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

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

1 PLEASE TAKE NOTICE that the Receiver in *Plata v. Schwarzenegger*, Case No. C01-
2 1351 TEH, has filed herewith his Twenty-Ninth Tri-Annual Report.
3 Dated: June 1, 2015

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

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

Twenty-ninth Tri-Annual Report of the Federal Receiver For January 1–April 30, 2015

June 1, 2015

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 Requirements

A. Reporting Requirements and New Reporting Format

This is the twenty-ninth report filed by the Receivership, and the twenty-third 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 for this and future reports, 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 will be removed going forward, 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 (2) 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 (3) 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 (3) 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, 2015, through April 30, 2015, and includes the following:

Office of the Inspector General – Cycle 4

The Office of Inspector General's (OIG's) Cycle 4 Medical Inspections commenced during the week of January 26, 2015. The first facility inspected was Folsom State Prison (FSP), followed by Correctional Training Facility, California Rehabilitation Center (CRC), California Correctional Center, and North Kern State Prison (NKSP) during this reporting period. The OIG has issued its final report for FSP, and the institution received an overall rating of "Adequate." California Correctional Health Care Services (CCHCS) has compiled information regarding FSP for consideration by the Receiver and stakeholders.

Armstrong

CCHCS staff continue in their progress to implement a reliable solution for providing sign language interpreters at all clinical encounters. Following successful field testing, a vendor was selected to provide on-demand video remote interpreting (VRI) services for all medical encounters, including psychiatric technician rounds completed in segregated housing units. Corrections Services purchased portable workstations that connect wirelessly to the internet and provide VRI services in the nine (9) impacted institutions. Included in this initiative is the installation of additional desktop cameras at specific clinical locations to extend the availability of this service to the needed areas. Policy and procedure updates were completed and are undergoing internal stakeholder review and approval with an anticipated implementation by July 2015.

Coccidioidomycosis Testing

In January 2015, CCHCS conducted mass coccidioidomycosis (cocci) skin testing. CCHCS analyzed the mass screening data in depth and found that less than five (5) percent of patients tested had adverse reactions. CCHCS also found that while 38 percent of patients accepted the testing, the acceptance rate varied by race/ethnicity. Among African Americans, 25 percent accepted the test; in contrast, 44 percent of Latinos and 46 percent of Whites accepted the test. The acceptance of the cocci skin test by patients also varied by location. For example, 41 percent of patients at Avenal State Prison (ASP) accepted the test, while only 29 percent of patients at Pleasant Valley State Prison (PVSP) accepted the cocci skin test. While the positive test rate overall was 8.6 percent, the positive test rate among patients currently residing at ASP or PVSP was 16.2 percent and the positive test rate among patients residing in counties that are not considered to be “cocci endemic” was only 7.6 percent.

After the mass cocci skin testing, CCHCS initiated cocci skin testing in the reception centers and continues to offer the cocci skin test to patients who have not been tested. As of April 29, 2015, 80 percent of men currently residing in CDCR institutions have been offered the cocci skin test. Of those men offered the cocci skin test, 39 percent accepted the test and of those who accepted the test, 99.6 percent (35,150 men) were actually tested. Of the men tested, 32,130 tested negative. As planned, CCHCS revised the Quality Management Cocci Risk Registry to incorporate the results of the cocci skin test and those who tested negative are now medically restricted from residing in the Cocci 2 Area (ASP and PVSP).

Currently, CCHCS continues to offer the cocci skin test to the 10,742 untested patients who are not already excluded from residence at ASP or PVSP for either custody reasons (e.g., condemned patients) or medical reasons (e.g., medical high risk). CCHCS continues to educate all patients about the cocci skin test, including information about adverse effects and the positive test rate in the CCHCS population. The cocci skin test is available to any patient who requests the test, if the patient has not already been tested.

CCHCS plans to offer testing to patients residing in out-of-state prisons (e.g., California Out-of-State Facility patients). The education for these patients on the cocci skin test has started and the offer of cocci skin testing will commence in August 2015.

CCHCS also continues to confer with counterparts at the Centers for Disease Control and Prevention and the California Department of Public Health regarding CCHCS’ cocci prevention program.

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
As reported in the Twenty-eighth Tri-Annual Report, little progress has been made in resolving, much less improving, the quality of care provided to the approximately 4,200 patients housed at the seven (7) contracted Modified Community Correctional Facilities (MCCF) in California. On-site audits have consistently and repeatedly highlighted poor clinical performance deficits and a lack of accountability. Although CDCR added registered nurse (RN) coverage on all three (3) shifts, systemic failures in the delivery of medical care include failure to consistently employ and retain qualified physicians, and failure to establish performance metrics as well as quality improvement processes. Under the current staffing model, there continues to be a lack of consistency in the qualifications, ongoing training, performance and accountability of physicians and clinical staff in general. Although the CDCR contract calls for the physicians to provide coverage five (5) days a week, several of the facilities are unable to secure a qualified physician. In at least one (1) case during this reporting period, patients did not have access to a physician for well over a month. These lapses cause patients to be returned to CDCR institutions where the medically necessary care is provided by CCHCS clinical staff instead of the contractor's staff.

At the end of May 2015, CCHCS submitted recommendations to CDCR's Contract Beds Unit identifying the need to amend the current contract. The recommendations detailed necessary changes to the existing MCCF contract language that would address health care delivery gaps and clearly define physician expectations as it relates to health care staffing and the relationships between health care delivered at the MCCF and the associated CDCR hub institution.

On April 15, 2015, in a population status benchmark report submitted to the Three-Judge Panel, the CDCR announced success in exceeding the court-ordered reduction by several thousand inmates. Shortly thereafter, CCHCS was requested by the CDCR to collaborate in facilitating the return of one-fourth of the approximately 8,100 inmates from four (4) existing out-of-state contract facilities. This shift will likely increase the CDCR's reliance on the MCCF capacity at a time when the quality and access to care at these facilities continues to decline. The CCHCS and CDCR staff are working collaboratively to implement additional remedial plans for the delivery of health care in the MCCFs.

