FUTTERMAN DUPREE DODD CROLEY MAIER LLP
MARTIN H. DODD (104363)
601 Montgomery Street, Suite 333
San Francisco, California 94111
Telephone: (415) 399-3840
Facsimile: (415) 399-3838
mdodd@fddcm.com

Attorneys for Receiver
J. Clark Kelso

**UNITED STATES DISTRICT COURT**

**FOR THE EASTERN DISTRICT OF CALIFORNIA**

**AND FOR THE NORTHERN DISTRICT OF CALIFORNIA**

| | |
|---|---|
| MARCIANO PLATA, et al.,<br>*Plaintiffs*,<br>v.<br>EDMUND G. BROWN, JR., et al.,<br>*Defendants*. | Case No. C01-1351-JST |
| RALPH COLEMAN, et al.,<br>*Plaintiffs*,<br>v.<br>EDMUND G. BROWN, JR., et al.,<br>*Defendants*. | Case No. CIV-S-90-0520-KJM-DB |
| JOHN ARMSTRONG, et al.,<br>*Plaintiffs*,<br>v.<br>EDMUND G. BROWN, JR., et al.,<br>*Defendants*. | Case No. C94-2307-CW |

**NOTICE OF FILING OF RECEIVER'S THIRTY-NINTH TRI-ANNUAL REPORT**

///

///

///

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

Dated: October 1, 2018

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-ninth Tri-Annual Report of the Federal Receiver For May 1 – August 31, 2018

**October 1, 2018**

## 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.

# Table of Contents

## Section 1: Status and Progress Concerning Remaining Statewide Gaps

### A. Reporting Requirements and Reporting Format

This is the thirty-ninth report filed by the Receivership, and the thirty-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 https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/2006-02-14_Order_Appointing_Receiver.pdf)

The Court's March 27, 2014, Order Re: Receiver's Tri-Annual Report directs the Receiver to summarize 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.

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. (https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/T11_20090601_11thTriAnnualReport.pdf)

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 May 1 through August 31, 2018, and includes the following:

(i) Office of the Inspector General

As of the filing of this report, the Office of the Inspector General (OIG) has completed or initiated medical inspections at all 35 institutions for Cycle 5. The OIG issued final reports for Avenal State Prison (ASP), California City Correctional Facility (CAC), California Men's Colony (CMC), Correctional Training Facility (CTF), California Institution for Women (CIW), Sierra Conservation Center (SCC), Central California Women's Facility (CCWF), and Mule Creek State Prison (MCSP). CAC received a proficient rating; ASP, CMC, CIW and SCC received adequate ratings; and CTF, CCWF, and MCSP received inadequate ratings. The OIG expects to commence Cycle 6 in January 2019.

(ii) Delegations

As of the filing of this report, the Receiver has delegated to CDCR authority for the medical operations at 18 institutions. Meet-and-confer meetings were held on May 22, 2018; July 24, 2018; and August 29, 2018. During this reporting period, the Receiver delegated CMC on May 31, 2018, and Valley State Prison (VSP) on July 23, 2018. Monitoring of institution performance for all 18 delegated sites continues to ensure sustainability. Meet-and-confer meetings have been scheduled with the parties through April 2019 to discuss the potential delegation of additional institutions.

(iii) *Armstrong*

All parties in the *Armstrong* case continue to refine a joint audit tool to measure compliance components of the case. Following the completion of the audit at California State Prison, Los Angeles County, all parties discussed and updated the tool based on feedback and outcomes related to the May 2018 review. These discussions and decisions included the Office of Audits and Court Compliance, plaintiffs' counsel, CDCR and California Correctional Health Care Services (CCHCS) staff. The agreed-upon changes were utilized during the joint audit at Richard J. Donovan Correctional Facility (RJD) in August 2018. The next use of the joint audit tool is tentatively scheduled for the week of October 1, 2018, at the Substance Abuse and Treatment Facility (SATF) at Corcoran.

Both CDCR and CCHCS have been tracking allegations of staff non-compliance with the *Armstrong* Remedial Plan through a manual process. On September 4, 2018, Corrections Services, in

collaboration with Division of Adult Institutions and Division of Adult Parole Operations, successfully implemented an Allegation Log Tracking System (ALTS) to track and report Disability Placement Program and Developmental Disability Program allegations of staff non-compliance. In preparation of ALTS implementation, CCHCS' Field Operations conducted training in August 2018 for all Chief Executive Officers (CEO), CEO designees, and Health Care Compliance Analysts. Reports compiled within ALTS will replace the reporting of allegations of non-compliance via a manual spreadsheet, beginning with new allegations identified during the month of September 2018.

