CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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

Eighteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action
For May 1 – August 31, 2011

September 15, 2011

California Correctional Health Care Receivership

Vision:

As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

Mission:

Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates 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: Executive Summary

In our final Tri-Annual report for 2011, the accomplishments for the period of May 1 through August 31, 2011 are highlighted. Progress continues toward implementing the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights of progress include the following:

- Correctional Health Care Chief Executive Officer (CEO) – Since the CEO examination was launched on December 24, 2008, 555 CEO applicants have been added to the certification list. Based on current pairing of institutions, 23 CEOs have been hired of the 25 positions to be filled statewide. Recruitment efforts are under way to fill the remaining vacancies.
- Correctional Health Care Chief Nurse Executive (CNE) - Since the Receiver's Nurse Executive examination commenced in September 2008, 504 CNE applicants have been added to the certification list and 25 CNEs have been hired for the 26 positions to be filled statewide.
- Correctional Health Care Medical Executive (CME) - Since the Receiver's Medical Executive examination was launched in December 2008, 162 CME applicants have been added to the certification list. Twenty-three CMEs have been hired of the 27 positions to be filled statewide.
- Correctional Health Care Clinical Executives - The Receiver's Clinical Executive examination was launched in November 2009 for four disciplines: Laboratory, Imaging, Dietary, and Pharmacy. All vacancies for the Receiver's Clinical Executives have been filled as of August 2, 2011.
- Chief Support Executive (CSE) – The CSE is a new addition to the institution leadership infrastructure. The CSE is a Career Executive Assignment that will serve as the chief operating officer to the institution CEO, for Health Care Services, and is responsible for plant operations, fiscal services, budgets, contracts, procurement, and administrative and fiscal policy development. Ten CSEs have been hired to fill the 25 statewide positions, one under each CEO.
- Medical Savings - The two-year post audit effort has resulted in $29 million in refunds as of August 2011. These refunds represent overpayments recovered by Equiclaim (formerly Viant) during the two-year post audit period of July 1, 2007 through June 30, 2009, as well as voluntary provider refunds and ongoing retrospective audits. A new law, effective July 1, 2011 will allow money recovered prior to July 1, 2011 to be augmented to the appropriation to the Prison Medical Care budget for the fiscal year (FY) 2010/2011. Further, money recovered on or after July 1, 2011, will be augmented to the appropriation to the Prison Medical Care budget for the FY in which the recovered funds are received.
- Health Net Federal Services, LLC (Health Net) – As of June 30, 2011, Health Net fulfilled their contracted requirements for Phase Two by having 100 percent of the provider network in place ensuring patient-inmate access to care.

While improvements continue in many important areas, the momentum of these efforts continues to be affected by the State's budget and fiscal crisis and severe overcrowding in several prisons. The budget and fiscal crisis are likely to continue for the foreseeable future, and

the Receivership is doing everything it can to reduce expenditures without cutting into core health care areas. However, productivity is impacted throughout the organization, and coupled with some staff turnover; certain projects and initiatives have been delayed in their implementation. Due to these factors, this report reflects extensions on some of the objectives and action item dates to fulfill the goals.

As mentioned in prior reports, our scores in the areas of timely access to primary care physicians and timely access to medications continue to lag. With the beginning of realignment now only weeks away, we should see a substantial drop in overcrowding in the major reception centers almost immediately. We are anxiously awaiting this reduction so we can evaluate the impact of overcrowding reduction upon our ability to provide more timely access to care and better medication management. We are also now examining a renewed focus on "getting back to basics" in these two critical areas where it appears the other initiatives of the Turnaround Plan have simply not achieved much traction.

During the 2009/2010 legislative session, California Correctional Health Care Services (CCHCS) sponsored several successful bills that became effective on January 1, 2011. These legislative changes authorize the Central Pharmacy, require a UM program, require electronic management of provider claims, and establish a medical parole process. The medical parole bill creates a new category for permanently medically incapacitated inmates that allows corrections to save on guarding costs and to apply for federal reimbursement for these patient-inmates' health care costs. CDCR took the lead and worked with CCHCS to write emergency regulations for the new medical parole process. Since the last report, implementation of the new medical parole law has continued to progress and the State has now successfully placed six patient-inmates on medical parole. In addition, the Board of Parole Hearings has scheduled hearing dates for 24 more candidates, meaning that many more patient-inmates are expected to medically parole this year.

Also this year, CCHCS had language included in the budget trailer bill, which passed at the beginning of this month with the State budget. The first relevant section in the trailer bill allows CCHCS to credit audit recovery funds from previous fiscal years to the current year's budget. This means that CCHCS was able to use close to $29 million recovered from audits of previous fiscal years to help balance the budget for FY 2010/2011 and any more money recovered will be credited to the year in which it is collected. The second section of language made necessary technical changes to a new law from last year. That law allows CCHCS to work with the Department of Health Care Services to receive federal financial participation for the health care costs of patient-inmates in community hospitals.

Format of the Report

To assist the reader, this Report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions. Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part

of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the CCHCS website http://www.cphcs.ca.gov/receiver_mo.aspx.

2. *Appendices*: In addition to providing metrics, this report also references documents in the Appendices of this report.

3. *Website References*: Whenever possible website references are provided.

RTPA Matrix

In an effort to provide timely and accurate progress reports on the RTPA to the Courts and other vested stakeholders, this format provides an activity status report by enterprise, for statewide applications/programs, and by institution, as appropriate for and in coordination with that operation.

The Enterprise Project Deployment worksheet and the Institution Project Deployment worksheet provide an illustration of the progress made toward each action item outlined in the RTPA and reported in the Tri-Annual Report. The Enterprise Project Deployment worksheet captures projects specifically assigned to the Receiver for broad administrative handling, analysis or testing. The Institution Project Deployment captures the status of all other activity by institution. Reporting will reflect activity that is completed, on schedule, delayed or not progressing, with corresponding dates. The Tri-Annual Report will continue to provide a narrative status report.

Due to the size of the document, the Matrix is included as Appendix 1.

Information Technology Project Matrix

In addition to the RTPA Matrix, a separate chart has been created to specifically illustrate the major technology projects and the deployment of those projects. This document is included as Appendix 2.

Section 2: The Receiver's Reporting Requirements

This is the eighteenth report filed by the Receivership, and the twelfth submitted by Receiver 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 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)

In support of the coordination efforts by the four federal courts responsible for the major health care class actions pending against the CDCR, the Receiver files the Tri-Annual Report in four different federal court class action cases: *Armstrong, Coleman, Perez, 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_tri.aspx)

Four court coordination activities include: facilities and construction; telemedicine and information technology; pharmacy; recruitment and hiring; credentialing and privileging; and space coordination.

Section 3: Status of the Receiver's Turnaround Plan Initiatives

Goal 1: Ensure Timely Access to Health Care Services

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation

This action is completed.

Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons

This action is completed.

New processes have been implemented and revisions to the Reception Center Policy and Procedures are being finalized. Once finalized and adopted, we will proceed with statewide implementation of the revised policy and procedures.

Action 1.1.3. By January 2010, begin using the new medical classification system at each reception center prison.

This action is completed.

Action 1.1.4. By January 2011, complete statewide implementation of the medical classification system throughout CDCR institutions.

This action is completed.

On March 8, 2010, all non-reception center institutions began implementation of the Medical Classification System.

