CALIFORNIA
PRISON HEALTH CARE
RECEIVERSHIP CORP.

J. Clark Kelso
Receiver

April 24, 2008

Dear Dr. Greifinger:

Thank you for your close reading of our draft strategic plan and for your longstanding leadership in correctional health care. We will respond to each of your points.

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.)

As you have acknowledged, the draft strategic plan addresses this domain in Objective 4, including Action 4.2.1., "Establish sustainable quality measurement, evaluation and patient safety programs." We share your sense of the importance of the quality program, but we had compelling reasons for putting other items on top.

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.

We agree and will make this change.

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.

We acknowledge your insight. At a statewide level, the Office of the Receiver has been focused on creating basic infrastructure elements as a precondition for delivering adequate care within prison, but we have supported reentry initiatives at local prisons, *e.g.*, San Quentin. Now that we are actively engaged in creating new facilities and information systems, reentry is emerging as a strategic driver in its own right, so we are beginning to consider its place in our goals and objectives.

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.

There are historical and organizational reasons for continuing to use the term "sick call" in our system, but we agree that we need to move to a primary care model, and that

commitment is reflected in our Access-to-Care Initiative. We would welcome your feedback on that initiative.

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.

Although not detailed within the draft strategic plan, the Receiver as well as current CDCR policy do explicitly hold wardens responsible for performance regarding health care access.

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.

Objective 2.3 addresses acute hospital care, and the Access-to-Care Initiative is more explicit about developing a utilization management system to ensure appropriate use of hospital services. As noted under Objective 2.2, the Pharmacy and Therapeutics Committee has developed new medication management protocols for a number of chronic illnesses, including diabetes. We chose to begin our first comprehensive practice redesign initiative with asthma rather than diabetes, but our focus on diabetes will begin well before the asthma initiative is fully completed.

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.

We have developed and implemented appropriate policies regarding non-formulary medications. We do not believe this issue needs to be in our strategic plan.

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.

We addressed tracking in Objective 1.5., "Establish Health Care Scheduling and Patient-Inmate Tracking System."

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.]

You will be pleased to hear that the CDCR's initial credentialing procedures are relatively mature. A state-of-the-art credentialing database, which we are currently implementing, will facilitate improvements in our recredentialing practices. This item did not rise to strategic importance as we drafted our plan.

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.

We are quite familiar with the term, "special needs," as used for example in Anno BJ, et al., *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates*. (Middletown, CT: Criminal Justice Institute; 2004). We have done original research on long-term care needs of prison inmates. (See Lumetra and Abt Associates reports on the CPR website, http://www.cprinc.org/resources_other.htm. Publications for peer-reviewed journals are in draft form.) The "special needs" designation is used to cover a variety of conditions, some of which do not automatically justify the higher levels of care offered that will be offered in the new health care facilities, so we have not found it useful in this context.

Thank you again for your careful and generous review of our draft strategic plan. We appreciate your many contributions, including your recent and very useful book emphasizing the public health dimensions of prison medicine.

Sincerely,

J. Clark Kelso
Receiver