Transportation Vehicles
The management of transportation vehicles, a function previously delegated by the Receiver to the Secretary, has been slow to emerge. Over the course of the past year, CCHCS successfully delivered 47 replacement vehicles to institutions. The CDCR continues in its efforts to retrofit these vehicles with the appropriate security modifications and install law enforcement

telecommunication radios. These vehicles are scheduled to be placed into service at the end of the second quarter of 2015.

In September 2014, CDCR initiated procurement for the first of 13 medical Emergency Response Vehicles (ERVs). During this reporting period, CCHCS took delivery of three (3) ERVs, and was advised the fourth and final procurement endeavor for four (4) additional ERVs was processed on April 24, 2015, and is pending award.

Lastly, the purchase orders for five (5) para-transit vehicles was awarded effective April 3, 2015, and are scheduled for delivery the first quarter of 2016. The procurement of the one (1) 22-passenger para-transit bus did not occur, although negotiations continue between CDCR and the vendor. The repeated efforts of CCHCS staff to obtain a procurement plan for the ongoing replacement of medical transportation vehicles were met with little progress. However, CDCR is now in the initial stages of developing an overall vehicle replacement plan that will encompass an annual survey and assessment of all vehicles. Upon receipt of the survey data, CDCR, working collaboratively with CCHCS, will reassess and develop an overall vehicle procurement plan on an annual basis.

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 Twenty-eighth Tri-Annual Report, Cerner Corporation has been selected to provide a commercial "off-the-shelf" Electronic Health Records System (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 Testing Phase.

During this reporting period, the EHRS project team initiated user-acceptance and system-acceptance testing on the workflows for more than 192 health care delivery processes. The project team performed a "Mock" clinic that demonstrated the solution build, to date, for the different modules to include Computer Provider Order Entry, mental health, scheduling, PowerChart, and ambulatory care. Project Communication and Organizational Change Management team members have continued the Learning and Adoption Phase engaging Change Ambassadors from the field and headquarters to provide solution demonstrations to their respective sites and staff. Additionally, several ECHOS articles (e.g., Devices, Project Roles, Information Technology support) and testimonial videos have been published and distributed informing enterprise-wide staff on the new EHRS. Finally, the training team is finalizing the curriculum and training material to support the approved training plan.

The EHRS project team continues to support the integration of an electronic dental record solution into the EHRS and is presently monitoring the completion of the requirements document.

Overall, the ECHOS project is 48 percent complete, and implementation of the EHRS will begin in October 2015.

B. Scheduling and Access to Care

Scheduling Process Improvement Initiative

In 2014, CCHCS introduced a statewide Scheduling Process Improvement (SPI) Initiative, which provided a structured process and a set of tools to improve access to care and scheduling efficiency locally. Phase I of the initiative included information and activities to improve the reliability of scheduling data, use of performance data to target specific scheduling processes, and the application of quality improvement techniques to improve scheduling efficiency and

access to care. A few of the institutions that used the SPI tools and resources were able to make substantial and sustainable improvements to local scheduling processes resulting in Scheduling Best Practices. Common themes emerged from the Best Practices and were incorporated into Phase II of the scheduling process improvement initiative.

In February and March 2015, CCHCS made SPI Phase II tools and strategies available to all institutions on the Quality Management Portal under a redesigned Scheduling Process Improvement Initiative Resources page (refer to Figure 1). Fourteen (14) institutions statewide received targeted technical assistance that included a customized report to help staff identify and analyze scheduling system problems, a webinar plus on-site hands-on training on key scheduling processes, and ongoing assistance through weekly forums. Nursing leadership statewide were also provided an orientation to SPI Phase II to familiarize them with their new role as leaders overseeing local medical scheduling processes.

Figure 1, Scheduling Process Improvement Initiative

C. Care Management

In the summer of 2014, CCHCS established the Population Management Care Coordination (PMCC) Committee with two (2) main objectives: Create a nursing focused care coordination model and improve health care transfers.

<u>Care Coordination Subgroup</u>

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 the summer of 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. Policy and training for the use of this tool is in development with an implementation targeted for the summer of 2015.

The Care Coordination subgroup has also updated the Medication Management policy and procedures to be reflective of the Complete Care Model of health care delivery. The policy and procedures are currently in the executive approval process with a target date for training in late June or July 2015 and a statewide implementation in August 2015.

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

- Establishing Patient Service Plans, 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 planned for late summer of 2015.
- Developing Disease Management Protocols for Nursing Care Managers. Implementation of Care Management of Complex Care Patients is planned for the fall of 2015.
- Developing, modifying and updating Complete Care Model 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 Complete Care Model policy and procedure, which is the anchor of the series, is currently in the executive review process. Completion of the series of policies is planned for the summer and fall of 2015. Next steps will be training development and implementation planning that will occur in the fall or winter of 2015.

Transfer Subgroup

In the fall of 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 application. This application automatically transfers medical hold information to the Strategic Offender Management System simultaneously, and places a movement warning on the patient. The subgroup has completed statewide education to both clinical and custodial staff. CCHCS is currently in the process of provisioning RN staff statewide to give RNs 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 undergoing final revisions as recommended during the approval process. 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. Train-the-trainer training for the new transfer tools and processes were conducted in

April 2015. Training of all institutional nursing staff and statewide implementation is expected by July 31, 2015.

Care Coordination and Case Management Tool – Patient Summary

In early 2015, Regional Nurse Executives and the Population Management Care Coordination Steering Committee organized a workgroup to develop a Patient Summary tool for screening clinical appropriateness for possible patient transfers, and to coordinate those transfers and ensure continuity of care. The Patient Summary, included as Appendix 1, is designed to be a clinical snapshot providing the most relevant patient health information including:

- Patient Demographics.
- Scheduling and Access to Care – Effective communication, disability status, accommodations, list of upcoming appointments, prior high priority specialty appointments.
- Medication Management – Polypharmacy, allergies, recently expired medications, list of active medications.
- Care Management – Prior higher level of care events, most recent Medical Classification Chrono, durable medical equipment.
- Disease Management and Prevention – Existing alerts from patient registries, list of diagnoses, dates / status of preventive care and screening.