On April 28, 2011 all 33 institutions had been certified and had implemented the Medical Classification System.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on health care access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution.

This action is completed.

Action 1.2.2. By July 2011, the Receiver will have fully implemented Health Care Access Units and developed health care access processes at all CDCR institutions.

This action is ongoing. Progress during this reporting period is as follows:

Health Care Access

CCHCS continues to work with CDCR to facilitate patient-inmate access to health care services. Although the Monthly Health Care Access Quality Report (AQR) data indicates that on average Health Care Access Units (HCAU) are operating above 90%, there are many institutions that are failing to consistently meet the 85% performance requirement in all areas of health care delivery (medical, mental health, dental, and diagnostic).

Operational Assessments

The process of reviewing the CCHCS custody operations at institutions to determine the effectiveness of the positions allocated for access to care, as well as reduce any identifiable barriers has been underway since October of 2010. Since the last report, Operational Assessments have been conducted at California Correctional Center (CCC), Central California Women's Facility (CCWF), Calipatria State Prison, Wasco State Prison, California Institution for Men (CIM), San Quentin State Prison, California Institution for Women (CIW), and Richard J. Donovan Correctional Facility (RJD). The first round of Operational Assessments was completed by June 2011, for all 33 institutions.

The second round of operational assessments will be conducted at all 33 institutions to evaluate self-sustainability and to ensure Corrective Action Plan (CAP) measures are still in place. The assessments are scheduled to begin in October 2011, with anticipated completion by April 2012.

Webinar training for all HCAU Associate Wardens and Captains was held in April and May 2011. As part of this training, a copy of the assessment tool and all elements assessed as part of the Operational Assessment was provided to all participants, as well as assisting all institutions with the assessment process. Webinar training is currently underway for all HCAU Associate Wardens and Captains with regard to the follow-up review process. This training is expected to be conducted for all 33 institutions by September 2011.

Monthly Health Care AQR - Data Collection Instrument

AQR data remained stable during this reporting period. July's AQR indicated that 85.7% of all patient-inmates that received ducat(s) for a health care appointment(s) were seen by a health care provider. Specific to custody performance, the number of patient-inmates *Not Seen Due to Custody* represented 0.6% of the total number of ducats.

Revisions aimed at providing clarification to the AQR Instructions and Counting Rules were implemented July 1, 2011. Webinar training for all HCAU Associate Wardens, Captains, and Analysts was held June 21 and 22, 2011.

Webinar training covering data entry of the AQR into COMPSTAT (CDCR database) for all HCAU Associate Wardens and Analysts was held April 28 and 29, 2011. Incorporation of the AQR into COMPSTAT was implemented, effective July 1, 2011 and reports are available for monitoring by CDCR. Monthly Health Care Access Reports are available for viewing under the HCAU tab on the COMPSTAT SharePoint website. During the next reporting period the AQR reports in COMPSTAT will be reviewed for efficacy.

Refer to Appendix 3 for the Executive Summary and Health Care AQRs for April 2011 through July 2011.

Vehicles

Vehicle management responsibilities were identified for transition back to the oversight of CDCR in December 2010. While awaiting a formal response, CCHCS continues to monitor vehicle usage.

Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System

Action 1.3.1. Work with CDCR to accelerate the development of the Strategic Offender Management System with a scheduling and inmate tracking system as one of its first deliverables.

This action is ongoing. Progress during this reporting period is as follows:

The CCHCS Health Care Scheduling System (HCSS) Project Team began deploying HCSS to the women's institutions. Workshops and training began for the Medical and Dental staff at CIW in mid-May in preparation for the system going live on May 25, 2011. After an initial adjustment period, additional training and process review was undertaken. Because of some policy changes that were implemented last year by the Dental Program, the full benefits of HCSS will not be available to Dental until a new Dental-specific version can be implemented, possibly next year as part of Release 2 of HCSS. The new system has worked quite well for Medical at CIW, which discontinued its use of the Interim Medical Scheduling and Tracking System (IMSATS) on May 25, with the implementation of HCSS.

The CIW Mental Health Program deployment followed Medical and Dental as a pilot on June 29, 2011. The delayed implementation for Mental Health was to allow time to make changes to the Interface to the existing MHTS.Net system. A pilot was required to allow for the new system to interface with custom designed complexities of the Mental Health program, and evaluate workload impacts on schedulers and the continuing refinements needed to the interface. The addition of the new system has contributed to an increased backlog for the Mental Health staff. Some additional enhancements were implemented in HCSS in late July and additional training was conducted. Although acceptance of HCSS has improved, some operational difficulties remained, so the HCSS deployment team has remained on site through late August to work with the Mental Health staff on business processes and to provide additional training. Moreover, defects have continued to appear in the Interface, leading to the need to implement, test, and deploy more changes to the HCSS software. Overall, the success rate for

over 25,000 messages transferred over the interface by mid-August is over 97%, with the objective of being near 100% by September 1, 2011.

Several prototype management reports from the ad hoc reporting system were presented to CIW and headquarters staff during August. Essential operational reports are already in use by the CIW staff. CCHCS executives and managers are now working with the HCSS project team to better define the reporting needs. While the project team is currently preparing the prototype reports, strategies have been developed to move this function to the Institutions and Headquarters staff to measure and evaluate performance data.

The HCSS project team is now preparing for the deployment of SOMS to the first two men's institutions – California Rehabilitation Center (CRC) and CIM – during November and December. The HCSS project is now comprised of four deployment teams, which will enable the solution to be implemented at four men's institutions each month beginning in February 2012. A deployment sequence was approved by the HCSS Core Leadership Team at its meeting on August 12, 2011. The sequence is based upon balancing the following prioritization criteria:

(1) Absence of an automated system
(2) Regional proximity to other institutions being deployed
(3) Seasonal and weather conditions at time of planned deployment
(4) Complexity and size of institution (more complex would generally go later)

The HCSS Core Leadership Team continues to meet monthly and holds special meetings when major issues arise and decisions are needed. Increasing interest in HCSS is being expressed by the institutions and programs. We have recently provided demonstrations to the Telemedicine Program in Headquarters and the executive staff of California Medical Facility (CMF) and have been asked to schedule sessions with the Office of the Inspector General (OIG), California State Prison, Solano (SOL), California State Prison, Sacramento, and Folsom State Prison (FSP).

Objective 1.4. Establish a Standardized Utilization Management System

Action 1.4.1. By May 2010, open long-term care unit.
This action is completed.

Action 1.4.2. By October 2010, establish a centralized UM System.
This action is completed. Progress during this reporting period is as follows:

The CCHCS UM Program, as required by law per AB 1628, continues to focus its activities on timely access and provision of cost effective services. Hospital bed rounds in high volume hospitals remain a priority and with much success in reducing hospital days. Though improved, institutional medical leadership involvement during hospital rounds is still lacking in some institutions. This factor contributes significantly to timely return of patient-inmates to institutions and reducing administrative bed days (see Table 1 for administrative bed days report).

Individual institutional conferences are regularly convened with medical leadership to discuss service utilization, barriers to contain cost and unnecessary referrals, and ways to collaborate and support institutional staff. UM will provide direction and guidance to institution staff in restructuring the existing Medical Authorization Review Committees to align with the new Institutional Utilization Management Committee's (IUMC) purpose and structure. UM will provide institution specific Primary Care Provider based reports, hospital utilization, and use of network providers as the focus of discussion during the IUMC meetings.

