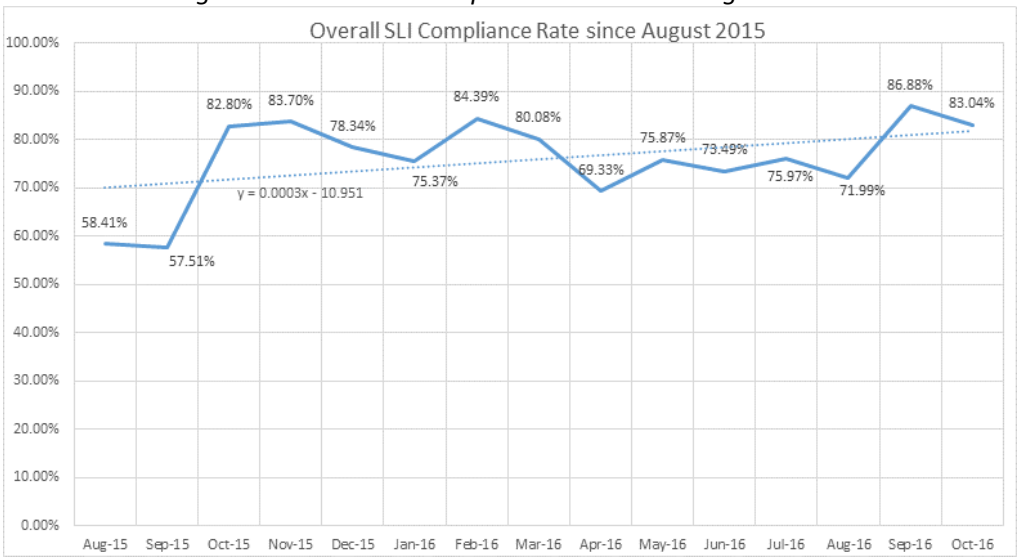
As of this reporting period, the OIG has issued job start letters for the Cycle 5 Medical Inspections at Valley State Prison (VSP), California Medical Facility (CMF), and Ironwood State Prison (ISP).

Armstrong

During this reporting period, the Field Operation's Health Care Class Action Liaison (HCCAL) unit continued to conduct monthly sign language interpreter (SLI) audits of all health care encounters for patients requiring SLI, monthly reconciliations of the Disability Placement Program (DPP) Accountability Log, and periodic site visits to institutions for Process and Document Reviews (PDRs) and spot training events.

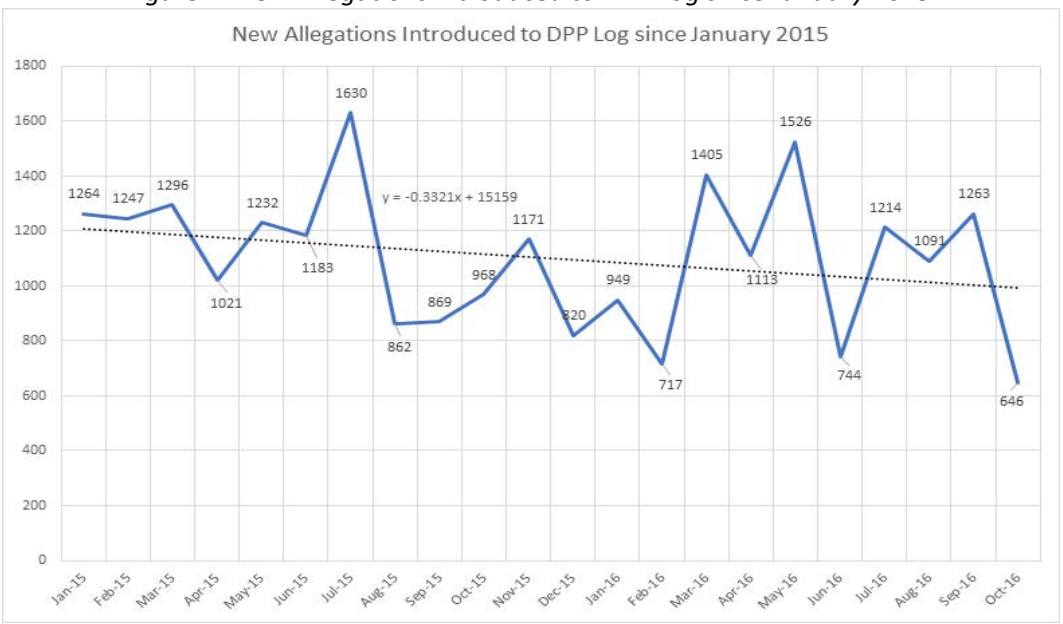
The HCCAL's monthly audits have shown an increase in compliance with providing SLI over the months of July through October 2016, with the average compliance rate at 79.47 percent for the same period (April through July 2016, was 73.5 percent). The overall long-term trend for SLI compliance also continues on its upward trend, as it has since August 2015 (refer to Figure 1). With the availability of video remote interpreter (VRI) services 24 hours a day, 365 days a year, and 22 of the 35 institutions provisioned access, HCCAL anticipates performance to continue to trend upward as institutions become fully familiarized and incorporate the SLI/VRI resources into local operating procedures (LOPs).

Figure 1: Overall SLI Compliance Rate since August 2015



Recent months have shown a slight increase in new DPP allegations, with a four-month average of 1,053 cases per month (July through October 2016). However, the overall long-term trend for new cases has been steadily declining since January 2015 (refer to Figure 2). Recent improved collaboration between health care and custody staff in the process of responding to *Armstrong* Monitoring Tour (AMT) findings provides for better management of class members. However, concern is still held regarding the lack of designated and trained Health Care Compliance Analyst (HCCA) back-ups at numerous institutions; a factor that may be contributing significantly to the recently observed uptick in new allegations.

Figure 2: New Allegations Introduced to DPP Log since January 2015



PDRs were conducted at 13 institutions, including CIM, CRC, CIW, PVSP, ASP, VSP, North Kern State Prison (NKSP), KVSP, CHCF, CAC, Mule Creek State Prison (MCSP), CTF and California State Prison, Solano (SOL). The purpose of these reviews is to audit compliance with DPP and the *Armstrong* Remedial Plan, conduct onsite training and conferencing to improve compliance, and follow-up during and after AMTs to gauge success. Major issues driving DPP non-compliance across the majority of institutions include the following:

- Patients being denied access to Durable Medical Equipment (DME) during transfer from one institution to another institution and in some cases from one facility to another facility within the same institution, and failure to ensure accountability for such events;
- Lack of coordination regarding tracking, timely delivery, and repair of DME and wheelchairs;
- Clinical staff not documenting Effective Communication;
- Staff not relying on Disability and Effective Communication System (DECS) to identify the required accommodation(s) for patients;
- Staff not updating DECS when appropriate to match the best accommodation(s) for patients;
- Reasonable Accommodation Panel responses are not comprehensive, do not always include health care input, and frequently do not resolve the issue(s) brought forward;
- Staff lack of awareness of SLI and VRI services at permanent hearing and/or speech disability (DPH/DPS) designated institutions;
- HCCAs frequently over-tasked with numerous duties and responsibilities, to the detriment of core duties; and,
- LOPs non-existent or out-of-date.

Health Care Appeals Pilot

The Health Care Appeals Pilot (Pilot) was filed with the Secretary of State on September 1, 2015, and implemented at three institutions: CCWF, SATF, and SOL. The Pilot incorporated two main changes, which includes the elimination of one institutional level of review and the implementation of a Registered Nurse (RN) to conduct clinical triage and facilitate early face-to-face clinical intervention when necessary.

Clinical intervention has made patient access to care more efficient by allowing patients to ask questions during the interview process and receive patient education regarding their existing plan of care, medications, and future appointments. In addition, the early identification of urgent/emergent issues makes certain that patients are seen by the appropriate discipline regardless of how the appeal itself is processed.

The Inmate Correspondence and Appeals Branch is preparing for statewide implementation of the Health Care Appeals Pilot, pending budget approval.