The Patient Summary will also be used by care teams during their daily huddles and as decision support during complex care management activities.

D. Facilities

Regarding clinical facility upgrades through the Health Care Facility Improvement Program (HCFIP) projects, the last five (5) projects are in the preliminary design phase and 26 projects have proceeded into and/or have completed the working drawings phase. Of those 26 projects, 19 projects have been approved by the Office of the State Fire Marshal (SFM) and submitted to the Department of Finance (DOF) for approval to proceed to bid. To date, DOF has approved 16 of the 19 projects. The DOF also approved the award of contracts to general contractors for the HCFIP projects at Mule Creek State Prison (MCSP) and Richard J. Donovan Correctional Facility (RJD). Nine (9) more projects (California Institution for Men, California Institution for Women, California Men's Colony, California Medical Facility, Deuel Vocational Institution, FSP, NKSP, California State Prison – Sacramento [SAC], and Wasco State Prison [WSP]) are scheduled to be advertised for bid in May and June, 2015. In addition, significant procurement and mobilization activities are occurring by Inmate Ward Labor (IWL). The IWL construction (shovel in the ground) activities are underway for HCFIP projects at several institutions (ASP, California State Prison – Los Angeles County, SAC, RJD, and California State Prison – Solano) and for Statewide Medication Distribution projects at several other institutions (Calipatria State Prison, California Correctional Center, Centinela State Prison, Chuckawalla Valley State Prison, High Desert State Prison, and Ironwood State Prison).

Some schedule adjustments occurred due to additional design time required to implement SFM code compliance for general contractor documents, to reflect general contractor bid and award dates, and CDCR/CCHCS efforts to ensure integration of operational continuity plans and swing space. The revised schedules continue to reflect construction at ASP being completed in 2015 and construction of the remaining projects being completed in 2016 and 2017.

While CDCR continues to face schedule and budget challenges of the HCFIP projects and significant challenges in maintaining operational continuity in the facilities during construction, CDCR sustains the commitment, focus, and ability to manage construction and activation of these complex projects.

Section 3: Quality Assurance and Continuous Improvement Program

QM Program Infrastructure Update

The CCHCS Quality Management Program is composed of foundational elements including a strategic planning process, performance evaluation system, communication and coordination of improvement activities, use of nationally-recognized improvement tools and techniques, and staff development programs to build quality improvement capacity. The present Quality Management governance structure in place is the mechanism for coordinating these elements so that the health care system operates efficiently and effectively. During this reporting period, the Statewide Quality Management Committee (QMC) convened for three (3) sessions and discussed 2014 performance trends and best practices, potential updates to the Performance Improvement Plan for 2016–18, Joint Commission mock survey at headquarters, and the Receiver's Transition Plan and delegation process.

In addition to the governance structure at the statewide level, institutions are also required to have a well-functioning set of committee structures in place locally. The Institution QMC is responsible for developing and disseminating their annual Performance Improvement Work Plan (PIWP) and updating the PIWP at least quarterly; assigning improvement projects to subcommittees; monitoring the progress of projects and related performance objectives; and intervening when projects are not showing progress, among other functions. To support an effective local committee structure, Quality Management Support Units (QMSUs) are being trained on committee support tools, resources, and techniques. Training will be offered in the following three (3) major parts over the next three (3) to six (6) months:

- Part 1, Quality Management Committee Structure – Focuses on the purpose and functions of the committee structure; roles and responsibilities of various staff involved in committees either as a chairperson, member, or support staff; and the tools and resources available to help staff organize, coordinate, communicate, and manage change using the committee structure.
- Part 2, Managing Improvement Projects – Teaches staff nationally-recognized problem analysis and improvement techniques and when to use them; applying the Cycle of Change as a framework for managing change; and effective use of project management tools and techniques to support a local Quality/Process Improvement Team.
- Part 3, Data Driven Decision-Making – An in-depth look at ways in which data can be used to identify and analyze quality problems and assess progress toward improvement goals.

Polypharmacy Improvement Initiative

As of April 2015, five (5) percent of the total patient population in CDCR, or more than 6,300 patients, had current prescriptions for ten (10) or more medications. Many of these patients are considered clinically complex, and all are at risk for medication adherence problems and drug-drug interactions. To address this patient safety concern, the Statewide Patient Safety and Pharmacy and Therapeutics Committees formed an interdisciplinary workgroup to develop

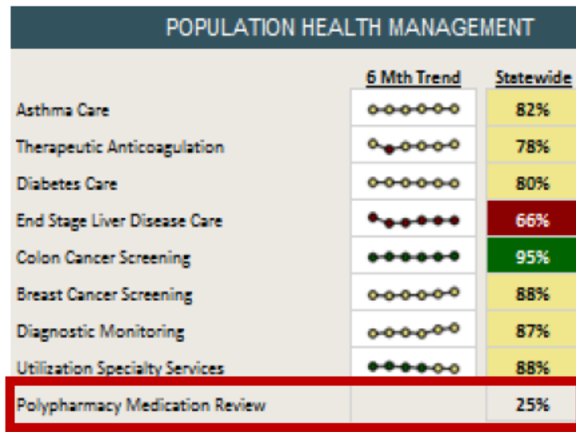
a process for medication regimen reviews, clinical decision support including a Polypharmacy Registry and continuing education training.

The Health Care Services Performance Improvement Plan 2013–15 also identifies polypharmacy as a priority area with the following performance objective:

"By December 31, 2015, 95% or more of patients prescribed 10 or more medications will have their medication regimens reviewed consistent with requirements."

Baseline results of Polypharmacy medication reviews are now available on the Health Care Services Dashboard under the Population Health Management domain (refer to Figure 2). Reporting will remain in monitoring status (but not color-coded) until 2016 to allow institutions a period of time to operationalize a local polypharmacy review process.