The Web Census and Discharge Data Information system (CADDIS) system is now fully implemented in all 33 institutions. Real time census reports are now available to staff with Web CADDIS access.

Collaboration with the Prison Health Care Provider Network in monitoring provider performance and service availability continues. Institutions are encouraged to complete the Potential Quality Improvement (PQI) forms for any provider issues. The goal is to be able to stratify providers (Tier 1 versus Tier 2) based on peer reviews and cost.

UM has been working closely with the Quality Improvement Department in identifying potentially avoidable hospitalizations. Information will be provided to institutional leadership to develop and implement solutions within their institutions in managing these patient-inmates and avoid costly hospitalizations.

UM has also been in the forefront in the deployment of the Medical Parole legislation. To date, UM has processed over 50 Medical Parole applications, with six successfully granted Medical Paroles by the Board of Parole Hearing. UM continues to expand its Skilled Nursing Facility provider pool for Medical Parolees.

Goal 2: Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services

Objective 2.1. **Redesign and Standardize Access and Medical Processes for Primary Care**

Action 2.1.1. By July 2009, complete the redesign of sick call processes, forms, and staffing models.

This action is ongoing. Progress during this reporting period is as follows:

The Episodic Care Policy and Procedure is in the final review and approval phase. Upon approval, we will proceed with the rollout and implementation.

Action 2.1.2. By July 2010, implement the new system in all institutions.

This action is ongoing. Progress during this reporting period is as follows:

Upon approval of the Policy and Procedure, the implementation team will begin a phased rollout at seven institutions. Full implementation at all institutions will follow.

Objective 2.2. **Improve Chronic Care System to Support Proactive, Planned Care**

Action 2.2.1. By April 2009, complete a comprehensive, one-year Chronic Care Initiative to assess and remediate systemic weaknesses in how chronic care is delivered.

This action is completed.

Objective 2.3. **Improve Emergency Response to Reduce Avoidable Morbidity and Mortality**

Action 2.3.1. Immediately finalize, adopt and communicate an Emergency Medical Response System policy to all institutions.

This action is completed.

Action 2.3.2. By July 2009, develop and implement certification standards for all clinical staff and training programs for all clinical and custody staff.

This action is completed.

Action 2.3.3. By January 2009, inventory, assess and standardize equipment to support emergency medical response.

This action is completed.

Objective 2.4. **Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality**

Action 2.4.1. By June 2009, establish standard utilization management and care management processes and policies applicable to referrals to specialty care and hospitals.

This action is completed. Progress during this reporting period is as follows:

The UM program is continuing its oversight over the provision of care in community hospitals and for specialty services. While Table 1 is inclusive of all bed day utilization in community hospitals, Table 2 only includes those days that are not medically necessary or days that could have been avoided should there have been available institutional beds (administrative or aberrant bed days). Table 3 illustrates the volume of Specialty Referrals.

Table 1: Community Hospital Bed Utilization Data

Institution	Total Admits	Total Discharges	Total Census Days	Average Daily Census	Average Length of Stay	Patient-Inmate Population	Bed Days per 1000 Patient-Inmates Projected for the Year
Aug-09	1,102	1,001	9,913	332	9.0	152,072	782.2
Sep-09	1,107	1,129	9,206	302	8.3	152,870	722.7
Oct-09	1,027	1,060	8,567	261	8.2	153,906	668.0
Nov-09	1,004	995	8,253	275	8.2	153,203	646.4
Dec-09	1,065	1,085	8,256	266	7.8	154,154	642.7
Jan-10	990	978	7,430	240	7.5	153,261	581.8
Feb-10	963	956	6,973	249	7.2	152,501	548.7
Mar-10	1,126	1,133	7,676	248	6.8	151,972	606.1
Apr-10	1,124	1,113	7,505	250	6.7	151,759	593.4
May-10	1,044	1,058	7,534	243	7.2	151,396	597.2
Jun-10	1,155	1,142	7,772	259	6.7	151,376	616.1
Jul-10	1,081	1,123	7,571	243	7.0	150,365	604.2
Aug-10	1,159	1,143	7,532	243	6.5	150,365	601.1
Sep-10	1,080	1,056	7,065	235	6.5	149,784	566.0
Oct-10	1,013	1,035	7,061	227	7.0	147,920	572.8
Nov-10	916	924	6,170	206	6.7	148,003	500.3
Dec-10	977	982	6,522	210.4	6.7	146,632	533.7
Jan-11	935	943	6,325	204.0	6.8	145,719	520.9
Feb-11	779	780	5,135	183.4	6.6	145,704	422.9
Mar-11	957	965	5,764	185.9	6.0	146,590	471.8
Apr-11	911	907	5,586	186.2	6.1	147,166	455.5
May-11	896	884	5,049	162.9	5.6	147,308	411.3
June-11	912	915	4,817	160.6	5.3	147,436	392.1

Note: Total number of discharges exceeds total number of admissions due to the methodology used in counting admissions and discharges for the month. Some patient-inmates are overflows from the prior month and discharged during the reporting month.

Table 2: Community Hospital Administrative Bed Data*

	Amount Paid	Number of Administrative Days
Jul-09	$201,812	190
Aug-09	$263,396	254
Sep-09	$447,153	392
Oct-09	$434,200	446
Nov-09	$417,592	484
Dec-09	$661,777	611
Jan-10	$556,078	574
Feb-10	$440,090	411
Mar-10	$867,543	882
Apr-10	$690,872	741
May-10	$567,439	586
Jun-10	$665,973	787
Jul-10	$405,863	401
Aug-10	$640,182	590
Sep-10	$689,977	607
Oct-10	$534,638	511
Nov-10	$426,041	489
Dec-10	$338,293	344
Jan-11	$346,145	349
Feb-11	$395,716	411
Mar-11	$428,041	473
Apr-11	$302,267	369
May-11	$358,435	410
Grand Total	$11,079,523	11,312

*This table is based on all claims paid by the Third Party Administrator as of Aug 4, 2011 and may not reflect all activity. This table is based on paid claims, not billed amounts.

Table 3: Specialty Referral Volume - Requests For Services (RFS) - Total Volume

	Statewide Total	RFS/1000 patient-inmates/month
Monthly Baseline: 08/09	25,000	
Apr-09	21,222	137.2
May-09	16,608	104.4
Jun-09	16,680	109.7
Jul-09	15,750	102.9
Aug-09	14,060	92.5
Sep-09	14,698	98.2
Oct-09	15,059	97.9
Nov-09	12,439	81.2
Dec-09	13,539	87.8
Jan-10	12,466	81.3
Feb-10	13,328	87.4
Mar-10	14,761	95.7
Apr-10	13,056	86.2
May-10	11,292	74.6
Jun-10	12,466	82.4
Jul-10	10,669	71.0
Aug-10	12,362	82.2
Sep-10	12,194	81.4
Oct-10	11,342	76.3
Nov-10	11,342	68.4
Dec-10	11,608	79.2
Jan-11	10,267	70.5
Feb-11	10,040	68.9
Mar-11	11,582	79.0
Apr-11	9,840	66.9
May-11	10,542	71.6
Jun-11	11,290	76.6

Action 2.4.2. By October 2010, establish on a statewide basis approved contracts with specialty care providers and hospitals.

