VIA EMAIL ONLY

October 9, 2018

To: **All Plata Counsel**

Re: **Assessing Medical Systems for the California Prison Health Care Receivership Corporation: MORTALITY REVIEW POLICY AND PRACTICE**

This letter acknowledges receipt of the final report entitled, "*Assessing Medical Systems for the California Prison Health Care Receivership Corporation: MORTALITY REVIEW POLICY AND PRACTICE* "(Report), prepared by The Criminal Justice & Health Program at the University of California, San Francisco. I have consulted with California Correctional Health Care Services (CCHCS) managers regarding the report and make the following observations:

On August 17, 2017, the parties filed a Joint Case Management Statement, the purpose of which was to identify all issues that remained to be resolved in the case. In a section of the joint statement reflecting issues that only the PLO believed remained to be resolved, mention was made of "Problems with quality of care review and staff accountability processes: peer review, death review, annual physician evaluations, the patient safety program, and internal affairs investigations." (Joint Case Management Statement, p. 13, line 24, 8/17/2017) In response, the Receiver engaged the services of Dr. Brie Williams from the University of California, San Francisco, to examine a number of these systems and evaluate their adequacy when assessed against community practices in large healthcare organizations.

Dr. Williams and her team produced a draft report which, on August 21, 2018, was distributed to the parties for review and comment. The State chose not to submit a written comment, but orally communicated to the Receiver its agreement with the report and its recommendations. The PLO's comment was as follows:

> Plaintiffs agree with the report's recommendations including that CCHCS death reviews be streamlined, identify and initiate action regarding individuals at fault and systemic opportunities for improvement, and improve its focus on the latter.
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> Plaintiffs request that the report also recommend that (1) the physician and nurse death reviewers receive training and be certified as competent in identifying opportunities for improvement, and (2) death reviews be closely monitored and publicly reported on by an adequately staffed and funded independent public authority.

The report states that CCHCS reviewers identified only 25% of the opportunities for improvement that the UCSF reviewers did. Draft Report at 13. This is a disturbingly low percentage. While focusing more on identifying such opportunities may help, reviewers must also be trained in what to look for, and certified as competent to do so. The report should so recommend.

In addition, the report should recommend that an independent public authority, adequately staffed and funded, closely monitor and publicly report on CCHCS death reviews. Independent monitoring and reporting, of the kind currently done by California's Office of inspector General regarding use of force and related investigations, will work to ensure that reviews are adequate, including in the identification of opportunities for improvement. In addition, prisons are public institutions, and deaths of the people incarcerated therein are a public concern. Via independent monitoring and reporting, the public can both be assured of minimal adequacy of reviews and have access to assessments regarding causes of death and the care provided to those who die.

On the issue of training, I agree that physician and nurse death reviewers should undergo both initial and periodic training and self-reflective evaluation. I disagree, however, with the rationale for this training. The PLO misses the point when it complains about the "disturbingly low percentage" of opportunities for improvement found by CCHCS reviewers compared with UCSF reviewers. As well documented in the report, the current death review process is not primarily focused on identification of opportunities for improvement; it is focused much more on identification of provider or other errors. Given this focus, the disparity in the number of opportunities for improvement discovered by UCSF reviewers is not a reflection on the competence of CCHCS reviewers; instead, it is a reflection of the difference between what we currently do in death review and what UCSF is recommending that we do in the future. That said, I agree that as part of implementing a new death review process consistent with UCSF recommendations, we should consider starting with a completely new set of reviewers, and those reviewers should be appropriately trained in the new process and should periodically evaluate their own performance.

On the issue of certification, I have not discovered any precedent or practice in the community for certification of death reviewers. In the absence of any such community practice, I will not direct the creation of a certification process unique to our system. Particularly in light of my decision to direct training and self-evaluation of death reviewers, a separate certification program is unnecessary.

On the issue of close monitoring by an independent public authority, I disagree with the need for such a process. We have been conducting death reviews without such close monitoring for ten years, and there is no substantial evidence that those reviews have been anything but professionally done. The UCSF report does not disparage the quality of the current reviews given the purposes for which death reviews are currently being done. Instead, the UCSF report strongly reinforces the initial steps already taken by CCHCS to add opportunities for improvement to the review process and essentially recommends that, for the future, we fully commit ourselves to a process that focuses primarily upon opportunities for improvement. In these circumstances, I see no need for close monitoring of the process.

On the issue of public reporting, I agree that there is significant benefit to having a public report on death reviews. For the last decade, we have engaged an independent expert, Dr. Kent Imai, to produce an annual report on CCHCS death reviews. We will continue this process of independent review and analysis.

In light of the above, I have decided to accept the draft report without significant change, and Dr. Williams submitted her final report on September 27, 2018.

I have directed staff to implement the recommendations in the report as follows:

1. Put quality improvement at the center of the process by:
    a. Eliminating the “preventability” finding and replacing it with a finding of “expected / unexpected with or without opportunities for improvement.”
    b. Assessing the death review process by tracking and reporting on opportunities for improvement generated by the death review process.
    c. Developing “standardized mortality ratios” to assist in evaluating mortality outcomes.

2. Emphasize action, system-wide when appropriate, by:
    a. Redrawing forms to motivate analysis (versus description).
    b. Streamlining the process.
    c. As the new death review process is implemented, assessing any obstacles to the timeliness of death reviews.
    d. Directing the Quality Management program to incorporate, as appropriate, death review opportunities for improvement into our overall quality improvement initiatives.

3. Ensure a culture of ongoing learning by:

a. Implementing within each region a quarterly morbidity and mortality conference.
b. Adopting initial and ongoing training and self-evaluation processes for death reviewers.

The draft report contains a number of recommendations that I have decided not to implement at this time. Those recommendations, and the reason for my decision not to implement at this time, are as follows:

- **Redefine existing committees to drive quality improvement.** The focus of this study was on the death review process. The study did not undertake a comprehensive organizational analysis that would fully inform any recommendations for making structural changes throughout headquarters. Those type of organizational decisions implicate much broader considerations.

- **Allow any staff person to complete an anonymous death review in the first 48 hours after a death.** I am concerned about the feasibility and value of this recommendation as drafted in the context of the immediate aftermath of a death. Currently, I already expect institution leadership and providers to identify any urgent safety and quality concerns arising out of a death. Authorizing others to complete a basic death review anonymously at the same time risks possible confusion in any necessary investigation that may be occurring simultaneously.

- **Implementing a "quality star" system.** This recommendation has important organizational implications that deserve to be evaluated in a context broader than an assessment of the death review process. The issue will be referred to the Quality Management program for consideration in the context of death review and quality improvement and to the executive team for consideration more broadly.

Sincerely,

J. Clark Kelso
Receiver