Figure 2, Population Health Management



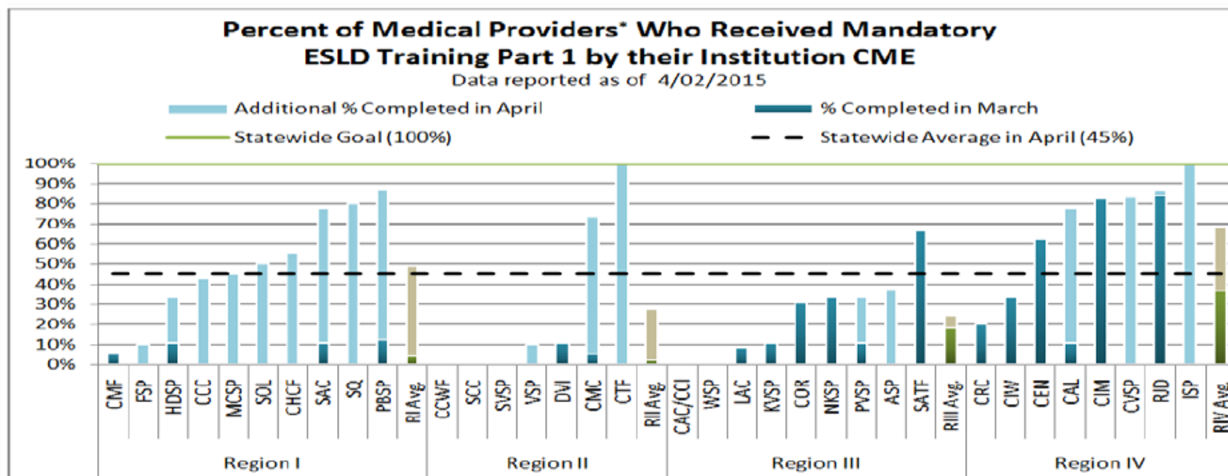
POPULATION HEALTH MANAGEMENT

	6 Mth Trend	Statewide
Asthma Care		82%
Therapeutic Anticoagulation		78%
Diabetes Care		80%
End Stage Liver Disease Care		66%
Colon Cancer Screening		95%
Breast Cancer Screening		88%
Diagnostic Monitoring		87%
Utilization Specialty Services		88%
Polypharmacy Medication Review		25%

End Stage Liver Disease Improvement Initiative

End Stage Liver Disease (ESLD) remains the second leading cause of death within CCHCS over the past five (5) years and there continues to be "Possibly Preventable" deaths in this category. To help care teams manage these complex patients, decision support tools were developed including an ESLD Care Guide, Patient Registry, and mandated Continuing Education (CE) for clinicians. The ESLD CE training material was presented in two (2) parts that 1) focused on case studies and appropriate treatment; and 2) oriented providers to the ESLD Patient Registry. Institution Chief Medical Executives were trained on the CE and made responsible for ensuring their provider staff completed the mandated training – as of April 2015, 45 percent of all provider staff statewide met this requirement (refer to Figure 3).

Figure 3. Percent of Medical Providers Who Received Mandatory ESLD Training Part 1 by their Institution CME



Patient Safety Priorities

During this reporting period, the Statewide Patient Safety Committee selected the following eight (8) improvement priorities for the next 12–18 months with an emphasis on improving program infrastructure and tackling system vulnerabilities that place patients at risk for adverse/sentinel events:

1. Establish a Medication Process Improvement Initiative.
2. Implement a Quarterly Health Care Incident Reporting Dashboard.
3. Refine the Health Care Incident Reporting Taxonomy.
4. Update the Health Care Incident Reporting Process.
5. Simplify the Health Care Incident Reporting Form.
6. Provide Patient Safety Program Update Training.
7. Re-survey Health Care Staff on Patient Safety Culture.
8. Disseminate the 2015 Annual Patient Safety Report.

Patient Safety Priority – Quarterly Dashboard

Health care incident reports have been collected since 2012 and data from the reporting system has been analyzed and summarized for various audiences, but was not made available in an accessible format for health care staff until now. The Patient Safety Quarterly Dashboard, currently in its final stages of design and testing, will provide institution-specific data regarding incidents reported through the Health Care Incident Reporting System during a reporting quarter, and includes a summary of incident reports received, details related to medication errors and root cause analyses, and record-level data for deeper analysis and trending. Every quarter, the Patient Safety Dashboard will summarize major statewide findings and activities during the quarter, for example:

- During the first quarter of 2015, there were 1,261 health care incidents reported through the Health Care Incident Reporting System. This is more than twice the number reported during the first quarter of 2014, suggesting that health care staff are becoming more comfortable using this reporting system.
- Medication errors represent approximately 90 percent of all reported health care incidents; however, the vast majority of the errors did not harm patients (i.e., less than Level 4), which is good news because it provides opportunities to improve clinical processes before harm occurs.
- In 2014, 35 reported cases were identified as adverse/sentinel events requiring a Root Cause Analysis. Of those 35 events, 54 percent involved breakdowns during transitions of care or handoffs, which have already been identified as a major improvement priority by leadership resulting in changes in the transfer process and development of decision tools and training spearheaded by Population Management Care Coordination Steering Committee.

Patient Safety Priority – Medication Process Improvement Initiative

The 2014 Patient Safety Report identified medication processes as a major factor in adverse patient outcomes. Data from the 2014 report revealed that medication-related problems contributed to patient deaths, system lapses identified through death reviews, potentially avoidable hospitalizations, and represented over 90 percent of all reported health care incidents. The Statewide Patient Safety Committee has established a Medication Process Improvement Initiative that will charter workgroups to develop tools, resources, training and best practices to improve patient safety around medication-related processes and specific medications or medication classes.

Patient Identification

National Patient Safety Week occurred during this reporting period and CCHCS/Division of Health Care Services (DHCS) focused its patient safety awareness campaign on a common patient safety problem – patient misidentification. To help staff see that this particular problem is not discipline-specific, a Patient Safety Story was written about patients in three (3) separate health care processes that experienced an adverse event as a result of patient misidentification (refer to Figure 4). The story included a comprehensive training presentation by the Statewide Nursing Program on the six (6) Patient Rights as a way to provide additional decision support to those involved in the medication administration process.