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:

Clinician Staffing

The Receiver's 2008 *Turnaround Plan of Action*, "Achieving a Constitutional Level of Medical Care in California's Prisons" (June 6, 2008), described the then-existing delivery of medical services within California's prisons as "chaotic, episodic and often untimely encounters between patients and clinicians who, given the lack of reliable patient information and support systems, are placed in a responsive position with no incentives or feedback loops to encourage good medical practices." *Turnaround Plan of Action*, p. iii. The risk of harm to patients was obvious.

The *Turnaround Plan of Action* was formulated to transform the delivery of medical services so that patient-clinician encounters were "proactive, planned, informed, patient-centered, and professional." *Id*., p. iii. In short, we sought to bring well-accepted principles of care management, based on an adequately resourced medical infrastructure, to California's prison medical system.

In the 2015 update to the Court, entitled "Special Report: Improvements in the Quality of California's Prison Medical Care System" (March 10, 2015), we reported that while the quality of medical care had "substantially improved from the inception of the Receivership in 2006 to the present, . . . there remain a number of improvement efforts initiated by the Receiver that must be completed." *Id*., p. 1. The gaps identified in that report included availability and usability of health information, scheduling and access to care, care management, and health care infrastructure at facilities. *Id.*, pp. 3-4.

With respect to staffing, the Special Report indicated that "we now have in place competent, experienced leadership and staff at headquarters, in four regional offices, and in all of the institutions." *Id.*, p. 1. At that time, according to the 2015 CCHCS Dashboard, the statewide staffing level for medical providers was 101 percent; 27 institutions had staffing levels above 90 percent; 7 institutions had staffing levels between 80 percent and 89 percent; and only one institution (Salinas Valley State Prison [SVSP]) had a staffing level below 80 percent.

Unfortunately, there has been significant deterioration in our provider staffing from the time of the Special Report to the present. Matters became so serious that the Prison Law Office sent a letter to the Court in October 2016 calling for a meeting of the parties and the Receiver with the Court to discuss immediate actions which would address the problem. There have been two such meetings, one in December 2016 and the second in January 2017, and significant progress is being made in those conversations. Details regarding the shortfalls and our current efforts to address them are explained below in Section 5(B).

Health Care Monitoring Audit Instruction Guide and Audit Tool

This reporting period has resulted in considerable changes to the Health Care Monitoring Audit Instruction Guide and the onsite Audit Tool used to evaluate the quality of the medical care provided in the contract facilities. The changes to the Health Care Monitoring Audit Instruction Guide and the onsite Audit Tool were necessary to reflect the procedural updates which have occurred during the preceding year. One of the primary changes was reflected in the reduction of the required percentage scoring necessary to achieve a passing score or an Adequate rating. The threshold was reduced from 85 percent to 80 percent. Although, some of the facilities have managed to receive an Adequate rating, challenges remain with consistently meeting the requirements, which continues to affect and impact access to care.

In-State Contracting for Community Correctional Facilities

The total Modified Community Correctional Facility (MCCF) patient population as of December 31, 2016, was 3,918 (92.89 percent) of the budgeted capacity of 4,218.

During the months of November and December 2016, California Correctional Health Care Services (CCHCS) conducted two Health Care Monitoring Audits: one each at Desert View MCCF and Central Valley MCCF, respectively. Although the facilities received an overall Adequate rating, there is room for improvement related to consistent performance and access to care. Desert View MCCF marginally passed the onsite audit with a score of 80.2 percent, while Central Valley MCCF performed better with a score of 88.3 percent.

CCHCS has discussed with CDCR's Contract Beds Unit (CBU) the ongoing problem at Desert View MCCF, related to the turnover of their provider staffing. It is essential that all contract vendors ensure that new providers are trained in correctional medicine and receive hands-on training at the designated CDCR hub institutions.

Vendors are continuing to fail at completing essential provider peer reviews required to evaluate the performance levels of primary care providers for the MCCFs. CCHCS continues to collaborate with CBU to improve this expectation.

Mandatory provider coverage has been inconsistent at the MCCFs. As a result of erratic provider coverage, CCHCS now receives weekly schedules which provide rosters on onsite hours worked by credentialed providers in order to track mandatory coverage for all MCCFs.

Out-of-State Contract Facilities

On October 13, 2016, Corrections Corporation of America (CCA) advised CCHCS that it was rebranding its corporate enterprise as CoreCivic. This change has been reflected in all correspondence and CCA will now be referred to as CoreCivic.

There has been a slight decrease of 2.5 percentage points in the California Out-of-State Correctional Facilities (COCF) patient population during this reporting period; the population

was reduced from 4,814 to 4,694. The total COCF patient population as of December 31, 2016, is 4,694 (or 95.8 percent) of the budgeted capacity of 4,900.

During the month of October 2016, CCHCS conducted an onsite audit at the Tallahatchie County Correctional Facility (TCCF) resulting in a score of 84.9 percent and an overall rating of Adequate. The general delivery of medical care has improved at TCCF; however, continued training on all policies is necessary to ensure the facility is consistently providing effective patient care. CBU was advised and will ensure the facility's corrective action plan adequately addresses how TCCF will fix their identified deficiencies.

Although there were no scheduled Health Care Monitoring Audits conducted at the La Palma Correctional Center (LPCC) during this reporting period, CCHCS was advised that LPCC has been without a mid-level provider for over 45 days. CCHCS has been actively monitoring the situation to ensure aggressive recruitment is in place to fill the vacancy.

Transportation Vehicles

In October 2012, the responsibility of providing an adequate health care transport vehicle fleet was delegated to CDCR. During the past four years, CCHCS has been working collaboratively with CDCR to establish a cohesive procurement plan that addresses the replacement of an aging vehicle fleet along with the procurement of additional transport vehicles required to meet the access to care needs of the patient population.

During this reporting period, CDCR has established a governance body that directly addresses departmental concerns and procurement issues for the overall CDCR vehicle fleet. The governance body includes staff from CCHCS and ensures that health care access needs are addressed. In November 2016, the Deputy Director, Office of Business Services (OBS), CDCR, issued a directive to executive staff for both CDCR and CCHCS to work together in assessing their overall vehicle needs for the 2016–17 and 2017–18 budget years. The Deputy Director and his staff organized training classes to address the roles of the new fleet coordinators for both CDCR and CCHCS staff. Two staff members from Corrections Services, CCHCS, were also invited and attended the training.

In the previous Tri-Annual Report, CDCR's OBS indicated they submitted proposed procurement orders for 227 vehicles utilizing fiscal year (FY) 15–16 funds. Of the 227 vehicles originally proposed, 202 were earmarked for health care. OBS is now reporting the total vehicles being purchased has been reduced to 201, which remains a significant procurement for health care vehicles.

Table 1: Fiscal Year 2015–16 Vehicle Requisition provides a status on the progress toward placing health care vehicles in service.

Table 1: Fiscal Year 2015–16 Vehicle Requisition					
Vehicle Type	# Ordered	# Received	# In-Service	Projected Dates	Comments
Transportation Vans	143	137	0	Complete 8-10 Vans per week	CALPIA is currently finalizing the security modification prototype.
Para-Transit Bus	4	0	0	Projected delivery date of July 2017	
Sedans	6	6	5	Completion Feb 2017	Currently installing security modifications/radios
SUV Transport Vehicle	39	39	7	Completion Feb 2017	Currently installing radio
Emergency Response Vehicles	4	4	4		
Electric Carts	5	2	2		(3) pending delivery – 2nd quarter 2017
Total	201	188	18		

In the current FY, CDCR/Division of Adult Institutions (DAI) submitted proposed procurement orders for 114 vehicles which have been identified for replacement according to the Fleet Assessment Plan. Of the proposed purchase orders, 112 vehicles were identified for health care. Refer to Table 2: Fiscal Year 2016–17 Vehicle Requisition.