This action is completed. Progress during this reporting period is as follows:

Medical Contracting

CCHCS continues its partnership with Health Net to maintain a statewide network of specialty care providers and hospitals for California's 33 correctional facilities. As of June 30, 2011,

Health Net fulfilled their contracted requirements for Phase Two by having 100% of the provider network in place ensuring patient-inmates' access to care.

CCHCS continues to contract with non-network providers for on-site and registry service contracts on a statewide basis to ensure continued access to medical care services and equitable rate(s) for reimbursement for services rendered. Our contracts system and Business Information System (BIS) are part of our internal business processes now and as such we will continue to make system/process improvements as necessary while we move into a maintenance and operation phase.

Action 2.4.3. By November 2009, ensure specialty care and hospital providers' invoices are processed in a timely manner.

This action is completed. Progress during this reporting period is as follows:

Two-Year Post Audit

The two-year post audit effort has resulted in $29 million in refunds as of August 2011. These refunds represent overpayments recovered by Equiclaim (formerly Viant) during the two-year post audit period of July 1, 2007 through June 30, 2009, as well as voluntary provider refunds and ongoing retrospective audits. A new law, effective July 1, 2011 will allow money recovered prior to July 1, 2011 to be augmented to the appropriation to the Prison Medical Care budget for the FY 2010/2011. Further, money recovered on or after July 1, 2011, will be augmented to the appropriation to the Prison Medical Care budget for the FY in which the recovered funds are received.

Goal 3: Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1 **Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions**

Action 3.1.1. By January 2010, fill ninety percent of nursing positions.

This action is completed. Progress during this reporting period is as follows:

As of July 2011, over 95% of the nursing positions have been filled statewide, a 1.5% increase since the last report at 94%. This percentage is an average of six State nursing classifications.

More specifically, the goal of filling 90% or higher of the RN positions has held steady at 26 institutions (79% of all institutions). Eleven institutions (33%) have filled 100% of their RN positions during this reporting period, an increase of three.

The goal of filling 90% or higher of the LVN positions has been achieved at 28 institutions (85%), an increase of two institutions achieving this level. The balance of five institutions (15%) has filled 83 to 86% of their LVN positions.

The following hiring-related initiatives took place during the reporting period: A variety of online job postings were the focus of hiring activities during the reporting period. Nursing vacancies are posted on multiple websites, including www.ChangingPrisonHealthCare.org, www.Indeed.com, www.VetJobs.com, school career websites, and several more. Each job posting often represents multiple vacancies at an institution. Staff monitors vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

For details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for April 2011, May 2011, June 2011 and July 2011. These reports are included as Appendix 4. Included at the beginning of each Human Resources Recruitment and Retention Report are maps that 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.

Action 3.1.2. By January 2010, fill ninety percent of physician positions.

This action is ongoing. Progress during this reporting period is as follows:

In general, physician recruitment efforts continued to focus on hard-to-fill institutions during the reporting period. Most urban institutions have now hired their full complement of primary care providers.

As of July 2011, just over 88% of physician positions are filled, virtually unchanged from the previous report. This percentage is an average of all three State physician classifications. More specifically, 65% of the Chief Medical Officer (CMO)/Receiver's Medical Executive positions are filled, no change since the last report. Note that the CMO positions are being abolished through

attrition since the role of the Chief Medical Executive is no longer filled with the CMO classification, but rather, the Receiver's Medical Executive classification. Chief Physician & Surgeon (CP&S) increased to 92% filled from the previous 86% filled; and 93% of the Physician & Surgeon (P&S) positions are filled, unchanged from the last report.

Twenty-three institutions (70%) have achieved the goal of filling 90% of their P&S positions; 20 of these institutions (61%) have filled 100% of their P&S positions. Two institutions (6%) have filled 80 – 89% of their P&S positions, with eight institutions having less than 80% filled.

While the Central Valley region continues to be hard-to-fill, the use of Cejka Search, a vendor for physician and executive search services, is producing measurable results. As of August 2011, Cejka has referred 20 doctors for consideration; one physician has started at Substance Abuse Treatment Facility and one at Avenal State Prison, and two are pending final clearance before starting at Pleasant Valley State Prison. The Cejka contract has been a successful addition to our in-house recruitment efforts.

Job postings continue to be placed online at CCHCS's recruitment website, other online job boards, and staff continues to recruit at medical conferences.

For details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for April 2011, May 2011, June 2011 and July 2011. These reports are included as Appendix 4. 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.

Objective 3.2 Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2010, establish and staff new executive leadership positions.
Action 3.2.2. By March 2010, establish and staff regional leadership structure.

These actions are completed. Progress during this reporting period is as follows:

Since the CEO examination was launched on December 24, 2008, 555 CEO applicants have been added to the certification list. Based on current pairing of institutions, we have hired 23 CEOs to fill the 25 positions statewide. Recruitment efforts continue to fill the vacancies.

Strategically, CEO positions have been filled statewide and these individuals are playing a pivotal role in establishing the remainder of the clinical leadership structure. Twenty-three CEO positions have been filled statewide. There are eight pairings of institutions (16 institutions) that will be under the direction of one CEO at each of the paired institutions.

Since the Receiver's Nurse Executive examination commenced in September 2008, 504 Nurse Executive applicants have been added to the certification list and 25 Nurse Executives have

been hired. Due to the varying institutional medical missions between North Kern State Prison (NKSP) and Kern Valley State Prison (KVSP), it was determined that they should not be paired. As a result, it was determined that seven pairings of institutions (14 institutions) was appropriate for the purpose of hiring Institution Chief Nurse Executives. Therefore 26 Institution Chief Nurse Executives will be filled statewide.

Since the Receiver's Medical Executive examination was launched in December 2008, 192 Medical Executive applicants have been added to the certification list. Twenty-three Institution Medical Executives have been hired. Due to the varying institutional medical missions between NKSP and KVSP, it was determined that they should not be paired. As a result, it was determined that six pairings of institutions was appropriate for the purpose of hiring Institution CMEs. Therefore, 27 Institution CMEs will be filled statewide.

The Receiver's Clinical Executive examination was launched in November 2009 for four disciplines: Laboratory, Imaging, Dietary, and Pharmacy. All vacancies for the Receiver's Clinical Executive have been filled as of August 2, 2011.

The Chief Support Executive is a new addition to the institution leadership infrastructure. The Chief Support Executive is a Career Executive Assignment that will serve as the chief operating officer to the institution CEO, for Health Care Services and is responsible for plant operations, fiscal services, budgets, contracts, procurement, and administrative and fiscal policy development. Efforts to fill 25 positions, one under each CEO, have begun. Ten Chief Support Executives have been hired.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2010, establish statewide organizational orientation for all new health care hires.

This action is complete. Progress of implementation during this reporting period is as follows:

Status of New Employee Orientation and Training

In January 2010, all thirty-three institution In-Service Training (IST) offices were delegated the responsibility of providing Health Care New Employee Orientation (HCNEO) to Medical, Mental Health, Dental, and other allied health and support staff. HCNEO curriculum was in part derived from IST NEO content; extracting all relevant topics necessary to orient health care employees to safely work in a correctional environment and ensuring continuity statewide. Additional topics necessary to appropriately orient health care new hires were added to the curriculum.