(iv) Changes in Specialty Referral and Authorization Process

On July 30, 2018, an electronic Request for Service (eRFS) process was implemented and replaced the manual, paper specialty referral and review process. Where the paper process was vulnerable to lost documentation and human error in the approval routing process, the eRFS is a rules-based PowerForm within the Electronic Health Record System (EHRS) that follows defined workflows.

The eRFS process enables providers to directly order certain specialty services that are routine and necessary, without additional review by Utilization Management (UM) nurses and physician supervisors. The eRFS is customizable and allows the ability to continuously refine workflows to add or remove additional direct-order specialty services based on objective claims and patient outcome data. Within eRFS, providers select one of 52 specialty orders which includes a drop-down field with the procedures provided by that specialty listed in alphabetical order. In contrast, the paper-based process required providers to manually select from approximately 1,500 different order options. Consolidating and reducing the unnecessary variations in orders for the same specialty creates an efficiency for providers, maintains the same level of service to the patient, and makes specialty service data more reliable.

Requests for specialty services that continue to require review by the UM nurse and local physician supervisor are automatically routed to a new EHRS multi-patient task list. The eRFS also provides assurances against the provision of services that are excluded under California Code of Regulations, Title 15, Section 3999.200, or present an undue risk to patients without first being reviewed at the CCHCS headquarters' level. With a few clicks within eRFS, an approved order is sent to the scheduling queue, or for an excluded or high-risk procedure, the order is automatically routed to the headquarters' message center for review.

(v) Women's Health

The Women's Health Program, in conjunction with CCHCS' subject matter experts and the Department of Homeland Security, created an eLearning course entitled "Transgender Identity in a Correctional Setting." The training defines transgender identity terms, identifies important events in transgender history, identifies challenges faced by transgender patients, recognizes the transgender population within CDCR, identifies how to create a welcoming environment, and describes the Mental Health Program's role in supporting the transgender population. All health care staff at the identified transgender hub institutions were enrolled and are expected to complete the training no later than October 2018.

On August 9, 2018, University of California, San Francisco, provided an on-site clinical training at CCWF. The training focused on serious illness and population aging in the correctional setting, advance care planning, decision-making capacity, prognostication and cognitive impairment, and dementia. The training will be conducted at CIW on October 11, 2018.

(vi) Direct and Resonance

The EHRS was successfully implemented at all institutions statewide as of November 2017. CCHCS is currently working with external providers to implement the Cerner Direct and Resonance functionality, which will provide CCHCS the capability to utilize secure electronic communication to send and receive data from the patient health record. Staff will be able to select documents from the patient's chart, along with the transition of care referral summary, to send to external providers who also utilize the Cerner system. The benefit of Direct and Resonance is the reduction of hardcopy records transferred with patients. The first two external providers anticipated to utilize the Direct and Resonance are Mercy Bakersfield and San Joaquin General Hospital.

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

(i) In-State and Out-of-State Contracting for Community Correctional Facilities

During this reporting period, CCHCS conducted a total of four in-state audits. Systemwide issues in the area of Chronic Care Medication and Daily Care Team Huddles are improving. While audits show the number of huddles is increasing, the documentation of what transpired at the huddle is lacking necessary details. Also, it was determined that the facility nursing staff were administering monthly refill medications as soon as they were received, four days prior to the administration date, which resulted in discrepancies between the automated pharmacy refill issuance dates and the facilities' administration dates. Facility nursing staff are now aware of the issue and are waiting to administer the medications one day prior to the exhaustion of the supply.

As of August 24, 2018, the total inmate population housed at in-state contracted facilities is 4,016 or 97.59 percent of the budgeted capacity of 4,115. During the reporting period, one audit report for an in-state contracted facility was published with a rating of Adequate. The in-state contracted facilities are still in the process of being added to the over-the-counter (OTC) medication contract, enabling facilities to order OTC medications pursuant to CCHCS policy.