Figure 4, Sharing Safety Stories

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES — PATIENT SAFETY COMMITTEE AND ADVERSE SENTINEL EVENT COMMITTEE

Sharing Safety Stories
March 2015

Patient Misidentification Leads to Adverse Events – Three Stories

Liver Biopsy on the Wrong Patient

During the morning on a regular clinic day, a Primary Care Provider (PCP) saw Mr. B, a 30-year old man complaining of shoulder pain. The PCP initiated a specialty services request for physical therapy as part of the treatment plan for this patient.

In the afternoon of the same day, the PCP saw Mr. K, who had been diagnosed with a liver condition. During this appointment, the PCP explained the need for a liver biopsy. Mr. K agreed to the procedure, and the PCP completed the specialty services request – but inadvertently used Mr. B's name and CDCR number under the demographic portion of the referral form instead of Mr. K's.

Using the information provided by medical staff, custody officers brought Mr. B to a local community hospital for the liver biopsy. Mr. B, whose primary language is not English, was confused about what was happening, but thought it had something to do with his shoulder and tried to be cooperative. Hospital staff completed the liver biopsy and Mr. B returned to the prison. The following day, he complained of nausea and vomiting and was ultimately admitted to the hospital due to complications. He was released two days later without permanent injury.

Tooth Extraction on the Wrong Patient

Mr. L reported to the dental clinic for extraction of two teeth on a day when his assigned dentist was not available. The dentist on duty was seeing both patient lines – his own and that of the other dentist.

During the preparation for treatment, Mr. L's paperwork was inadvertently switched with another patient. Using the incorrect documentation, the dentist on duty mistakenly extracted a tooth that was not on the patient's treatment plan.

When the error was discovered shortly after it occurred, it was reported immediately. Mr. L was returned to the clinic and the situation explained to him. Follow-up treatment ensured that the extraction site healed properly and the correct teeth were extracted.

Medication Administered to the Wrong Patient

A nurse administering medications during an afternoon pill line accidentally gave an inmate seizure medication that had not been prescribed to him. The nurse had been checking each inmate's identification during the medication pass, but had confused two patients with the same last name, housed in the same yard, one of which had been a recent transfer to the institution.

Shortly after taking the medication, the patient began to display seizure-like symptoms. He was immediately transferred to the TTA and, after additional evaluation, was transferred to the local hospital's emergency room. The inmate was released from the emergency room after observation and has experienced no further symptoms.

It takes a team to achieve quality and safety — Page 1

Increase Reporting

Whether or not CCHCS/DHCS can acquire data to trend and identify broken processes and other patient safety concerns is dependent upon health care incidents and medication errors reported by health care staff. In January 2015, the Patient Safety Committee convened a focus group with representatives from institutions that had a high volume of medication error reports in 2014 to discuss strategies to improve reporting rates.

Participating institutions were asked to explain how they created an environment that encourages staff to report health incidents and describe the structures they put in place to review and take action on safety issues that were identified through the incidents. A best practice to "Improve Your Reporting Rate" was developed based on the focus group discussion and disseminated to all health care staff.

Section 4: Receiver's Delegation of Authority

Receivership Transition Plan

On March 10, 2015, Judge Thelton Henderson issued an order, entitled Order Modifying Receivership Transition Plan, 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 back one at a time after the Receiver, through several steps, determines that a prison is providing adequate medical care.

Under the plan, the OIG first completes their medical inspection of the prison and provides an overall rating regarding the care provided (as previously reported, the OIG has redesigned its medical inspection process by enhancing its quantitative compliance testing and adding qualitative clinical case reviews). There are three (3) rating categories: Proficient, Adequate, or Inadequate. Should a prison receive an Adequate or Proficient rating, the Receiver will then consider the OIG report, as well as data from the CCHCS dashboard and other internal monitoring tools. If the Receiver determines that an institution is suitable for return to CDCR control, he will execute a revocable delegation of authority to the Secretary of CDCR to take over management of that institution's medical care. The Receiver's delegation creates a rebuttable presumption that medical care provided in the prison is constitutionally adequate.

In addition, prior to executing any delegation of authority, the Receiver must meet and confer with both parties to the lawsuit, as well as consult with the court experts. Under the new order, any party that disagrees with the Receiver's delegation decision (either to delegate or not delegate) may challenge the decision by filing a motion in court. However, that party would have the burden of proof.

The Receiver will also continue to determine the appropriateness and timing of delegating additional core headquarters functions to CDCR. When a prison or headquarters function is delegated to CDCR, the Receiver will provide monthly monitoring reports to the Court that provide a public record concerning the performance of the operations. A delegation can be revoked by the Receiver after meeting with both parties and the court experts. However, if the Receiver leaves all delegations in place without revocation for a one-year period certifying that all functions and institutions have been delegated, it will create a rebuttable presumption of system-wide constitutional adequacy and sustainability. When that occurs, the Prison Law Office will have 120 days in which to challenge the presumption. If no such motion is filed, the Court will proceed with steps to terminate the Receivership and the underlying *Plata* case.

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 2014 through March 2015. Due to recent turnover in institution Health Care Access Unit (HCAU) Analysts, Field Operations staff provided AQR training at CCHCS headquarters on March 27, 2015. Staff from six (6) institutions attended.

During this reporting period, Field Operations staff continued to collaborate and coach institution staff on improving data collection processes, specifically with tracking and reporting patient access to mental health group appointments. As a result, institutions were reminded of the statewide mandate, which requires the outcomes of all priority health care ducats, inclusive of those issued for mental health group appointments, be recorded on a custody tracking sheet for data validation purposes. As these institutions began utilizing the required custody tracking process, many challenges were encountered with capturing and recording the outcomes due to the enormous volume of appointments. This problem surfaced at MCSP as of the December 2014 AQR publication. Their score of 26.49 percent ultimately caused the statewide overall custody performance indicator to fall below the Receiver's benchmark of 99 percent as outlined in the delegation related to HCAUs. While showing improvement since the December report, the monthly statewide overall custody performance indicator has not met or exceeded the benchmark.