The number of institutions implementing the three-day HCNEO curriculum has increased to nine during this reporting period as a result of CEO involvement. Other institutions are working on collaborating with neighboring institutions, at their CEO's request. It is anticipated that this collaboration will not only increase the number of institutions implementing HCNEO, it will also increase the number of sessions scheduled which will result in timely orientation to new hires

and may contribute to the networking and sharing of qualified training staff to deliver the training.

Last quarter it was reported that factors contributing to the decline of institutions implementing HCNEO were due to delays in the approval of program specific orientation, scheduling issues, and site specific challenges. During this reporting period options for a more efficient approach to orientation training were discussed and considered. As a result, an alternate HCNEO subject outline was developed and distributed to the CEOs and IST managers, providing flexibility at the local level to schedule CDCR and CCHCS employees together for portions of new employee orientation. The Security and *Armstrong* Overview lesson plans were updated to include recent changes in Policy. The Pre-Orientation Guide was completed and distributed to the CEOs. Lastly, the SharePoint site where all institution staff will have access to training materials and resources continues to be developed.

Ongoing communication and assistance will continue with the institutions' CCHCS staff to monitor the progress of the HCNEO implementation.

Status of the Proctoring/Mentoring Program

In collaboration with institutional health care executive leadership (CEOs and CNEs), the Nursing Proctor/Mentor Program will be fully implemented by January 2012.

Action 3.3.2. By January 2009, win accreditation for CDCR as a CONTINUING MEDICAL EDUCATION provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education.

The action is completed. Progress during this reporting period is as follows:

Since receiving accreditation with commendation in February 2011 from the Institute of Medical Quality, we have continued to enhance overall access to the Continuing Medical Education Program by focusing on organizational improvement in such areas as intranet development, the creation of a Continuing Medical Education Activity Evaluation Tool, and revision to the Continuing Medical Education category one credit application. In the area of activity planning, we are developing several new Continuing Medical Education webinars.

Providing Continuing Medical Education activities related to the improvement of patient-inmate health care is the central focus of the CCHCS Continuing Medical Education Committee. The physicians and surgeons, mental health, dental, and nursing providers who comprise the committee make it possible to fully recognize and combine the various clinical disciplines within CCHCS. Medical staff and committee members continue to work with other programs (mental health, dental, and allied health) in order to assess the educational needs of all CCHCS clinicians. In addition, attending the CCHCS continuing medical education activities qualifies clinicians for continuing education credit through their respective licensing boards.

In this reporting period the Continuing Medical Education program conducted 769 hours of education on Diagnosis of HIV; Introduction to the Mental Health Services Delivery System

(MHSDS) for Medical Staff; Prognosis and Palliative Care; Asthma Update; and Management of the Angry Pain Patient. These educational activities were provided in 16 sessions to 679 licensed health care staff of which 483 were physicians.

Continuing Medical Education is an ongoing program and as such the administrative support staff and committee members are constantly working on the next educational activities that will provide CCHCS specific education that supports and improves the correctional health care system.

The following ten educational activities are in various stages of development, review, approval, and implementation.

- Behavioral Pain Management
- Personality Disorders
- Acute Joint Pain
- Preventable Hospitalizations
- Insomnia
- Cardiovascular Part III: Chest Pain
- Catatonia
- HIV – In-Depth Care
- Motivational Interviewing
- Identifying the Medically High-Risk Patient-Inmate

Goal 4: Implement Quality Improvement Programs

Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program

Action 4.1.1. By July 2011, establish sustainable quality measurement, evaluation and patient safety programs.

This action is ongoing. Progress during this reporting period is as follows:

During the last reporting period, CCHCS issued a Performance Improvement Plan for 2011-2012, a document which describes priority improvement areas, statewide improvement strategies, and performance measures that will be used to determine the success of improvement strategies. The performance measures listed in the Performance Improvement Plan evaluate the effectiveness of the critical clinical and administrative processes, allowing CCHCS to continuously survey system performance and address identified improvement opportunities. Please see the updated Performance Improvement Plan 2011-2012, Appendix 5.

Performance measures in the Performance Improvement Plan are incorporated into the Health Care Services Dashboard, with most data updated monthly. During this reporting period, CCHCS updated the Performance Improvement Plan to more strongly emphasize implementation of an integrated health care services delivery system, including the Medical Classification System and primary care model, as a means of improving patient-inmate outcomes and cost-efficiency. Accordingly, in September 2011, CCHCS will add measures to the Dashboard to evaluate appropriate placement of medically high-risk patient-inmates and important aspects of the primary care model, including continuity of care and coordination of care. In addition, the Dashboard will monitor admissions to a higher level of care by mental health high utilizers – patient-inmates who experience frequent deterioration in their condition, are vulnerable to self-harm/suicide, require repeat admissions to higher levels of care, use most of the Suicide Watch and outpatient/inpatient resources, and tend to have health issues that overlap with other problem areas such as pain management. Please see the updated Health Care Services Dashboard, Appendix 6.

An important element of an integrated health care services delivery system is the effective management of clinically complex patient-inmates, a subset of the patient-inmate population who is at risk for negative health outcomes and drives the majority of resource utilization. During this reporting period, CCHCS established standardized criteria for identifying clinically complex patient-inmates in accordance with severity of their medical, mental health, and dental conditions, and began issuing a monthly patient-inmate list for each institution to support patient-inmate tracking and management. In fall 2011, CCHCS will release a baseline report providing descriptive and performance data for clinically complex patient-inmates, with an emphasis on appropriate placement of these patient-inmates and promoting a consistent relationship with an assigned primary care team. CCHCS will also continue to assess the management of mental health high utilizers through periodic reports to the CCHCS executive team and the provision of monthly patient-inmate lists to mental health staff.

As part of a series of performance reports on priority improvement areas identified in the Performance Improvement Plan, CCHCS issued an initial performance report on Human Immunodeficiency Virus (HIV) screening rates for patient-inmates as they are processed through Reception Centers. In addition, CCHCS issued a second round of performance reports regarding asthma care and breast and colon cancer screening, both of which showed progress towards reaching performance objectives. Please see Appendix 7 for the asthma performance report, as well as reports on HIV (Appendix 8) and cancer screening (Appendix 9).

Action 4.1.2. By July 2009, work with the Office of the Inspector General to establish an audit program focused on compliance with Plata requirements.

This action is completed.

Objective 4.2. Establish a Quality Improvement Program

Part of the Quality Improvement Program is the implementation of a Credentialing and Privileging Program. The Program contains both a formal committee and a support unit to process all initial and reappointment medical staff applications, while ensuring all providers have appropriate and current credentials. Below is a summary of activity during this reporting period:

Credentials Committee

The Credentials Committee is responsible for ensuring that only providers who meet the quality of care, professional conduct, credentialing requirements, and practice standards are granted credential approval and core privileges to provide health care services to patient-inmates.

During this review period, the Credentials Committee reviewed 61 provider cases as detailed in Tables 4 and 5.