Table 2: Fiscal Year 2016–17 Vehicle Requisition					
Vehicle Type	# Ordered	# Received	# In-Service	Projected Dates	Comments
Transportation Vans	75	10	0	Unknown	Anticipated receipt of vehicles Jan to April 2017
Para-Transit Bus	1	0	0	October 2017	Not Received
SUV Transport Vehicle	34	31	0	Remaining (3) – May 2017	Pending security modifications
Emergency Response Vehicles	2	2	2		
Total	112	43	2		

In an effort to address the serious shortage of Americans with Disabilities Act (ADA) vehicles to transport mobility impaired patients to medical appointments, CDCR's OBS identified funding to purchase an additional 35 vehicles to replenish the deteriorating ADA vehicle fleet. According to OBS staff, these vehicles were anticipated to be purchased and placed into service during the fourth quarter of 2016. OBS now reports that they failed to initiate the procurement process for these vehicles. At the time of submission of this report to the Court, OBS advises they are actively investigating emergency measures that can be instituted to redirect the required resources and equipment to compensate for this oversight. There is no projected date for delivery or date for the vehicles to be placed in service.

CCHCS and CDCR continue to work collaboratively to ensure the necessary vehicles are at the correct institution (e.g., recently the number of wheelchair-dependent patients increased at California State Prison, Los Angeles County [LAC]), resulting in an increase in the number of

on/offsite medical appointments. LAC did not have the resources to facilitate or manage the increased movement. Through the collaborative efforts between CCHCS and the Vehicle Management Unit in DAI, a sufficient number of ADA vehicles were redirected to LAC to accommodate and manage the access to care needs of the disabled patient population.

Recently, CDCR/CCHCS completed the activation of the "In Fill" projects at both MCSP and RJD. To accommodate the expanding number of patients and their medical needs, CDCR purchased an additional 23 ADA health care transport vehicles. Twenty-two of the twenty-three vehicles have been received and placed in service; the remaining ADA bus designated for RJD is undergoing a final Department of General Services re-inspection and is projected to be in service by the end of January 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 previous 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 Organization Solution. The project is presently in the statewide deployment phase.

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

As of this reporting period, EHRS has been implemented at 11 institutions. Refer to Table 3: EHRS Rollout.

Table 3. EHRS Rollout

Event	Go Live Date	Institutions
Pilot	10/27/2015	CIW, CCWF, FSP/FWF
Rollout 1	8/23/2016	SOL
Rollout 2	9/20/2016	PBSP, CTF
Rollout 3	10/18/2016	CAC, CRC
Rollout 4	11/15/2016	CCC, SCC, CCI
Rollout 5	1/10/2017	HDSP, CMC, CVSP
Rollout 6	2/7/2017	ASP, CEN
Rollout 7	3/7/2017	SQ, DVI, ISP
Rollout 8	4/4/2017	VSP, KVSP

Event	Go Live Date	Institutions
Rollout 9	5/9/2017	SAC, PVSP
Rollout 10	6/6/2017	NKSP, CAL
Rollout 11	7/11/2017	CHCF
Rollout 12	8/15/2017	SATF, CIM
Rollout 13	9/12/2017	CMF, SVSP
Rollout 14	10/10/2017	WSP, RJD
Rollout 15	10/31/2017	MCSP, LAC, COR

Planning activities continue for the implementation of the remaining institutions. Statewide implementation of the EHRS is estimated to be completed by October 2017.

In response to feedback from institutions, implementation of the EHRS was not planned for December 2016. In addition to training and preparation work, this time was used for a major system code upgrade from the vendor. The upgrade was completed successfully.

Overall, the EHRS project is on track and meeting scheduled milestones and activities as we continue to implement remaining EHRS functionality and complete statewide implementation of the EHRS.

B. Scheduling and Access to Care

During this reporting period, institutions continued to apply scheduling principles learned at the Complete Care Model (CCM) Learning Session for Scheduling and Access to Care, including establishment of a scheduling system infrastructure and strategies for both managing the demand for health care services and optimizing the supply of appointments. Technical support from regional teams and customized improvement tools accompanied this initiative. In addition, CCHCS issued a series of tools to assist institutions as they transfer scheduling functions to the new EHRS.

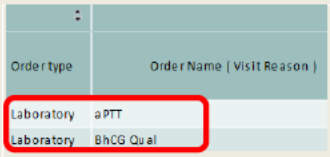
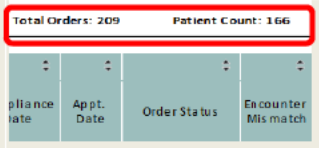
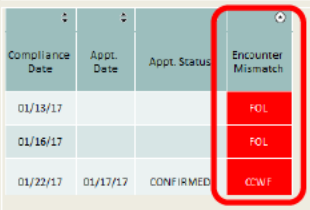
<u>Support to EHRS Institutions</u>

An immediate concern as institutions adopt the EHRS is the impact to productivity affiliated with assimilating the new information system into clinic operations. Institution supervisors and managers need to know where appointment backlog is accumulating and the exact extent of backlog. To reduce variability across institutions and to provide reliable information management reports, it is important for health care staff to follow standardized methods for entering data into the EHRS.

A number of guidelines have been developed to help EHRS-enabled institutions be more consistent when creating orders and scheduling appointments as a way to address variation in scheduling processes and variations in how staff use system functions. Training has been built into EHRS preparation activities to ensure that upcoming institutions are equipped with the knowledge and hands-on experience to successfully apply these scheduling practices.

During this reporting period, new functions were added to the Scheduling Registry in response to additional operational and management information needs elevated by EHRS institutions. Specifically, CCHCS made changes to the Scheduling Registry as shown in Table 4.

Table 4: Changes to Scheduling Registry

New Report **No Pending PCP**		• This new tab will show all High/Medium Risk and Low Risk Chronic Care patients who do not have an active order to be seen by a Primary Care Provider. • Filter Options are available to quickly find all the patients who may have "fallen through the cracks" at an institution. • This report is patient specific and contains the clinical information risk factors necessary to quickly triage a potentially overlooked patient population and determine the appropriate actions/treatment.
Laboratory Orders		• The Scheduling Registry now includes laboratory orders, which now appear in the Order Queue, Overdue Orders, and Check Performance tabs.
Patient & Order Counts		• Order and patient counts are now visible on the top right of the report. These counts will update based on filter parameters selected.
Encounter Mismatch		• A new column has been added to Order Queue and Overdue Orders to indicate if there is an active order in a different encounter (i.e., an active order exists at a previous institution or inpatient encounter). This allows institutions to clean up duplicative encounters for a single patient and ensure all applicable orders have been successfully transferred from one area of care to another.

Institutions can access the Scheduling Registries through the Quality Management Portal under "Care Team Tools."

Performance Monitoring

On a quarterly basis, Regional Quality Management Support Units perform onsite assessments of CCM implementation progress as each new topic is introduced. With the introduction of the Scheduling and Access to Care Learning Session, scheduling infrastructure elements were incorporated into the CCM Assessment Tool, and will be monitored in subsequent onsite reviews. Pre-assessments of each institution's scheduling practices were conducted in June 2016 and a follow-up assessment was completed in October 2016. In just a few months of implementation, institutions are at or above goal for over half of the 16 assessment measures and are continuing to trend up on all remaining measures. Table 5 provides a comparison between statewide baseline data and the latest findings.