As indicated in previous Tri-Annual Reports, the time and shift system ("TeleStaff") does not provide certain data points the institutions are required to report to complete the AQR. TeleStaff continues to require adapted data retrieval methods for Transportation and Medical Guarding hourly overtime, permanent intermittent employee, and redirected staff hours. Since the institutions are unable to extract the data utilizing a single report, Field Operations staff has trained all HCAU Analysts at the institutions on how to accurately obtain and calculate the information. As a result of ongoing discussion between the Division of Adult Institution's Program Support Unit and Field Operations staff, the Program Support Unit staff is developing a single reporting mechanism for the analysts to utilize.

Custody Access to Care Success Rate

Statewide AQRs were published for the months of December 2014 through March 2015 during this reporting period. The average custody *Access to Care Success Rate* for this period was 93.75 percent, below the Receiver's benchmark of 99 percent as explained in the preceding section of this report. This represents a decrease of 5.83 percentage points as compared to the Twenty-eighth Tri-Annual reporting period (inclusive of data from August through November 2014).

Refer to Figure 5 for a summary, by month, of the number of institutions failing to attain the 99 percent benchmark established in the delegation.

Figure 5, Institutions Failing to Attain the 99.00% Standard for the Custody Access to Care Success Rate

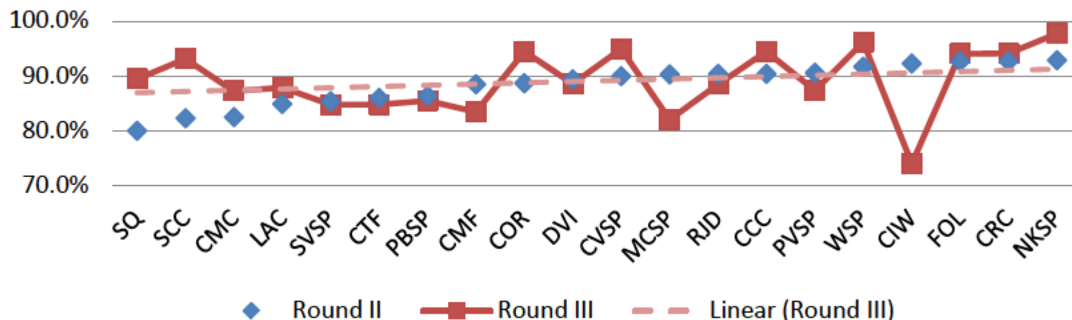
**Institutions Failing to Attain the 99.00%
Standard for the Custody Access to Care Success Rate**

Dec-14	Jan-15	Feb-15	Mar-15
CCWF 89.50%			
CMF 98.04%		CIW 98.67%	
COR 98.59%		DVI 98.42%	
LAC 63.19%	KVSP 98.83%	LAC 78.57%	
MCSP 26.49%	LAC 71.03%	MCSP 88.77%	
PVSP 97.04%	MCSP 26.59%	PBSP 98.69%	
SOL 95.62%	PVSP 97.78%	SAC 97.62%	COR 97.16%
SVSP 86.84%	SOL 98.96%	SVSP 92.93%	LAC 80.88%
VSP 97.33%	SVSP 87.91%	VSP 93.14%	MCSP 98.74%

For institutions failing to attain the benchmark, 28 Corrective Action Plans (CAPs) were required during this reporting period. Field Operations received 27 of these CAPs.

<u>Operations Monitoring Audits</u>
As of the close of this reporting period, Field Operations has completed two (2) annual audits of 33 adult institutions[1], and is nearing completion of the third annual audit cycle. As an extension to the Round III audit cycle, Field Operations is now conducting six-month reviews for institutions with low overall or component scores. Cumulatively, Round I, II and III scores indicate an average *net* improvement of 3.2 percentage points overall.

Figure 6, Round II vs. Round III Audit Performance



While five (5) institutions' overall scores remain below 85 percent after Round III, the majority have risen substantially above that benchmark. Refer to Figure 6, Round II vs. Round III Audit Performance. Despite this trend, significant non-compliance concerns remain, and new non-compliance issues continue to surface at some locations. Many institutions struggle to comply with simple documentation requirements necessary to prove continuity of patient access to care. Other institutions show weak compliance in areas directly impacting patient care, such as monitoring of patients recently discharged from a Mental Health Crisis

[1] The California Health Care Facility and California City institutions are not part of the HCAU audit cycle.

Bed (MHCB), ensuring MHCB transfers occur timely, and ensuring patients with prescribed keep-on-person (KOP) medications have unobstructed access to those medications. While many institutions have matured in embracing health care as a normal function of daily operations, some pockets of resistance remain. The following are specific examples in which the annual Round III audit, or subsequent Round III six-month review, found corrective action items which persisted through several audit cycles, and remain significantly non-compliant:

- Custody staff failing to move medications with patients transferring between facilities (MCSP, CRC).
- Custody officers packing KOP medications with the patient's personal property (RJD/NKSP).
- Diabetic patients not having access to food within 30 minutes of receiving insulin treatment (WSP).
- Custody welfare checks of patients not occurring following discharge from an MHCB (RJD/PVSP).