As of August 24, 2018, the total out-of-state correctional facility patient population was 2,014 or 87.72 percent of the budgeted capacity of 2,296. As of June 27, 2018, all patients have been transferred out of the Tallahatchie County Correctional Facility, and it has been closed to California patients. Currently, the only out-of-state facility remaining is La Palma Correctional Facility in Arizona. Since June 29, 2018, the patient population has reduced from 2,845 to 2,014. During this reporting period, an audit report for the two out-of-state facilities was published, each with a rating of Adequate.

(ii) Transportation Vehicles

A budget change proposal, which will allow CDCR to replace 291 existing high-priority health care fleet assets and purchase an additional 47 vehicles to expand the fleet statewide, was approved by the State Legislature as part of the Fiscal Year (FY) 2018-19 budget. This is the first instance of CDCR expanding the health care fleet since the Federal Receiver delegated procurement authority to CDCR in September 2012. CCHCS will continue to monitor the procurement, security retrofitting, and delivery of these vehicles to the respective institutions. As of August 6, 2018, 92 vehicles were received at California State Prison, Solano (SOL), which is where the Prison Industry Authority vehicle retrofit operation is located. Twenty vehicles are receiving security modifications, 51 are staged and waiting to receive security modifications, 19 are in various stages of radio installation and Federal Communications Commission checks, 2 are ready for shipping, and 9 vehicles were inspected. Of the 12 ordered Americans with Disability Act vehicles, 4 are currently off-site for installation of wheelchair lifts, 2 are pending delivery to off-site wheelchair lifts, and 6 have not been received.

(iii) Health Care Infrastructure at Facilities

Several sub-projects were activated during this reporting period. The more notable activations include the Central Health Services Building, Administrative Segregation and A yard primary care clinic, and three medication distribution rooms at California State Prison, Sacramento (SAC); new Complex Facility Clinic at SOL; new primary care clinic on West Facility at CMC; new primary care clinics on A yard and D yard at CTF; renovations of existing primary care clinics on B yard, and C yard at MCSP; renovations of existing primary care clinics at Salinas Valley State Prison (SVSP); primary care clinic additions at Pleasant Valley State Prison (PVSP); and Correctional Case Management Building at North Kern State Prison (NKSP).

Due to delays in construction at CIW, CDCR agreed to fund a modular medical clinic. The modular clinic was originally expected to be completed before March 30, 2018; however, this date was extended to July and then October 2018. As a result, the modular medical clinic is no longer needed at CIW and will be placed at the California Rehabilitation Center (CRC) to address space deficiencies at that institution until a more permanent solution can be implemented. As the modular clinics are relocating to CRC, the site plans must be revised which will delay the clinic opening until late spring 2019.

For the last four years, the Receiver's Tri-Annual Reports have listed a litany of project barriers, including schedule delays, revisions to project timelines, failures to obtain State Fire Marshal approvals, and other problems with the construction program. The very program that was initiated to ameliorate inadequate and substandard health care clinic space has instead placed the delivery of health care in many institutions at further risk. The Health Care Facility Improvement Program (HCFIP) continues to experience significant delays resulting from a number of factors as follows:

- Inadequate site investigation work prior to completing architectural drawings.
- Poor performance of architectural and engineering firms, resulting in delays addressing deficiencies following inadequate site investigation work.

- Poor performing construction contractors.
- Inability to adequately address deficiencies in fire, life, and safety systems in existing buildings resulting in delays in receiving State Fire Marshal approval of plans.
- Sub-contractors submitting inadequate plans for fire alarms and fire sprinklers, resulting in significant delays in plan approval and ultimate occupancy of new or remodeled space.
- In some locations, difficulty receiving State Fire Marshal Certificates of Occupancy on new space pending completion of work on fire, life, and safety systems in other existing spaces. This occasionally requires CDCR leadership to address directly with State Fire Marshall executives.

The inability to complete HCFIP in a timely manner has become a barrier to patient care at certain institutions. This is due in part to inadequacies in current infrastructure, swing space, and current space, all exacerbated by the continued construction delays. In many institutions, swing space that was intended to be utilized for a short time period has been in use for multiple years. Institutions accepted short-term compromises related to space, with the expectation that CDCR would complete the HCFIP projects based on the schedules provided at that time. Most swing space that the CCHCS is utilizing to provide patient care is deficient in some fashion, particularly with regard to infection control and patient privacy standards, and is even less adequate than the space CCHCS was utilizing prior to the start of HCFIP. These issues have been amplified by competing space priorities, roof leakage, and safety and security concerns. Some examples include the following:

- California State Prison, Corcoran (COR) was presented with construction plans to include approximately eight months of construction time to complete expansions and renovations of the various clinics. COR agreed to utilize swing space for this time period. Due to a variety of issues, the approximately eight-month period has extended to almost three years, and there are still issues that may delay completion of this space until next year.
- Originally, CIW made swing space plans for the primary care clinic based on a schedule indicating construction beginning in June 2015 and to be completed in August 2016. In order to accommodate construction, staff moved to several temporary locations throughout the institution. Due to significant design issues related to partially remodeling and rebuilding the existing clinic building as well as performance issues on the part of the contractor, the project was completed in September 2018 with activation projected to occur in October 2018.
- At SATF, staff moved out of the primary care clinics on A and B yards into alternative space in the former dialysis clinic, the gym for A yard, and the gym for B yard. They moved into swing space in June 2016 based on the assumption that construction would be complete in March 2017. Construction is not yet complete, and an engineering issue threatens to extend construction completion into November 2018. During the rainy season, the gym roofs leaked significantly resulting in the need to move the B yard clinical operations into the yard chapel and a classroom. After some repairs had been completed they moved back into the gym; however, other issues resulted in moving clinical operations back into

the chapel space; though this was more orderly and the institution addressed some of the previous concerns regarding handwashing and privacy.

The following chart indicates the original baseline completion date, the previously reported revised completion date, and the further revised completion date as of August 31, 2018. Every project, with the exception of Calipatria State Prison (CAL), is showing a delay from the previous reporting period for construction completion. Not including the four institutions that will have significant delays related to the need for additional funding, the greatest delay is at High Desert State Prison (HDSP) which is 344 days.

| | **Baseline Construction Completion Date** | **April 30, 2018 Revised Construction Completion Date** | **August 31, 2018 Revised Construction Completion Date** |
|---|---|---|---|
| VSP | January 27, 2016 | March 6, 2019 | June 17, 2019 |
| CIW | August 2, 2016 | June 6, 2018 | September 14, 2018 |
| SAC | November 7, 2016 | December 27, 2018 | March 1, 2019 |
| CMF | February 10, 2017 | February 26, 2019 | June 14, 2019 |
| DVI | March 21, 2017 | July 13, 2018 | October 31, 2018 |
| HDSP | April 17, 2017 | September 12, 2018 | August 22, 2019 |
| CCI | May 1, 2017 | April 15, 2019 | August 16, 2019 |
| RJD | May 26, 2017 | March 12, 2019 | April 22, 2019 |
| WSP | June 19, 2017 | June 11, 2019 | October 18, 2019 |
| NKSP | July 4, 2017 | April 15, 2019 | May 24, 2019 |
| SATF | July 28, 2017 | October 9, 2018 | January 2, 2019 |
| COR | July 31, 2017 | May 20, 2019 | October 7, 2019 |
| CTF | September 18, 2017 | February 8, 2019 | May 31, 2019 |
| SVSP | September 20, 2017 | June 18, 2018 | September 10, 2018 |
| CIM | September 26, 2017 | August 7, 2019 | December 24, 2019 |
| CCC | October 16, 2017 | March 15, 2019 | October 1, 2019 |
| SOL | November 6, 2017 | December 18, 2019 | July 21, 2020 |
| SCC | December 14, 2017 | May 28, 2019 | October 14, 2019 |
| MCSP | December 21, 2017 | August 18, 2018 | September 7, 2018 |
| FOL | December 21, 2017 | July 8, 2019 | November 29, 2019 |
| CMC | December 22, 2017 | August 30, 2019 | February 10, 2020 |
| KVSP | January 13, 2018 | April 17, 2019 | September 4, 2019 |
| CCWF | February 16, 2018 | July 10, 2019 | November 13, 2019 |
| PVSP | March 30, 2018 | April 28, 2019 | June 28, 2019 |
| PBSP | August 9, 2018 | March 26, 2019 | June 3, 2019 |
| ISP | February 19, 2019 | September 10, 2019 | November 21, 2019 |
| CVSP | February 28, 2019 | August 5, 2020 | September 22, 2020 |
| CAL | June 15, 2019 | June 19, 2020 | June 6, 2020 |
| CEN | September 1, 2019 | January 2, 2020 | March 20, 2020 |

An action taken by CDCR to minimize risk and control cost was to identify several projects that could shift from general contractors to inmate ward labor. In these instances, the general contractor was performing poorly and project delays were causing unnecessary costs. However,

due to the funding issues cited below, several of these sub-projects will now need to wait for a new funding source in order to begin work. None of these projects have begun, and as such this will not result in the utilization of swing space while the projects await the necessary, additional funding.