Table 5: Comparison between Statewide Baseline Data and Latest Findings

SCHEDULING & ACCESS	JUN	OCT
Designated Time Slot - Open Access	61%	85%
Appointment Times Varied by Patient Needs	55%	74%
Preference of Patients Considered When Scheduling Appointment	71%	83%
No Shows Escorted to Clinic to be Seen/Sign Refusal	75%	96%
PCP Completes Close Out Sheets	67%	73%
Institution Ensure that Patients get to Scheduled Appointments during Lockdown	--	100%
Care Teams get Approval by CEO or Clinical Exec before Modifying, Closing, Cancelling Clinic Hours, or Rescheduling Appointments	82%	86%
Designated Scheduling Supervisor	98%	100%
Super Users Available to Add/ Change Providers and Locations in Scheduling System	95%	97%
Scheduling Supervisor Verifies Daily Attendance and Ensure s Back-Ups are in Place	62%	83%
Scheduling Supervisor Review Daily Scheduling Management Reports	84%	100%
Quality Committee is Assigned to Oversee Scheduling/Access to Care	84%	100%
Committee Reviews the Scheduling Diagnostic Report with Institution Leaders at least Monthly Identifying Areas for Improvement, and Taking Actions	72%	91%
Ensure Accuracy of the Scheduling System Data	--	94%
Schedulers Provided with a Desk Procedure	81%	97%
Procedure Contain Written Process for Updating Providers/Locations in MedSATS	48%	80%

SCHEDULING & ACCESS	JUN	OCT
Composite Scores	74%	90%

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 2015 and November 2015. Development of policy and training for the use of this tool is delayed while the focus is placed on implementing the CCM and the EHRS, and is expected to resume early 2017.

In 2016, the Nursing Services Branch, Complete Care Oversight Team (CCOT) and Quality Management Support Unit (QMSU) collaborated to deliver training and education on collaboratives integral to the success of the CCM and EHRS implementation. Access to Care and Scheduling training sessions were mandated for all institutional Executive teams and QMSU teams. This training was designed to extend the knowledge, skills, and abilities of the primary care team to build on the Patient Centered Home Model of care. Also during this time, CCOT recognized that some institutions continued to struggle with the implementation of the original CCM collaborative. Quality Management with regional Executive teams developed and presented additional foundational collaborative training to support development of quality management infrastructure.

Each of the learning collaboratives was followed by an ongoing series of institutional visits by the regional QMSU, with support from headquarters. The visits included facilitation, coaching, and mentoring of institutional huddles and population management teams to ensure that the CCM process becomes an integral part of the institutions' health care culture. Currently

headquarters' Quality Management, along with the regional QMSUs are developing a wide variety of measurement tools to ensure that core CCM tenets become embedded in institutional practice and measure the effects of the CCM on patient care outcomes.

The Care Coordination subgroup continues to work with all involved stakeholders to update a wide variety of Inmate Medical Services Policies and Procedures (IMSP&P) to ensure that the CCM is fully integrated into the CCHCS health care delivery model and philosophy. Examples of this effort include the following initiatives:

- Updating the Inmate Tuberculosis (TB) Surveillance program based on the latest guidance from the Centers for Disease Control and Prevention. The updated Inmate TB Surveillance program is designed to leverage the CCM philosophy with the primary care team as the patient's primary care manager and using Public Health as a specialty care resource rather than the primary care provider.
- Updating the Emergency Response procedures with the inclusion of intranasal naloxone in the RN Urgent/Emergent Protocols. Each institution has developed a process through which intranasal naloxone is available at the scene of each emergency medical response thus ensuring a rapid response for each potential overdose incident.
- Interdisciplinary teams of mental health, nursing and custody staff have collaborated to develop a series of trainings for both health care and custody staff on a variety of topics across the care teams spectrum including the following:
    - 5-Day Follow-up Process for Mental Health Crisis Bed (MHCB) discharges to ensure that they are monitored after hours, weekends, and holidays when clinicians are not present at the institution.
    - An interdisciplinary team of mental health and nursing staff developed training for RN staff at the institutional level to integrate the mental health RN into Care Management through participation in mental health care management activities such as the Integrated Dual Disorder Treatment and attending morning huddles.
    - Development and initial implementation of the Medication Assisted Treatment for Substance Abuse Disorders Pilot Program within CDCR, beginning at CIM.
    - Development of the Crisis Intervention Team (nursing, mental health, and custody staff) to provide early, multidisciplinary intervention for patients who may have non-mental health issues rather than automatically admitting the patient to a MHCB. The program was tested at SVSP and is now being introduced to CIW to refine the program further.

With the core policies and procedures for CCM completed and the statewide training and implementation underway, PMCC has transitioned to CCOT with a focus on implementation, operations, and monitoring of CCM. CCOT is working to ensure that the CCM philosophy and care delivery model is maintained and is reflected in all new policies and procedures in development. This will ensure that fully integrated, multidisciplinary model of care is developed within CCHCS as the transition of responsibility back to CDCR progresses forward.

Late in 2016, CCOT began to explore methods to integrate medical, mental health and dental services within CDCR using the CCM as an inclusive patient-centered health care system.

CCHCS has identified clinical executive leadership and clinical supervision vacancies as contributing factors to the sustainability of CCM. In response to this, CCHCS headquarters supported institutions such as CMF, SAC, SOL, California State Prison, San Quentin (SQ), and SVSP with additional resources to address this gap. CCHCS also identified several institutions that continued to struggle with implementing standardized processes required for the success of CCM. In these cases, Nurse Consultant Program Review, Physician and/or QMSU staff were dispatched to review, retrain, and revise processes that would support CCM and the new delivery model. Headquarters Professional Education Unit and QMSU both provided extensive training to the staff who will be assisting the institutional care teams in order to accomplish this task.

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 was integrated into the learning sessions for the CCM in 2016, and will be further developed and delivered in the next series of collaboratives offered in 2017.
- Further developing and expanding the role of nursing as partners on the primary care team to provide planned, proactive patient care as health coaches, health educators and chronic care managers. In working towards this goal, standardized duty statements for all level of care nursing positions were developed in conjunction with CCHCS Human Resources. The standardized duty statements were issued to the institutions in December 2016. These duty statements will define and support the roles of the nursing staff as the Nursing Care Coordination/Management core policies and procedures are developed and implemented during 2017.

<u>Transfer Subgroup</u>

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

statewide on the ability to place a temporary medical hold on a patient to prevent inappropriate and unsafe transfers.

The Health Care Transfer policy and procedure has been updated to reflect the above changes, and training and education on the new process was completed in 2015. During this reporting period, CCOT is working collaboratively with regional teams and headquarters to streamline Reception Center processes and processes related to patient movement. This work will serve to further standardize the transfer process by utilizing new tools such as an automated Patient Summary sheet, a transfer check-list and the EHRS as it is implemented statewide. CCOT continues to work on improving the transfer process within CDCR through the review of processes as more institutions become active within the ECHOS/EHRS system. To ensure that our processes remain current and reflective of the needs of our patients and institutions, CCOT has formed the Transfer Process and the Reception Center workgroups to update current policies as areas for improvement are continually identified through the Quality Improvement Process.

D. Health Care Infrastructure at Facilities

Clinical facility upgrades through the Health Care Facility Improvement Program (HCFIP) projects are progressing. During this reporting period, the State Fire Marshal and Department of Finance approved working drawings and to proceed with construction for CAL and Centinela State Prison (CEN) in November 2016 and Chuckawalla Valley State Prison (CVSP) and ISP in December 2016. Working drawings to proceed with construction have now been approved for all HCFIP projects.

Activations occurring between September 1, 2016, and December 31, 2016, included additions and renovations to the Primary Care Clinic and a new Health Care Administration building at RJD and a new Administrative Segregation/Enhanced Outpatient Program Primary Care Clinic and a new Pharmacy/Lab building at MCSP. In total, eight HCFIP subprojects were completed at California Men's Colony (CMC), MCSP, and RJD during this reporting period. Construction activities are in progress at most of the other institutions.

As for the Statewide Medication Distribution projects, construction is progressing. To date, construction has been completed at six of the 22 institutions: CAL, CEN, CVSP, High Desert State Prison (HDSP), ISP, and Wasco State Prison (WSP).

Schedule delays continue to occur due to, but are not limited to, the following: onsite construction and fire alarm/existing infrastructure conditions; weather; efforts to safeguard operational continuity of care; and the securing of necessary swing space. The revised schedules reflect completion of construction in August 2019.