Section 5: Other Matters Deemed Appropriate for Judicial Review

A. California Health Care Facility – Level of Care Delivered

CHCF continues to remain focused on provider recruitment and on ensuring the delivery of quality health care to the patient population. During the reporting period, CHCF was on pause for medical CTC and Outpatient Housing Unit (OHU) intake. However, CHCF remained open for intake for Enhanced Outpatient Program, Correctional Clinical Case Management System, and MHCB Levels of Care. The following, additional specific updates for CHCF are provided:

Medical Services

- CHCF continues to struggle with limited medical provider resources and lack of viable candidates to fill vacancies. While many strides have been made in the recruitment and retention process and creative solutions have been implemented such as dual appointments and scheduling changes; this remains the focus of the Health Care administrative team. To assist CHCF, in late February 2015, a temporary policy exception for the medical OHU was granted. Also in late February 2015, a temporary program flex for the medical CTC was granted by the California Department of Public Health.
- CHCF continues to utilize Headquarters Telemedicine to assist with primary care coverage, particularly in the Special Outpatient treatment areas. Additionally, CHCF continues to work with headquarters to address the availability of offsite specialist's appointments and potential specialty appointment alternatives (e.g., contract with other area hospitals, provide additional on-site services) to increase access to care and ensure compliance timeframes are met.
- Significant program changes for allied health services have been implemented and have proven successful. Respiratory Care Services now offers 24 hours per day, seven (7) days per week coverage and the imaging process systems has been streamlined.
- Medication safety and non-formulary drugs remain priorities at CHCF and are being managed further by workgroups. During the reporting period, the number of medication errors has trended downwards and is a result of additional training and audits. CHCF continues to work on decreasing the number of non-formulary medications prescribed by both medical providers and psychiatrists. The Non-Formulary Workgroup focus is on addressing medications that are unsafe or of questionable utility and guide the prescribing physicians through protocols and support into prescribing formulary medications. In addition, they will focus on the taper-off process of non-formulary medication, as well as, the process when a non-formulary medication is denied.

<u>Quality Management</u>

- CHCF recently revised the QMC structure to further align with the statewide policy. As a result, there has been a significant reduction in the number of committees and subcommittees previously being held and CHCF has significantly streamlined the Quality Management process.
- A SharePoint site has been created, allowing staff to view current Quality Management activities and to help facilitate the flow of information and communication amongst all staff.
- *Armstrong* compliance at CHCF continues to improve. The Health Care Compliance Analyst has streamlined processes and assisted in training staff to successfully reduce the Disability Placement Program Log overdue allegations from 158 to 44.
- CHCF Institutional Utilization Management successfully met all institutional goals set for reductions. Of note, hospital admissions continue to decrease; administrative bed days remain at zero (0); there was a 13 percent decrease in Requests for Services from January to February 2015; and this continues to be on a downward trend.
- Significant progress has been made by the HCAU in addressing the backlog of overdue appeals. The percentage of overdue health care appeals for February 2015 was at 33 percent and then reduced further to 14 percent in April 2015. Department of State Hospitals (DSH) lacked an appeals coordinator for a period of time and had a significant backlog. For the month of April 2015, 111 appeals remained open, of which 78 were overdue. However, steady improvement is noted.
- Town Hall meetings continued to provide all staff an opportunity to meet and ask questions of the leadership team. The second set of meetings occurred over three (3) days with three (3) meetings per day in late February 2015. Based on survey results, staff and leadership both considered the effort a success.
- CCHCS staff continues to work collaboratively with CDCR and DSH in anticipation of routine California Department of Public Health Surveys, Headquarters monitoring tours and court monitoring tours.

<u>Nursing Services</u>

- CHCF's Falls Workgroup, which meets on a monthly basis, continues to make significant progress as evidenced by the decrease in the number of falls. March 2015 data shows a 39 percent decrease in the number of falls as compared to the data two months earlier in January 2015.
- Patient Safety Committee is currently reviewing its policy on the use of soft restraints for patients with dementia.
- The Wound Care Workgroup continues to meet on a monthly basis, with March 2015 data reflecting a decrease in the number of pressure ulcers and a continued downward trend.
- Increased areas of improvement and focus include a pneumonia vaccination program, sepsis prevention and early intervention plan, colon screening (which is currently 99 percent on the Dashboard), and meeting compliance with intake appointments.

Resource Management

- The Resource Management Committee continues to meet monthly. This Committee is responsible for the oversight and review of the CHCF Financial Services Subcommittee and Position Management Sub-Committee, which focus primarily on fiscal review including areas of overtime, contract medical costs, and position management control. Significant areas of improvement during the reporting period include:
    - Ability to provide more accurate budget projections.
    - Reduction in overtime costs for providers by 24 percent.
    - Reduction in overtime costs for nursing staff by 50 percent.
    - Reduction in urgent orders from an average of 20 or more per month to zero (0).
    - Stabilized par levels in housing units.
    - Recruited hundreds of nursing staff with a focus on hiring quality staff.
    - Provided remedial performance management training to supervisors.
- During the reporting period, CHCF was fortunate to welcome back our prior Chief Executive Officer in mid-April 2015. It was under her leadership that CHCF made substantial progress in meeting and maintaining quality of care standards. During this time, we were also able to hire a third Chief Physician and Surgeon and a Health Program Manager III. However, even with these significant hires, critical management positions such as the Correctional Health Services Administrator II, Health Program Manager II, and Supervising Registered Nurse II positions remain vacant.
- CHCF In-Service Training resumed Annual Training for CHCF-CCHCS staff in January 2015. The percentage of staff receiving New Employee Orientation and CTC Training is currently at 90 percent compliance.

Ongoing Priorities

- Recruitment and retention for providers and management positions.
- OIG Inspection: CHCF recently created an OIG medical inspection audit tool to assist in preparation for future inspections. The tool specifically outlines program areas and processes under review, measures of performance, audit sampling size, frequency of audits, and responsible staff.