CDCR requested an additional $73 million in order to complete construction of the various HCFIP projects. This request would have brought the total project authority to $1,092,000,000, from the previous level of $1,019,000,000. The hearing process was contentious and the Legislature expressed frustration with the cost overruns and delays and as a result only approved an augmentation of $43 million. Consequently, CDCR has had to devise a plan to address funding shortfalls, which will result in significant further delays pushing completion of HCFIP back to November 2021. The current mechanism by which State construction projects are funded has the potential to cause delays, as the preliminary plans, working drawings, and construction stages of a project are not typically funded through one single appropriation but are funded over multiple years. These schedules assume that only the construction phase needs to be funded because the design phase for HCFIP has been completed.

## Section 2: 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. CHCF is open to full admissions to General Population, Enhanced Outpatient Program, Outpatient, Specialized Outpatient, Outpatient Housing Unit, Correctional Treatment Center, and Dialysis levels of Care. CHCF opened a 30-bed Palliative Care Services Unit in July 2018 and plans to open a 30-bed Memory Unit by the end of the 2018 calendar year. As of August 29, 2018, CHCF is at 92 percent capacity (2,724 current population; 2,951 capacity). As depicted in the August 2018 Human Resource Recruitment and Retention Report (Refer to Appendix 1), 29 of the 36 budgeted provider positions at CHCF are filled as follows:

- Physician and Surgeon (P&S): 32 positions, 25 filled, 7 vacant
- Nurse Practitioners: 1 position, 1 filled, 0 vacant
- Physician Assistants: 3 positions, 3 filled, 0 vacant

As described in the August 27, 2018, Primary Care Provider Vacancy/Coverage Report (Refer to Appendix 2), civil service telemedicine providers and contract registry providers are utilized to deliver care at CHCF, which increases the coverage to over 100 percent for providers.

### B. Statewide Medical Staff Recruitment and Retention

CCHCS has made significant progress in addressing challenges present at the beginning of the Receivership and which were outlined in the March 10, 2015, *Special Report: Improvements in the Quality of California's Prison Medical Care System*. At the start of the Receivership, there was a need to quickly effect changes on several fronts to set the stage for further improvements. Most notable was the significant lack of qualified clinicians to provide adequate and timely patient care and salaries for providers that were substantially lower than standard market rate. In 2006, physician salaries were approximately 20 percent lower than the market median, and with no appropriate standard for hiring, a provider's competence could not be assured. Many of CDCR's providers were found to be "inadequately trained and poorly qualified." As a result, the Receivership established new salary models to bring CDCR's compensation to a competitive level with the private market. A new classification structure was developed, requiring physicians to be board certified in either Internal Medicine or Family Practice. To ensure the quality of these providers, a robust credentialing and peer review system was also established. These efforts positioned CCHCS to then pursue additional, rapid improvements. However, the Affordable Care Act in 2010 created a nationwide strain on the health care workforce, as demands for primary care providers increased over the supply. CCHCS began experiencing the impact of the nationwide shortage, as hiring and retaining quality providers put CCHCS in competition with the private sector. As physician private sector salary models increased, CCHCS lost its competitive edge in compensation and ensuring appropriate provider staffing by late 2016.

Continuing to progress as issues presented, CCHCS developed strategies to adapt and meet the new challenges. Through frequent assessment of staffing ratios, health care delivery models, and retention strategies, CCHCS has implemented a series of flexible and continuously evolving solutions to ensure the provision of quality health care services are delivered to patients in a timely manner via a stable provider workforce. The following summarizes progress in this regard during this reporting period:

- Enhanced recruitment and branding efforts over the past several years are designed to leverage CCHCS' position as an employer of choice within the health care community and have successfully created a continuously robust candidate pipeline. Since the beginning of the year, CCHCS has hired 44 new physicians, with 8 hired into the Telemedicine Program and 36 hired at institutions. Fifteen new Advanced Practice Providers were hired, with 6 hired into the Telemedicine Program and 9 at the institutions. With the increased focus on Advanced Practice Provider utilization, Advanced Practice Provider hires have increased by 150 percent during this reporting period.
- The Telemedicine Program has been a highly successful health care delivery strategy by supporting institutions experiencing staffing issues and providing specialty care to patients. The telemedicine provider workforce is 90 percent filled, with interviews pending for one vacancy and planned hires in process for the remaining three vacancies. Given the success of this particular strategy, possible expansion of the Telemedicine Program is being assessed.
- The Educational Partnership Program allows medical students and residents training opportunities within the correctional setting. This marketing tool not only serves to expand CCHCS' presence as a premier provider of health care through increased relationships with medical schools but also exposes future potential candidates to career options within correctional health care. With the enhanced focus, the program has increased from 4 to 19 partnerships for physicians and Advanced Practice Providers across 22 educational programs at 14 different institutions. In 2017 and 2018, a total of 109 students and residents rotated through CCHCS sites, with a projected expansion to 200 students/residents by 2020.
- The 15 percent pay differential strategy was broadly implemented in July 2017 for institutions with historically hard-to-recruit missions or locations. While 27 external and 6 internal hires were made following implementation, only 6 of the 13 institutions receiving the pay differential are currently staffed above 90 percent with on-site civil service providers. This strategy also contributed to disruption and unintended vacancies at certain institutions when providers transferred to an alternative site that offered the additional compensation. Given the minimal benefit, the pay differential strategy has not proven to be a durable or effective solution to staffing concerns within CCHCS.

Given the achievements resulting from the recruitment and rebranding strategies, retention is now a critical focus. CCHCS is continually adapting and responding to issues as they emerge. The following summarizes progress in this regard during this reporting period:

- Dual appointments allow physicians working full-time positions at one institution to provide third-watch or weekend support at another institution. During this reporting period, seven dual appointments are utilized at six sites to include ASP, CHCF, CTF, Deuel Vocational

Institution (DVI), NKSP, and VSP. Additionally, the Telemedicine Program's usage of dual appointments to assist institutions with part-time after-hours coverage has greatly expanded. There are currently 13 telemedicine providers in dual appointments which represents an increase of 62.5 percent during this reporting period.

- New Medical Provider Onboarding program provides a 12-week training program consisting of a 3-day training at headquarters, 2 weeks of rotational clinical observation, job shadowing, and at least 30 hours of protected training time. Thereafter, new providers conduct independent patient care duties with enhanced, evidence-based continuing medical education that focuses on improving patient outcomes and an improvement-focused Professional Practice Evaluation that allows medical leadership to provide mentorship and build positive relationships with new and current providers.

The August 2018 Human Resource Recruitment and Retention Report (Refer to Appendix 1), which is CCHCS' legacy reporting mechanism, only reports on-site civil service provider data and depicts 31 percent of institutions (11 institutions) have achieved the goal of filling 90 percent or higher of their civil service provider positions; 43 percent (15 institutions) have filled between 75 and 89 percent of their civil service provider positions, and 26 percent (9 institutions) have filled less than 75 percent of their civil service provider positions. As a result of the various recruitment and retention efforts outlined above, when on-site civil service, telemedicine, and contract registry providers are utilized to deliver care statewide, coverage at 30 institutions is at or above 90 percent (Refer to Appendix 2).

Since the filing of the March 10, 2015, *Special Report: Improvements in the Quality of California's Prison Medical Care System*, CCHCS has substantially resolved the issues related to hiring and retaining medical staff through increased usage of Advanced Practice Providers, statewide use of telemedicine for primary and specialty care, and focused recruitment and retention efforts.

**C. CCHCS Data Quality**

The Receiver continues to assess the impact of the EHRS implementation on the integrity of data presented in CCHCS performance reports and operational tools. As reported in the previous Tri-Annual Report, CCHCS initiated a number of active interventions which continued during this reporting period to improve data quality in areas currently considered problematic.

(i) Targeted Interventions for Measures Showing Data Entry Errors.