Section 3: Quality Assurance and Continuous Improvement Program

Complete Care Model – Learning Session IV: Quality Management System

During this reporting period, CCHCS held a fourth Learning Session in the CCM Collaborative focusing on full implementation of institution Quality Management systems. Completed in all four regions by the end of December 2016, the Learning Session emphasized four specific focus areas for 2017 – engaging staff, sustaining change, streamlining Quality Management Committee processes, and thorough and accurate documentation of improvement work.

Institution executives were provided with decision support tools developed from local best practices and participated in discussions on the following topics:

- Increasing staff engagement by communicating the institution's priorities to all levels of staff;
- Using the Cycle of Change to identify improvement priorities, implement improvement projects and sustain change;
- Making the best use of executives' time during Quality Management Committee so that it is an effective forum to identify and address quality, performance or patient safety problems; and,
- Improving documentation of quality forums, particularly with regard to effective minutes.

In an adjunctive session with regional and institution Quality Management staff, CCHCS introduced standards that will be used to assess institution Quality Management systems in 2017. Staff were briefed on data collection methods, sample scenarios and tools to be used to conduct the assessments. Baseline results of the Quality Management Assessment will be released in an updated version of the Dashboard in the first half of 2017.

A new CCM webpage has been developed to house all presentation materials from the Quality Management Learning Session and the assessment training. The page can be accessed through the "Quality Management System" link on the Quality Management Portal under the "Improvement Initiatives" section.

To establish a high-performing quality management system at individual institutions and at enterprise level, CCHCS needs to ensure that staff at different reporting levels have the improvement skills necessary to identify and resolve quality problems. In 2016 and 2017, CCHCS launched initiatives to train a wide range of CCHCS staff in Lean and Lean Six Sigma improvement models.

Process Improvement Techniques – Lean White Belt Certification Initiative

Announced via a joint signature memorandum from CDCR Secretary Scott Kernan and Federal Court Receiver J. Clark Kelso, the Lean White Belt Certification Initiative offers a one-day

orientation to Lean concepts and a tool kit to support implementation of Lean techniques on the job post-training. Each institution has been offered two onsite sessions serving up to 48 custody, administrative, and health care staff. Headquarters and regional staff are provided training through sessions in Sacramento or at regional offices.

- As of December 2016, 11 Lean White Belt training sessions had been offered to headquarters and regional staff.
- Thirteen institutions completed onsite training sessions.
- 767 staff statewide completed Lean White Belt training. The project goal is to certify 1,800 CDCR staff as Lean White Belts by the end of April 2017. To date, we are at 43 percent of goal.

The first phase of Lean White Belt certification is expected to continue through spring of 2017. In summer 2017, the initiative will transition to offering training at regional offices on a regular basis. During the final phase of the initiative, Lean White Belt Certification will be made available as part of the standard CDCR training curriculum.

Process Improvement Techniques – Lean Six Sigma

CCHCS received resources in 2016 to 1) establish a Lean Six Sigma training program for CDCR staff and 2) hire Master Black Belts in Lean Six Sigma to address high-priority, statewide quality problems.

Lean Six Sigma Green Belt Certification

During this reporting period, CCHCS identified Lean Six Sigma Green Belt candidates and improvement projects for the first Green Belt training cohort. Consultants delivered three training sessions to the first wave of candidates, who are expected to complete their training spring 2017. The second cohort of Lean Green Belt will begin in January 2017, with three more cohorts to follow.

Lean Six Sigma Statewide Projects

Master Black Belt consultants performed assessments of high priority statewide quality concerns and began working with CCHCS staff to develop and test improvements. Focus areas included Central Fill Pharmacy (CFP) operations, medication continuity during transfers, procurement and contract services, hiring processes, and 30-day readmissions to MHCB/DSH programs.

- The first series of interventions addressing CFP operations resulted in an increase in overall equipment efficiency from 55 percent to 73 percent in less than six months. CFP continues to apply Lean principles and techniques to identify additional program efficiencies to reduce costs and improve services to the institutions.
- An assessment of medication continuity during transfers, particularly in the EHRS environment, has led to refinements in the transfer process and creation of a Medication Continuity Report to monitor and drive improvement activities. Further

developments in this project will be aligned with the CCM Care Coordination initiative in 2017.

- Procurement, contract and hiring process assessments were in progress during the reporting period with initial findings indicating opportunities for improvement in areas such as identifying stock keeping units for commonly ordered goods to track par levels; leveraging the full capabilities of the CDCR Business Information System; opportunities to reduce the completion time for service contract process; and standardizing the hiring process with a focus on filling critical clinical vacancies.
- An evaluation of 30-day MHCB/DSH readmissions began at CHCF during this reporting period.

Improvement Tools – TB Registry

During this reporting period, CCHCS modified existing clinical tools to implement improvements to the statewide TB Program.

To align with new guidelines from the Centers for Disease Control and Prevention, CCHCS has discontinued using the Tuberculin Skin Test for mass annual TB evaluations. Under the new model for TB evaluations, institutions will screen patients for TB symptoms annually during their birth month, and will provide further testing and follow-up depending on the results of the symptom screening. Patients with known TB infection who have not been treated will be screened by RNs and encouraged to seek treatment, and patients at lower risk for TB will be screened by Licensed Vocational Nurses (LVNs).

The TB Registry has also been redesigned to support institutions in making this program change. The TB Registry now:

- Allows care teams to filter patients by birth month to identify those due for TB symptom screening.
- Indicates the nursing licensure (LVN or RN) recommended to screen each individual patient pursuant to current guidelines.
- Displays patients overdue for symptom screening.
- Provides the TB status for each patient, including TB Confirmed on Treatment, TB Suspect on Treatment, TB Confirmed Not on Treatment, TB Suspect Not on Treatment, History of TB Disease Treated, History of TB Disease Not Treated, Latent Tuberculosis Infection (LTBI) on Treatment, LTBI Treated, Remote LTBI not Treated, Recent LTBI not Treated, and no LTBI.
- Converts TB codes into MCC/Transportation Codes in order to communicate precautions to custody staff.

CCHCS' Public Health Branch and the Communications Office produced a video outlining the changes that is now being televised to the inmate population statewide. The CCHCS TB Care Guide and a new IMSP&P, Volume 10, Chapter 3.2, TB Surveillance Program Procedure, consistent with the new guidelines from Centers for Disease Control and Prevention are

currently under executive level review.

Performance Evaluation and Improvement Tools – Transfer Registry

With the implementation of the EHRS, medical and mental health providers were tasked with reconciling all orders for patients whose transfer resulted in an encounter change (which occurs any time a patient moves from one institution to another or changes from outpatient to inpatient settings). Nursing staff were tasked with coordinating order reconciliation and registering patients with their new primary care team. To assist health care staff through this complex process, a Transfer Registry was developed and introduced to EHRS institutions in November 2016.

The purpose of the Transfer Registry is to assist in appropriate primary care provider and care team assignments and to ensure orders (medication and all others) were reconciled correctly between open encounters. The Registry has three views: Institution Transfers, Care Team Transfers and Transfer Alerts. Each view displays only the most recent transfer within the last 30 days for each patient. Other distinctive functions of the views include the following:

- Institution Transfers – View of transfers that resulted in an encounter change, such as institution to institution or inpatient to institution. This view identifies patients who did not receive order reconciliation upon transfer as well as orders that do not match between the previous and current encounters.
- Care Team Transfers – View of transfers from care team to care team within the same institution. This view identifies patients that have not been properly re-registered to their appropriate care team or primary care provider after an intra-institution move. It also shows all appointment orders prior to patient transfer and any missed medication administrations since the patient transfer.
- Transfer Alerts – Patient-specific report highlighting the providers who completed the reconciliation, what orders looked like before and after transfer, and a list of all encounter changes within the last 30 days.

Within the first two months that the Transfer Registry was available, November and December 2016, the Transfer Registry was utilized by nearly 300 health care staff at EHRS institutions.