B. Statewide Medical Staff Recruitment and Retention

As of April 2015, 87 percent of the nursing positions have been filled statewide (this percentage is an average of six [6] State nursing classifications). More specifically, 74 percent of institutions (26 institutions) have filled 90 percent or higher of their RN positions. This represents an increase in compliance by 17 percent. Correspondingly, CCHCS experienced a decrease in those institutions with less than 89 percent staffing rates, with 17 percent of institutions (six [6] institutions) with fill rates between 80 and 89 percent of their RN positions and only nine (9) percent (three [3] institutions) with fill rates of 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 63 percent of institutions (22 institutions), and 17 percent (six [6] institutions) have

filled between 80 and 89 percent of their LVN positions. Only 20 percent of institutions (seven [7] 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 school career websites, www.ChangingPrisonHealthCare.org, www.Indeed.com, and www.VetJobs.com. Each job posting typically represents multiple vacancies at an institution, and CCHCS staff continues to monitor vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

In general, physician recruitment efforts continued to focus on "hard-to-fill" institutions during this reporting period. As of April 2015, 91 percent of physician and surgeon (P&S) positions are filled statewide (this percentage is an average of all three [3] State physician classifications). More specifically, 54 percent of institutions (19 institutions) have achieved the goal of filling 90 percent or higher of their P&S positions. Of these 19 institutions, 15 have filled 100 percent of their P&S positions. Additionally, 34 percent of institutions (12 institutions) have filled between 80 and 89 percent of their P&S positions, and 11 percent (four [4] institutions) have filled less than 80 percent of their P&S positions, which represents an increase of 9 percent of institutions no longer reporting fill rates of less than 80 percent.[2]

Workforce Development is continuing to look for innovative ways to improve this trend. Job postings for physicians continue to be placed online at the CCHCS' recruitment website and other online job boards, and staff continue to recruit at medical conferences. CCHCS' present and future recruitment efforts for nursing and primary care provider classifications include the following:

Sourcing – With Workforce Development's staffing request approved, the additional staffing will permit CCHCS to include sourcing as part of its recruitment efforts. Sourcing will allow Workforce Development to access resumes posted by health care professionals on specific websites where those health care professionals are actively seeking employment and engage directly with them.

Visa Sponsorship Program – The Visa Sponsorship program provides opportunities for international candidates looking to gain experience in the United States. The common feature of the various visa types that CCHCS sponsor, which includes TN, J-1 Waiver, H-1B and PERM, is that the employer is an integral part of the process. CCHCS is considered an exempt employer, which means CCHCS can sponsor more employees than the typical non-exempt employer. This program has proved invaluable in CCHCS' recruiting efforts for psychiatrists and has started to be utilized for other classifications including Nurse Practitioner and Recreation Therapist. To continue and expand this effective program, we have included language promoting visa sponsorship in all advertising for the P&S classifications.

[2]Percentages may not necessarily add to 100 percent due to rounding.

Classification Salary Review – In an effort to ensure that CCHCS remains competitive in an ever-changing market, we are conducting annual and periodic salary reviews of CCHCS' health care positions. This is achieved by contracting with CPS Human Resource Consulting to survey total compensation of health care professionals throughout the field on a nationwide level. The resulting data will be combined with additional analysis of data gathered by CCHCS to provide a more thorough and comprehensive review of our current pay plan structure against those of our top competitors (both public and private) and make necessary recommendations. Additional surveys will be conducted on a regular basis to identify potential salary trends so that we can stay abreast of the current labor market and remain competitive in the future.

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 Twenty-eighth Tri-Annual Report, Workforce Development and associated program staff have attended three (3) California-located conferences for the P&S classifications and two (2) conferences for the Pharmacy classifications. Additionally, CCHCS has maintained a presence at three (3) out-of-state conferences for the P&S classification and one (1) 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 in a way that no online posting or print advertisement can.

Educational Programs Within Our Institutions – As of this reporting period, 13 institutions are implementing formal health care education programs including rotations, clinicals, externships, and internships. These programs represent multiple Medical, Mental Health, Allied Health, and Dental Programs. CCHCS is working to expand these programs as a viable source for future candidates.

Workforce Development is working directly with programs to provide and implement statewide standards to our health care student rotations in order to improve ease and 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 – In addition to expanding and monitoring students as they engage in health care student rotations through CDCR institutions, Workforce Development is also working directly with California medical schools in an effort to promote correctional medicine as a specialty and CCHCS as an employer of choice.

Exit Survey – In an effort to address retention rates, CCHCS is piloting an Exit Survey at one of its institutions, with plans to roll-out the survey statewide in the coming months. 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.

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 (2) 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 (2) 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, compensation analysis, 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 2015. 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: Physicians Filled Percentage and Turnover Rate, Physicians Filled Percentage, Physician Turnover Rate, Nursing Filled Percentage and Turnover Rate, Nursing Filled Percentage, and Nursing Turnover Rate.

C. Joint Commission

As reported in the Twenty-eighth Tri-Annual Report, the CCHCS has reviewed various models of independent performance evaluation and is considering accreditation by the Joint Commission. During the reporting period, Joint Commission Resources (the teaching and consultative arm of the Joint Commission) conducted two (2) mock accreditation audits: one (1) at MCSP during the week of January 26, 2015, and the second at headquarters and FSP during the week of March 10, 2015. Joint Commission Resources provided two (2) reports that outlined their findings and recommendations at the institution and headquarters levels. The findings confirmed what the organization's leaders expected and highlighted areas of improvement. Joint Commission accreditation would enable the CDCR to monitor the provision of health care in a manner that is well understood within the health care industry. Further efforts in this area will plan around the implementation of EHRS, the OIG's medical inspections, and the transition and delegation activities that are presently underway.

D. Coordination with Other Lawsuits

During the reporting period, regular meetings between the three (3) federal courts, *Plata, Coleman,* and *Armstrong* (Coordination Group) class actions have continued. Coordination Group meetings were held on February 5 and March 11, 2015. Progress has continued during this reporting period and is captured in meeting minutes.

E. Master Contract Waiver Reporting

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

As ordered by the Court, included as Appendix 4, is a summary of the contracts the Receiver awarded during this reporting period, including a brief description of the contracts, the projects to which the contracts pertain, and the method the Receiver utilized to award the contracts (i.e., expedited formal bid, urgent informal bid, sole source).

F. Consultant Staff Engaged by the Receiver

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

G. 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 2015 were $604,129 and $0, respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 5.

2. Revenues

For the months of January through April 2015, the Receiver requested transfers of $400,000 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 fiscal year 2014–15 to CPR from the State of California is $1,200,000.

All funds were received in a timely manner.