In the Thirty-sixth Tri-Annual Report, CCHCS described in detail the data quality concerns presented in the implementation of an information system on the scale of the EHRS, which has impacted hundreds of health care processes and required re-working of legacy workflows. While a majority of the CCHCS Dashboard measures experienced minimal and transient data quality issues during the transition to the EHRS, a small number of measures were identified with data quality concerns. For most of these areas, inaccuracies are linked to a lack of adherence to EHRS workflows and associated data entry variation. In some cases, measurement methodologies have been refined, workflows have been adjusted, and new tools have been implemented to help address known data quality issues. All Dashboard domains with known data reliability issues

have been addressed with an improvement initiative of some form. The following summarizes some of the ways CCHCS has addressed these issues. During this reporting period, CCHCS:

- Created the Data Entry Flag Report to provide ongoing feedback to health care staff about adherence to EHRS workflows that impact two medical access metrics (Provider Routine Referrals 14 Days and Higher Level of Care). Since March 2018, CCHCS staff have accessed this report an average of 4,700 times per month, for a total of 29,000 reports run in approximately six months. As of August 2018, institutions statewide were within five percentage points of the 95 percent "green range" accuracy target for both metrics. Refer to Figure 1.

*Figure 1: Current Data Entry Flags Report, Statewide Trended View Results through August 2018*

**INSTITUTION DATA ENTRY FLAGS 12 MONTH TREND**

Statewide

*August 2018*

Institution Data | Statewide Comparison | Trended View

**PCP Routine Referrals 14 Days**

| Scheduling & Access to Care | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | 12 mo. Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCP Routine Referrals 14 Days- As Reported on Dashboard | 78% | 75% | 75% | 75% | 81% | 85% | 91% | 91% | 90% | 89% | 90% | 92% | |
| Percent of Correctly Placed PCP Routine Referrals 14 Days | - | - | - | 50% | 55% | 60% | 72% | 80% | 86% | 88% | 89% | 90% | |
| Adjusted PCP Routine Referrals 14 day Performance- Correct + Incorrect Orders | - | - | - | 69% | 74% | 77% | 84% | 85% | 86% | 86% | 87% | 89% | |

**Return from HLOC 5 Days**

| Scheduling & Access to Care | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | 12 mo. Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Return from HLOC 5 Days - As Reported on Dashboard | 73% | 77% | 69% | 73% | 78% | 83% | 86% | 88% | 90% | 87% | 87% | 88% | |
| Percent of Correctly Placed Orders After Return From HLOC | - | - | - | - | - | - | - | - | 87% | 88% | 88% | 90% | |
| Percent of Patients Seen Within 5 Days After Return from HLOC – All Discharges per Hospitalization Data | - | - | - | - | - | - | - | - | 83% | 81% | 80% | 83% | |

- Issued a Durable Medical Equipment Registry with data elements that assist supervisors in assessing workflow adherence and data entry practices.
- Utilizing field input, refined the methodology for the EHRS Timely Documentation metric for Licensed Vocational Nurse documentation.
- Continued to coordinate with Mental Health and Medical Services leadership to define what should be included and excluded on the Workload per Day metrics.

(ii) Evaluating Health Care Services Dashboard Accuracy – Independent Review.

During this reporting period, the Receiver contracted with software coding experts to assess the accuracy and integrity of the computer programs used to calculate measures displayed in the Health Care Services Dashboard. In August 2018, the experts began reverse-engineering Dashboard reporting logic, examining software modules that process information for specific Dashboard metrics. Upon completion of their assessment, the experts will report findings to the Receiver and the federal court; this report is anticipated by the end of December 2018.

**D. Coordination with Other Lawsuits**

Meetings between the three federal courts, *Plata, Coleman,* and *Armstrong* (Coordination Group) class actions have occurred periodically. No Coordination Group meetings took place during this reporting period.

**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 as well as 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.

The Receiver did not use the substitute contracting process during this reporting period.

**F. Consultant Staff Engaged by the Receiver**

As referred to in section C (iii) above regarding CCHCS Data Quality, effective June 15, 2018, the Receiver engaged the firm of Manatt, Phelps and Phillips to analyze data collection and validation processes at CCHCS that are used to compile health care delivery performance statistics which are published on the CCHCS Health Care Services Dashboard.

**G. Accounting of Expenditures**

(i) Expenses

The total net operating and capital expenses of the Office of the Receiver for the year ending in June 2018 was $1,338,359 and $0.00 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 3.

For the two months ending August 31, 2018, the net operating and capital expenses were $204,876 and $0.00 respectively.

(ii) Revenues

For the months of May and June 2018, the Receiver requested transfers of $300,000 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 2017–18 to the CPR from the State of California is $1,275,000.

For the two months July and August 2018, the Receiver requested transfers of $275,000 from the State to the CPR to replenish the operating fund of the office of the Receiver.

All funds were received in a timely manner.