

04/03/08 2:06 PM

Clark

Congratulations on your appointment as receiver. From what I hear, you have a formidable and exciting challenge. I'm happy to comment on the draft strategic plan. Please feel free to call or correspond if you would like to discuss anything further. I think the draft plan is excellent, with the exception of the areas I address below. These are my comments and opinions, based on my experience across the country, not specific to CDCR, which I don't know very well:

1. A sixth goal is critical for sustained improvement. "Develop a comprehensive quality management program, including performance measurement of access, credentials, and clinical quality. It belongs right on top.
This would include a quality management plan, an annual work plan, and an annual evaluation." (Objective 4 could be beefed up a bit.)
2. The mission should say "to integrate the delivery of . . ." instead of "coordinate." This will help break down the traditional walls between disciplines. Further, I recommend that addiction treatment be integrated, as well.
3. Consider reentry as part of the mission and strategic goals. It doesn't do any good to release a well-controlled schizophrenic to the streets, without housing and continuity of medical care. He or she will be back too soon.
4. "Sick call" is a widely-used term behind bars (and in the military).
In my opinion, "sick call" is should be abolished as a phrase, except for history books. It is archaic. Instead, I would focus on developing a primary care model, with continuity of care with a primary practitioner to the extent possible. Of course, other practitioners might be involved with acute care if the primary is not available.
5. In re: Objective 1.4, I would be explicit that the warden/superintendent of each facility be held accountable for performance in this area. In other words, staffing is not enough. The warden has to make sure that patients get to their practitioner in a timely way. This would apply for appointments, medications, and urgent and emergency care.
6. Goal 2 must have a typo. What about acute care? Add diabetes care.
It's amazing how effective good diabetes care can be in reducing morbidity, mortality, and cost of care. This shouldn't wait.
7. Objective 2.2 should have a section on non-formulary medication. Requests for non-formulary medications should be processed quickly. Denials should only be done by a physician. No one lower on the chain. The physician should document the medical reasons for each denial or recommendation for an alternative therapy.

8. Objective 2.3 Add something about a tracking system, and a provision for the patient to be seen at least every 30 days while an appointment is pending, with some provisions for waiver of the 30 day visit. That way, practitioners can be assured that the patient is not deteriorating during the waiting period.

9. Objective 3 is lacking a credentialing process. It should include, at a minimum, primary verification of license registration with the state board, including: a credentialing committee; a physician overseer of the committee; an inquiry into any sanctions or restrictions; the status of clinical privileges at hospitals, if any; a valid DEA or CDS certificate (physicians, PAs, DDS, etc.); primary verification of board certification, if any; work history; current malpractice insurance (if appropriate); history of professional liability claims that resulted in settlements or judgments; queries in the application as to reasons for any inability to perform the essential functions of the position, with or without accommodation; lack of present illegal drug use; history of loss of license and felony convictions; history of loss or limitation of privileges or disciplinary activity; and attestation by the applicant of the correctness and completeness of the application. Also, National Practitioner Data Bank query. Recredentialing should occur every three years, at a minimum. Dates of receipt of information and committee decisions should be well-documented. Staff should have an appeal process. [These are taken from the National Committee on Quality Assurance and they are similar to the requirements of the Joint Commission on Accreditation of Health Care Facilities.]

10. Objective 5.2 should refer to inmates with "special needs" including medical, mental, physical disability, etc. Special needs is a term of art in prisons.

Let me know if I can be of further help. I'm in my office today and tomorrow, Friday, but I may be hard to reach for the following three weeks. I'll check voicemail more than e-mail during that time.

Bob

Robert B. Greifinger, M.D.