Table 4: Provider Case Outcomes

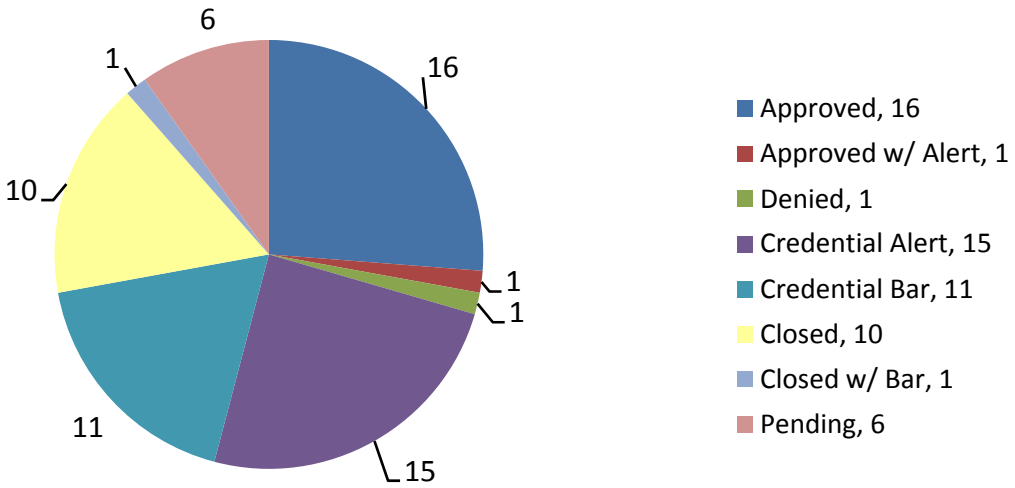
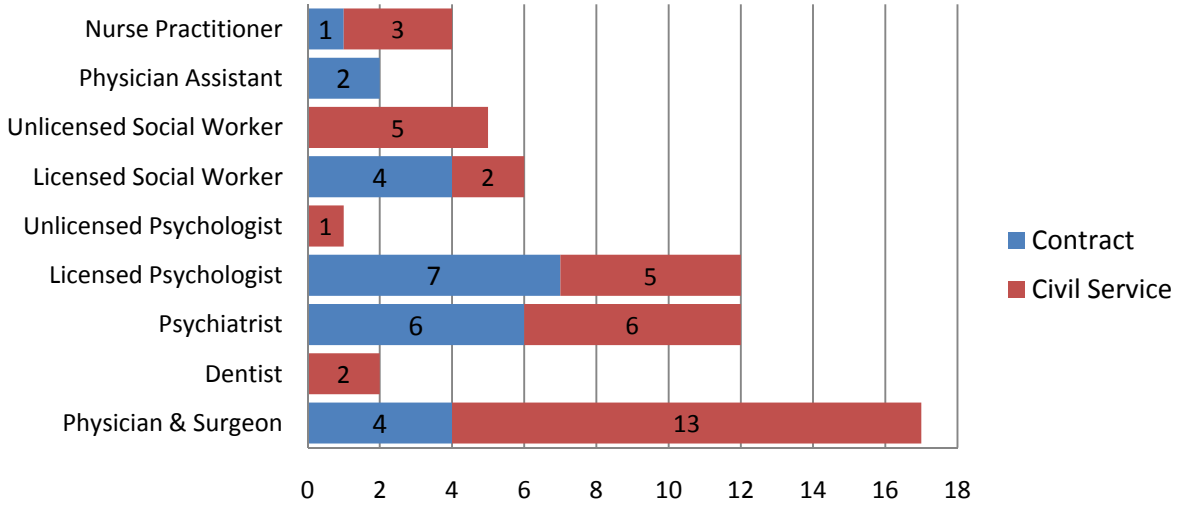


Table 5: Provider Cases Reviewed by Credentials Committee – May through August 2011



Initial Appointment to the Medical Staff

The initial appointment to medical staff consists of a formal credential review process of obtaining, verifying, and assessing the qualifications of an applicant to provide patient-inmate care, treatment, and services in and for CCHCS. All initial appointment activity is reported monthly to the Professional Practice Executive Committee (PPEC) and the Governing Body for approval. Within this reporting period, there were 462 credential applications received: 401 initial appointments to the medical staff, 24 lateral transfers, 12 promotions, and 25 credential file updates. Of these, 298 were approved, and 103 were closed due to the following:

Reason for file closure	Number Closed for each reason
Incomplete Applications	54
Institution Request Withdrawn	49

Additionally, 61 applications are pending completion at the time of report. The most common reasons for a pending status are incomplete applications and awaiting recommendations from previous employment.

Two-Year Reappointment Compliance

In order to maintain compliance with California Code of Regulations, Title 22, a two-year reappointment to medical staff is completed. Additionally, the two-year reappointment is standard practice in all health care settings; therefore the Credentials Verification Unit has established this process requirement.

During this reporting period, 242 civil service providers were notified to complete their two-year reappointment, of which 158 reappointments have been received and reviewed, and 84 reappointment applications remain pending. The most common reason for a pending status is the lack of a complete application.

During the previous reporting period, the Credentialing Program reported that there were 104 licensed independent practitioners whose reappointments were pending submission. The Credentials Verification Unit management continues to work with providers, as well as institutional management, to ensure the reappointment process is completed according to the required timelines. As a result of the collaborative efforts from all levels of leadership the 104 deficit has decreased to 42 pending reappointments broken down into the following classifications: three Dentists; one Nurse Practitioner; 15 Physician & Surgeons; one Pharmacist; four Psychiatrists; 13 Psychologists; five Social Workers.

Finally, during this reporting period, 172 reappointments (pending and new requests) were completed by the Credentials Verification Unit.

Tracking of License and Board Certification Expirations

To ensure provider compliance with State and CCHCS requirements, the Credentials Verification Unit monitors the activity of physician board certification and the licensure status of the various civil service Licensed Independent Practitioners and Allied Health Professionals.

The tracking of expiring license is an ongoing process with notifications being sent on a monthly basis to ensure that the practitioners have active and current credentials. During this reporting period, 43 Notice of Licensure Expirations were processed. The total is broken down into the following classifications: six Physician & Surgeons, two Psychiatrists, 14 Psychologists, 15 Dentists, one Nurse Practitioner, and five Social Workers.

Based on the current board expiration and renewal cycles, the Credentials Verification Unit reports no Physician and Surgeon board certifications are pending renewal.

> ***Action 4.2.1.(merged Action 4.2.1 and 4.2.3)**: **By January 2010, train and deploy existing staff--who work directly with institutional leadership--to serve as quality advisors and develop model quality improvement programs at selected institutions; identify clinical champions at the institutional level to implement continuous quality improvement locally; and develop a team to implement a statewide/systems-focused quality monitoring/measurement and improvement system under the guidance of an interdisciplinary Quality Management Committee.***

This action item is ongoing. Progress during this period is as follows:

In the organization's annual Performance Improvement Plan, CCHCS listed four major statewide strategies to improve health care system performance, patient-inmate outcomes, and cost-effectiveness at California prisons:

- Establish improvement priorities at institution level and align program activities with priorities.
- Integrate health care processes across disciplines and fully implement both the CCHCS Primary Care Model and the Healthcare Classification System.
- Provide information and tools to support process improvement.
- Monitor and evaluate delivery system performance.

Institution Improvement Plans and Strategic Alignment

During this reporting period and over the past nine months, a workgroup of Chief Executive Officers have collaborated with Quality Management Section staff to revise the Quality Management Program Policy and Procedures. Among other requirements, the revised policy calls for each institution to establish an annual improvement plan, which identifies local improvement priorities, performance objectives, and proposed strategies. An assessment tool to support institutions in identifying opportunities for improvement and a template for the improvement plan are in development.