Patient Safety Priority – Drug-Drug Interaction Checker and Enhanced Alerts Tool

During this reporting period, CCHCS released a Drug-Drug Interaction Checker and enhanced medication alerts tool to help providers identify and review potential drug-drug interactions when prescribing new medications. Unlike other tools used by providers that check medications against each other, such as Epocrates, Drug-Drug Interaction Checker scans a proposed new drug against all active medications in a patient's current treatment plan. To use the tool, the prescriber enters the CDCR number of a specific patient and the medication he or she wishes to prescribe. The Drug-Drug Interaction Checker matches the proposed drug against the patient's existing medication regimen and flags potential interactions, including the severity level of the interaction and background information.

Similar functions are accessible to staff as they implement EHRS. This tool is available to all institutions, allowing non-EHRS institutions to access this functionality prior to implementation. Links to the Drug-Drug Interaction Checker are located on the Patient Summary, Medication Management Profile, Medication Registry and the Quality Management Portal.

Patient Safety Priority – Medication Process Improvement Initiatives

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

Insulin Improvement Initiative

Last year, the Patient Safety Committee established an Insulin Improvement Initiative after identifying that insulin errors disproportionately contributed to high-severity (Level 4 through 6) medication errors. A designated workgroup developed Insulin Packages, including color-coded bins and labels for storing insulin by type; "Do Not Disturb" signs to help protect nurses and prevent distractions during insulin administration; and patient education to assist patients in taking an active and informed role in their health care. More than 350 insulin packages were assembled and distributed to 34 institutions statewide.

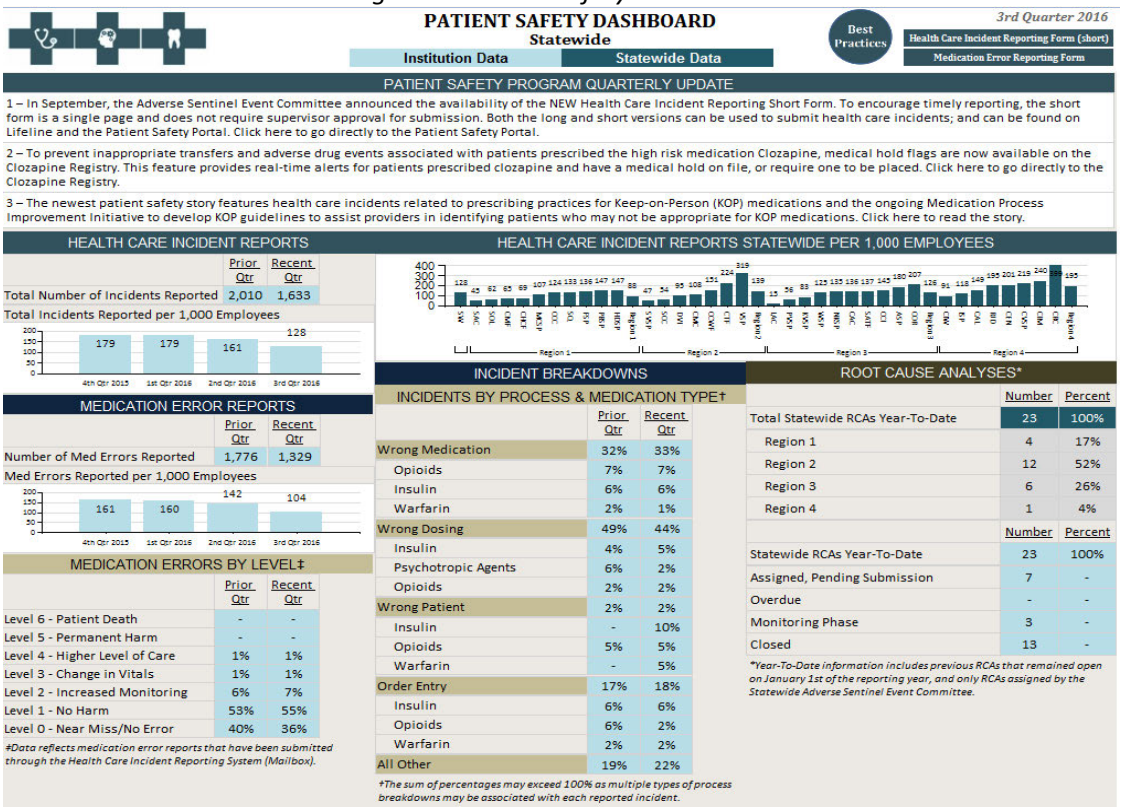
During this reporting period, the insulin resources webpage on Lifeline was updated and now includes all insulin initiative information, including an ordering guide which provides details on how to order replacement materials when needed.

As of December 2016, 82 percent of institutions indicated they were at least in the process of implementing the initiative. To continue monitoring progress, the Patient Safety Committee has requested local Pharmacists-in-Charge (PICs) complete a Supplemental Insulin Initiative Checklist during their mandated monthly medication area inspections. Local PICs were directed to complete these checklists and submit them to the health care incident reporting mailbox for a period of six months beginning in January 2017.

Patient Safety Dashboard and KOP Story

CCHCS began collecting health care incident and medication error reports in 2012 to identify problematic trends in health system performance and to identify and redesign health care processes that pose a potential danger to patients and staff. In June 2015, CCHCS began to make health care incident reporting data available to all health care staff via the Patient Safety Dashboard, a quarterly report summarizing incident trends at institutions, by region, and statewide. The Patient Safety Dashboard includes the volume of health care incident reports and medication errors, medication error breakdowns by severity level and type, as well as details related to root cause analyses. Refer to Figure 3: Patient Safety Dashboard.

Figure 3: Patient Safety Dashboard



PATIENT SAFETY DASHBOARD
Statewide

3rd Quarter 2016

Best Practices | Health Care Incident Reporting Form (short) | Medication Error Reporting Form

Institution Data | Statewide Data

PATIENT SAFETY PROGRAM QUARTERLY UPDATE

1 – In September, the Adverse Sentinel Event Committee announced the availability of the NEW Health Care Incident Reporting Short Form. To encourage timely reporting, the short form is a single page and does not require supervisor approval for submission. Both the long and short versions can be used to submit health care incidents; and can be found on Lifeline and the Patient Safety Portal. Click here to go directly to the Patient Safety Portal.

2 – To prevent inappropriate transfers and adverse drug events associated with patients prescribed the high risk medication Clozapine, medical hold flags are now available on the Clozapine Registry. This feature provides real-time alerts for patients prescribed clozapine and have a medical hold on file, or require one to be placed. Click here to go directly to the Clozapine Registry.

3 – The newest patient safety story features health care incidents related to prescribing practices for Keep-on-Person (KOP) medications and the ongoing Medication Process Improvement Initiative to develop KOP guidelines to assist providers in identifying patients who may not be appropriate for KOP medications. Click here to read the story.

HEALTH CARE INCIDENT REPORTS

	Prior Qtr	Recent Qtr
Total Number of Incidents Reported	2,010	1,633

Total Incidents Reported per 1,000 Employees

MEDICATION ERROR REPORTS

	Prior Qtr	Recent Qtr
Number of Med Errors Reported	1,776	1,329

Med Errors Reported per 1,000 Employees

MEDICATION ERRORS BY LEVEL‡

	Prior Qtr	Recent Qtr
Level 6 - Patient Death	-	-
Level 5 - Permanent Harm	-	-
Level 4 - Higher Level of Care	1%	1%
Level 3 - Change in Vitals	1%	1%
Level 2 - Increased Monitoring	6%	7%
Level 1 - No Harm	53%	55%
Level 0 - Near Miss/No Error	40%	36%

‡Data reflects medication error reports that have been submitted through the Health Care Incident Reporting System (Mailbox).

HEALTH CARE INCIDENT REPORTS STATEWIDE PER 1,000 EMPLOYEES

INCIDENT BREAKDOWNS

INCIDENTS BY PROCESS & MEDICATION TYPE†

	Prior Qtr	Recent Qtr
Wrong Medication	32%	33%
Opioids	7%	7%
Insulin	6%	6%
Warfarin	2%	1%
Wrong Dosing	49%	44%
Insulin	4%	5%
Psychotropic Agents	6%	2%
Opioids	2%	2%
Wrong Patient	2%	2%
Insulin	-	10%
Opioids	5%	5%
Warfarin	-	5%
Order Entry	17%	18%
Insulin	6%	6%
Opioids	6%	2%
Warfarin	2%	2%
All Other	19%	22%

†The sum of percentages may exceed 100% as multiple types of process breakdowns may be associated with each reported incident.

ROOT CAUSE ANALYSES*

	Number	Percent
Total Statewide RCAs Year-To-Date	23	100%
Region 1	4	17%
Region 2	12	52%
Region 3	6	26%
Region 4	1	4%

	Number	Percent
Statewide RCAs Year-To-Date	23	100%
Assigned, Pending Submission	7	-
Overdue	-	-
Monitoring Phase	3	-
Closed	13	-

**Year-To-Date information includes previous RCAs that remained open on January 1st of the reporting year, and only RCAs assigned by the Statewide Adverse Sentinel Event Committee.*

In November 2016, after identifying a trend in health care incidents involving medications prescribed keep-on-person (KOP) to patients with risk factors making this mode of prescription contraindicated, the statewide Patient Safety Committee convened appropriate stakeholders to create criteria that would make a patient ineligible for KOP medications and suggested the creation of alerts within EHRS to prevent KOP prescribing to patients due to factors such as a history of self-harm. The Patient Safety Committee released a Patient Safety Story to Lifeline detailing two of those incidents, also communicating the importance and impact of reporting patient safety incidents and concerns. The story was released statewide and has been identified as a potential concern across all disciplines.

Section 4: Receiver's Delegation of Authority

Receivership Transition Plan

During this reporting period, the Receiver delegated to CDCR authority for the medical operations at CIM on October 7, 2016, and ASP on October 19, 2016. To date, nine institutions have been delegated to CDCR authority. Delegated institution performance continues to be monitored to ensure sustainability. Meet-and-confer meetings have been scheduled with the parties during the next reporting period to discuss the potential delegation of CAL, CIW, and KVSP.

Access Quality Report

CCHCS' 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 1 for the Executive Summary and Health Care Access Quality Report for August through November 2016.

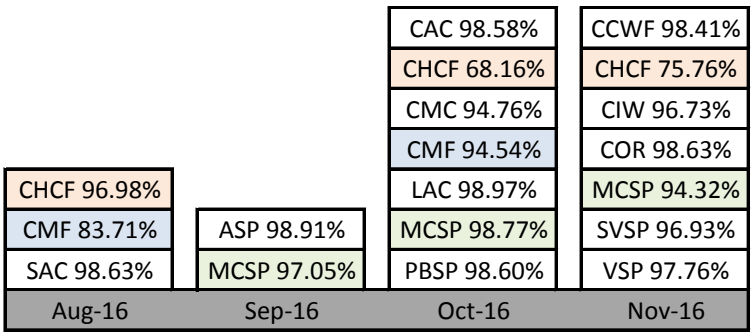
Effective with the November 2016 reporting cycle, Field Operations initiated AQR version 4.0. This update includes a new data element for capturing patient refusals of same-day "add-on" appointments within each health care discipline. This was the only change to the AQR which did not impact the established means of monitoring the Health Care Access Units (HCAU) or the performance indicators and performance targets outlined in the October 2012 *Delegation of Authority from the Receiver to the Secretary of the California Department of Corrections and Rehabilitation Related to the Health Care Access Units*.

Custody Access to Care Success Rate

During this reporting period, statewide AQRs were published for the months of August through November 2016. The average custody *Access to Care Success Rate* for this period was 98.32 percent, below the Receiver's benchmark of 99 percent. This represents a decrease of 1.03 percentage points as compared to the last reporting period, which included data from April through July 2016.

Refer to Figure 4, for a summary, by month, of the number of institutions failing to attain the 99 percent benchmark established in the delegation. The primary reason an institution fell below the benchmark is attributed to an increase in the number of ducats not completed due to a modified program which resulted in the cancellation and rescheduling of health care appointments at the affected institutions.

Figure 4: Institutions Failing to Attain the 99.00% Standard for the Custody Access to Care Success Rate



For institutions failing to attain the benchmark, 19 Corrective Action Plans were required.

Operations Monitoring Audits

During the reporting period, Field Operations staff conducted ten HCAU Operations Monitoring Audits. Two of the audits were Round IV Six-Month Limited Review(s) conducted at CIW and SAC for failure to meet designated thresholds in each of the audit components, and eight of the audits were Round V Annual Audits conducted at designated institutions. Eight of the ten audit reports have been published, while the two remaining reports are currently being finalized for publication.

In an effort to elevate and provide focused attention to the critical nature of the ongoing deficiencies identified by CCHCS during the audit process, CCHCS is referring those institutions with the ongoing deficiencies directly to the institution's respective Associate Director, DAI, CDCR, and Regional Health Care Executive, CCHCS, for review. Utilizing this philosophy of heightened accountability and transparency, it is incumbent upon Associate Director, DAI, CDCR, and Regional Health Care Executive, CCHCS, to provide sufficient oversight and leadership in order to achieve sustained resolution of critical issues. During this reporting period, six of the eight completed audits were referred for DAI CDCR and CCHCS level of review.

Corrections Services staff completed pre-delegation site reviews at six institutions during the reporting period including SQ, CMC, CIW, SATF, DVI and HDSP. Based on these reviews, there were custody practices identified at various locations that were deemed inconsistent with access to care expectations. In response to these onsite review findings, the information was presented to each respective Warden and Chief Executive Officer at the conclusion of each site review.

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 quality health care services to its patient population. During the reporting period, CHCF remained open to intake for Enhanced Outpatient Program, Special Outpatient Program, and Department of State Hospitals (DSH) admissions, as well as intake to its medical CTC and Outpatient Housing Units. CHCF is currently at 81 percent capacity (2,473 current population; 3060 capacity). Of the 41 provider positions at CHCF, 27 are currently filled as follows:

- Physician and Surgeon (P&S): 34 positions, 20 filled, 14 vacant
- Nurse Practitioners: 3 positions, 3 filled
- Physician Assistants: 4 positions, 4 filled

B. Statewide Medical Staff Recruitment and Retention

As of December 2016, 87 percent of the nursing positions have been filled statewide (this percentage is an average of four State nursing classifications). More specifically, 51 percent of institutions (18 institutions) have filled 90 percent or higher of their RN positions. This represents an increase from the previous Tri-Annual Report. For institutions with less than 90 percent staffing rates, 43 percent (15 institutions) have filled between 80 and 89 percent of their RN positions, a significant increase from the last report. Consequently, 6 percent (2 institutions) have filled less than 80 percent of their RN positions. The goal of filling 90 percent or higher of the LVN positions has been achieved at 54 percent of institutions (19 institutions), which is another significant increase from the previous Tri-Annual Report. Whereas, 26 percent (9 institutions) have filled between 80 and 89 percent of their LVN positions. At this time, 20 percent of institutions (7 institutions) have filled fewer than 80 percent of their LVN positions. We are continuing with focused recruiting efforts including establishing partnerships to create candidate pipelines with community colleges, geographically-focused advertisement, and attending job fairs.

In addition, the proposal to establish a Medical Assistant (MA) classification was approved by the State Personnel Board. The MA classification will be used in a provider support capacity. It is anticipated the eligible list for MA will be released in spring 2017 allowing institutions to begin using the classification by summer 2017. In preparation of release, CCHCS' Workforce Development has implemented a recruitment plan featuring collaboration with vocational trade schools to recruit new MA graduates and use of print and digital advertising efforts that will include American Association of Medical Assistants bi-monthly journal.