Once an improvement plan is established at an institution, institution leadership is responsible for achieving strategic alignment - communicating improvement priorities to staff and working with managers and supervisors to determine how program operations and day-to-day supervision will support performance objectives, and how care teams and other staff incorporate improvement activities for priority areas into day-to-day work. The revised Quality Management Program Policy and Procedures outline the committee structure and processes that are used to develop, implement, and evaluate the annual improvement plan.

An Integrated Health Care Delivery System

CCHCS delivers a continuum of health care services to patient-inmates, across multiple levels of care and in both outpatient and inpatient settings. Care is delivered by many different professional disciplines. CCHCS has adopted a multi-disciplinary, team-based primary care model to manage patient-inmates as they move through the continuum of care, based upon a number of nationally recognized models and paradigms. The CCHCS Primary Care Model emphasizes:

(1) Risk stratification of individual patient-inmates and patient-inmate populations using a classification system that determines each patient-inmate's health care risk and places the patient-inmate at a facility best equipped to manage his or her health care needs;
(2) A comprehensive patient-inmate focus;
(3) Interdisciplinary team-based care,
(4) Evidence-based practices;
(5) Active patient-inmate involvement and self management; and
(6) Decision support and information systems to assist in managing individual patient-inmates and patient-inmate populations, and facilitating continuous improvements in patient-inmate outcomes, clinical practice and processes of care.

A number of data sources, including a recent analysis of 2010 deaths, indicate that the CCHCS is still in the process of fully implementing the Primary Care Model at CDCR institutions. During this reporting period, CCHCS introduced two initiatives to support implementation of the CCHCS Primary Care Model. Under the first initiative, a multi-disciplinary group of custody, classification, and CCHCS staff identify medically high risk patient-inmates at institutions with basic health care missions and, when appropriate, move these patient-inmates to institutions equipped with additional resources to more efficiently care for these patient-inmates. During

this reporting period, the workgroup developed criteria for identifying medically complex patient-inmates based on pharmacy, laboratory, claims, and demographic data; worked with staff at select prisons to determine which patient-inmates should be transferred to an institution with an intermediate health care mission; and began to transfer eligible patient-inmates. This process will continue with other basic institutions, bringing the placement of medically high risk patient-inmates into better alignment with Medical Classification System requirements and institution health care missions. In September, CCHCS will release a registry of clinically complex patient-inmates to all institutions, to support ongoing improvement in the placement, monitoring, and management of this patient-inmate population.

The second initiative implements a statewide staff development and technical assistance program to help institutions to fully implement the CCHCS Primary Care Model. In September, CCHCS will establish a Primary Care Implementation Team to develop implementation tools and a training program for institution staff. The Primary Care Team Implementation Team will work with institutions that have developed sustainable processes for meeting the CCHCS primary care standards to identify best practices and disseminate them throughout the state. In addition, a subset of institutions with complex health care missions will be provided with on-site technical assistance and support, particularly at clinic level.

In the 2011-2012 Performance Improvement Plan, CCHCS commits to building performance improvement capacity by providing health care staff with quality improvement tools and staff development programs that teach process improvement skills and techniques. During this reporting period, the Chief Quality Officer initiated discussions with the Joint Commission and Veteran's Healthcare Administration to partner with these agencies in subsequent months to design and deliver training modules on improvement topics such as root cause analysis, process redesign, and rapid-cycle improvement. During the next reporting period, CCHCS staff will continue work on a quality improvement toolkit – a set of forms, educational resources, and examples that support the work of improvement teams as they apply specific improvement techniques – for broad dissemination.

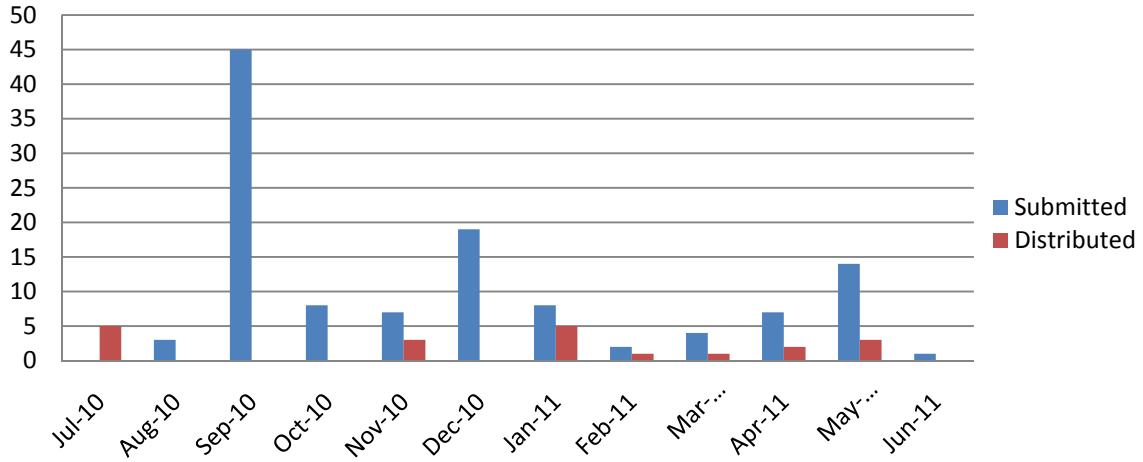
In a final major improvement strategy, CCHCS will continue to monitor and evaluate delivery system performance, continuing to release the monthly Health Care Services Dashboard and patient-inmate registries, providing analyses of patient-inmate deaths, sentinel events, and other health care information to identify opportunities for improvement, developing and providing Care guides and continuing medical education sessions, and issuing performance reports that evaluate the effectiveness and efficiency of critical clinical and administrative health care processes.

Action 4.2.2. By September 2009, establish a Policy Unit responsible for overseeing review, revision, posting and distribution of current policies and procedures.

This action is completed.

Table 6 shows the Policy Development Section (PDS) workload on a monthly basis. On average 9.83 policies were submitted to the PDS per month in FY 2010.

Table 6: Policies Submitted and Distributed by Month in FY 2010



Action 4.2.3. By January 2010, implement process improvement programs at all institutions involving trained clinical champions and supported by regional and statewide quality advisors.

This action is combined with Action 4.2.1.

Objective 4.3. Establish Medical Peer Review and Discipline Process to Ensure Quality of Care

Action 4.3.1. By July 2008, working with the State Personnel Board and other departments that provide direct medical services, establish an effective Peer Review and Discipline Process to improve the quality of care.

This action is completed.

In a health care organization, the Governing Body is the highest policy making body for the provision of health care. Consistent with community standards and health care organizations, the Governing Body is responsible for the administration, direction, monitoring, and quality of health care services provided to patient-inmates within CCHCS and CDCR adult institutions. The Governing Body met four times during the period between May and August 2011 to take final action on recommendations from the PPEC regarding practitioners.