During this reporting period, hiring-related initiatives for nursing classifications continued wherein a variety of online job postings were the focus of hiring activities. Nursing vacancies are posted on multiple websites, including www.ChangingPrisonHealthCare.org,

www.Nurse.com, www.AllNurses.com, and www.nursingworld.org. Each job posting typically represents multiple vacancies at an institution. CCHCS staff continues 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 December 2016, 31 percent of institutions (11 institutions) have achieved the goal of filling 90 percent or higher of their P&S positions. Of these 11 institutions, all are 100 percent filled. Additionally, 29 percent (ten institutions) have filled between 80 and 89 percent of their P&S positions, and 40 percent (14 institutions) have filled less than 80 percent of their P&S positions. To address this trend, promotion of P&S vacancies has expanded to include an increased use of digital web banners and E-Newsletter advertising with targeted professional medical associations. This digital outreach supplements our print and event presence, ensuring that a wide audience of potential candidates is reached. As of this reporting period, the following Table 6 represents current P&S statewide hiring status:

Table 6: Current Statewide Hiring Status for P&S

Institution	Candidates in Pre/Post Interview Process by Institution	Tentative Offers Accepted	Formal Offers Accepted – Not Started
ASP	0	0	0
CAC	0	0	0
CAL	0	0	0
CCC	0	0	0
CCI	0	0	0
CCWF	1	0	0
CEN	1	0	0
CHCF	6	2	1
CIM	0	0	0
CIW	5	0	0
CMC	0	1	0
CMF	1	0	0
COR	0	0	0
CRC	2	1	0
CTF	0	0	0
CVSP	0	0	0
DVI	0	0	0
FSP	0	0	0
HDSP	0	0	0
ISP	0	1	0
KVSP	0	0	0
LAC	1	0	1
MCSP	2	0	0

Institution	Candidates in Pre/Post Interview Process by Institution	Tentative Offers Accepted	Formal Offers Accepted – Not Started
NKSP	0	0	0
PBSP	0	0	0
PVSP	0	0	0
RJD	1	0	0
SAC	2	0	0
SATF	0	1	0
SCC	1	0	0
SOL	1	1	0
SQ	0	0	0
SVSP	0	1	0
Telemedicine	1	0	0
VSP	0	0	0
WSP	0	0	0
Grand Total:	**25**	**8**	**2**

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 continues to recruit at medical conferences. CCHCS' present and future recruitment efforts for nursing and primary care provider classifications include the following:

Centralized Hiring Efforts – Workforce Development has implemented a centralized hiring program designed to quickly and efficiently fill P&S positions by ushering candidates through the recruiting and hiring process with a principal point of contact from initial application through first date of hire. This program was implemented first at CHCF and was rolled out statewide in January 2016. Since the implementation of this program at CHCF in September 2015, 21 P&S candidates have been hired at CHCF. Additionally, 41 P&S candidates have been hired at the remaining 34 institutions statewide and within the telemedicine program, with 35 candidates in the hiring process currently. Refer to Table 6.

Sourcing – Promotional efforts on PracticeLink and LinkedIn have allowed the advertisement of career opportunities with CCHCS and have provided CCHCS' Workforce Development with a robust pool of candidates with whom to directly engage via sourcing. CCHCS' Workforce Development has gained access to résumés posted on specific websites by health care professionals who are actively seeking employment. These candidates are contacted by recruiters and interested candidates are forwarded directly to the Centralized Hiring Unit or related hiring program.

Recruitment of Medical Residents – In conjunction with current P&S recruiting efforts, and to proactively provide a pathway for new physicians to view correctional medicine as a viable career option, Workforce Development has expanded its efforts to recruit medical residents. The implementation of a recruitment plan featuring print ads in national career guides, attendance at resident-specific events, and targeted digital marketing in the form of E-Blasts to residents throughout the United States is underway. Additionally, the sourcing information detailed in the above paragraph will also be utilized to provide another avenue for direct resident outreach. Of the two residents who were engaged with CCHCS as of the date of the last Tri-Annual Report, one is currently prepared to join CCHCS' provider workforce upon graduation in July 2017 while the other has withdrawn from the hiring process. An additional resident recently entered the candidate pipeline and if hired will also be prepared to join CCHCS in July 2017.

Visa Sponsorship Program – The Visa Sponsorship program provides opportunities for CCHCS to recruit and hire international clinicians who have been trained in the United States and wish to remain and practice in this country. CCHCS is a cap exempt employer, which allows the department to sponsor H-1B nonimmigrant visas year round. This provides targeted recruitment opportunities to hire clinicians working for other United States employers and clinician-students who are in the United States completing their education. Additionally, CCHCS also sponsors J-1 Waivers, TN, National Interest Waivers, and petitions leading to permanent resident status. This program is currently used in CCHCS' recruiting efforts for P&S and has been utilized for other classifications including Psychiatrists, Clinical Psychologists, Nurse Practitioners, and Recreation Therapists. To continue and expand this program, CCHCS has 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. During this reporting period, Workforce Development has attended a total of two California-based 2016 conferences for the P&S classification, with an additional two California-based P&S conferences and one out-of-state P&S conference booked for spring 2017. 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 11 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 to support the Medical Program in their work 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 – The CCHCS exit survey is ready for finalization and statewide implementation. 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 – While Workforce Development continues engaging with Transition Assistance Programs (TAPs) at local military bases, we have found that, for post-military recruitment of physicians, many TAPs and military personnel utilize the direct hiring process that exists between the United States Armed Forces and the Department of Veterans Affairs. While this presents a challenge, Workforce Development's remedy is to work directly with AMSUS – The Society of Federal Health Professionals. Through advertising on this association's website and in their bi-monthly journal *Military Medicine*, in addition to attendance at their annual convention, Workforce Development is planning to present CCHCS as an employer of choice to health care professionals working in or seeking employment with federal agencies including the Department of Veterans Affairs. Future efforts will include leveraging the military relationships that many of CCHCS' current physicians have with their respective branches of service.

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

completion of the program, fellows will additionally have earned a Masters in Public Health and may be eligible to sit for their boards.

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

- Creating a platform to train and retain physicians who are board certified in Correctional Medicine for the State of California.
- Promoting excellence in Correctional Medicine and improving CCHCS' image, prestige, and position in the community.
- Promoting physician recruitment by attracting young graduates to Correctional Medicine.
- Setting future standards for quality in Correctional Medicine.
- Reducing recruitment costs by hiring at least two fellows per year at a reduced salary.
- Creating future leaders in Correctional Medicine and improving succession planning.
- Creating opportunities for CCHCS' medical executives and primary care providers to have advanced academic exposure and, in turn, boost morale.

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

For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September through December 2016. These reports are included as Appendix 2. Included at the beginning of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: Executive Leadership Filled Percentage and Turnover Rate, Clinical and Nursing Management Filled and Turnover Rate, Primary Care Providers Filled Percentage and Turnover Rate, Nursing Filled Percentage and Turnover Rate, and Pharmacy Filled Percentage and Turnover Rate.

C. Coordination with Other Lawsuits

Meetings between the three federal courts, *Plata, Coleman,* and *Armstrong* (Coordination Group) class actions have occurred periodically. A Coordination Group meeting was held on November 10, 2016.

D. Master Contract Waiver Reporting

On June 4, 2007, the Court approved the Receiver's Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007, Order and in addition to those project areas identified in supplemental orders issued since that date. The approved project areas, the substitute bidding procedures, and the Receiver's

corresponding reporting obligations are summarized in the Receiver's Seventh Quarterly Report and are fully articulated in the Court's Orders, and therefore, the Receiver will not reiterate those details here.

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

E. Consultant Staff Engaged by the Receiver

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

F. Accounting of Expenditures

1. **Expenses**
   The total net operating and capital expenses of the Office of the Receiver for the four-month period from September through December 2016 were $431,746 and $0, respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 3.

2. **Revenues**
   For the months of September through December 2016, the Receiver requested transfers of $450,000 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 2016–17 to CPR from the State of California is $625,000.

   All funds were received in a timely manner.