The PPEC met nine times and the Peer Review Subcommittee (PRSC) met eight times during the period of May through August 2011. The PPEC reviewed 47 cases and the PRSC reviewed 133 cases for a total of 180 cases reviewed regarding clinical practice concerns resulting in 245 actions. The PRSC closed 73 referrals and the PPEC made recommendations to the Governing Body for the closure of seven cases. Governing Body approved five recommendations for case closures during this reporting period. The other two cases are pending case closure at the September Governing Body meeting. There were three training and education plans and 25 monitoring plans initiated by the PPEC, and 38 training and education plans initiated by the PRSC for those providers whose standard of practice warranted closer review for a combined total of 66 action items for training and monitoring.

In this reporting period, the PPEC did not summarily suspend the privileges of any practitioner and zero providers were separated from State service while under investigation. The Governing Body did not issue any Notices of Final Proposed Action under the Federal court ordered physician policies that would have resulted in the revocation of privileges and termination of employment.

Graphical displays of PPEC and PRSC outcomes for the period May 2011 through August 2011 are presented in Tables 7, 8, 9, and 10.

Table 7: PPEC Activity for May 1, 2011 through August 31, 2011

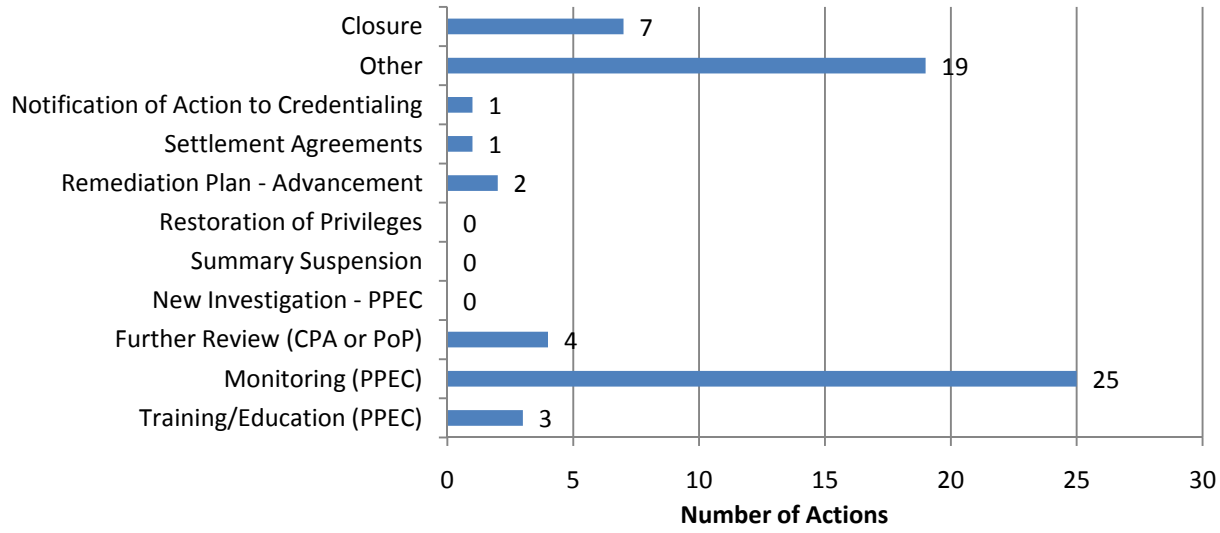


Table 8: PPEC Activity by Percentage for May 1, 2011 through August 31, 2011

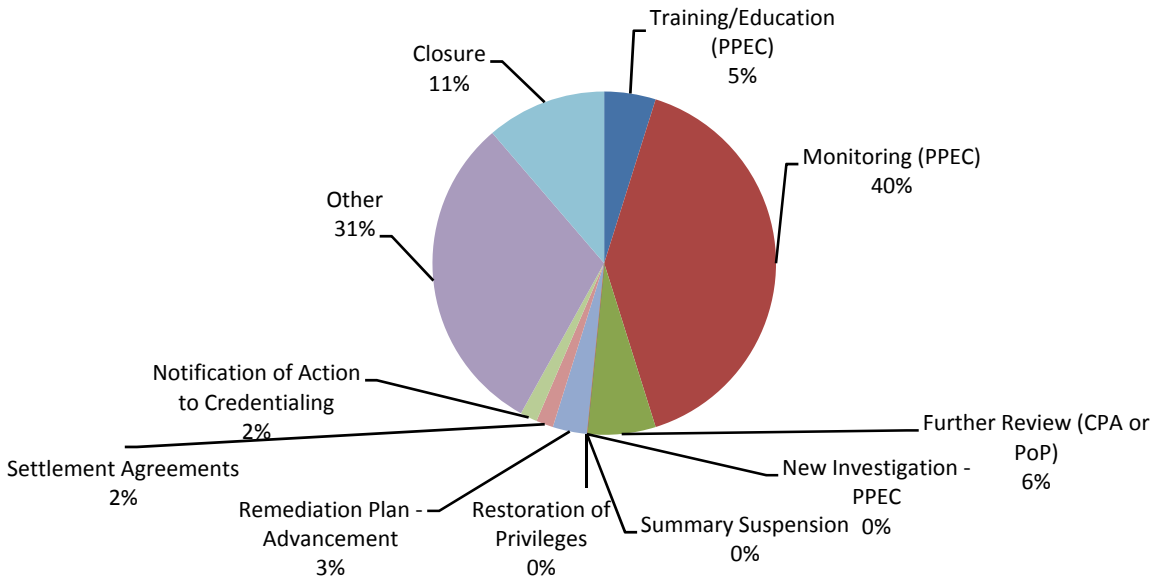


Table 9: PRSC Activity for May 1, 2011 through August 31, 2011

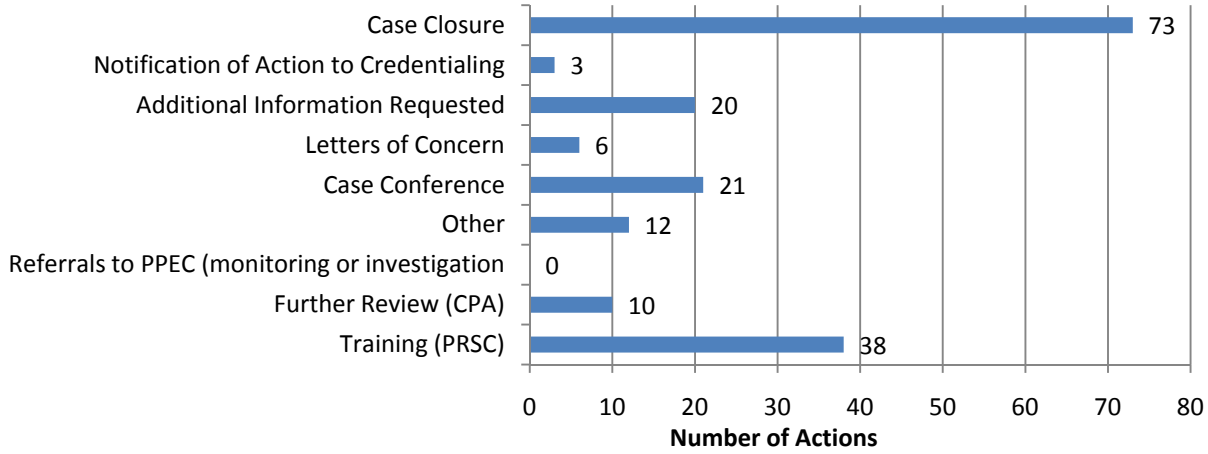
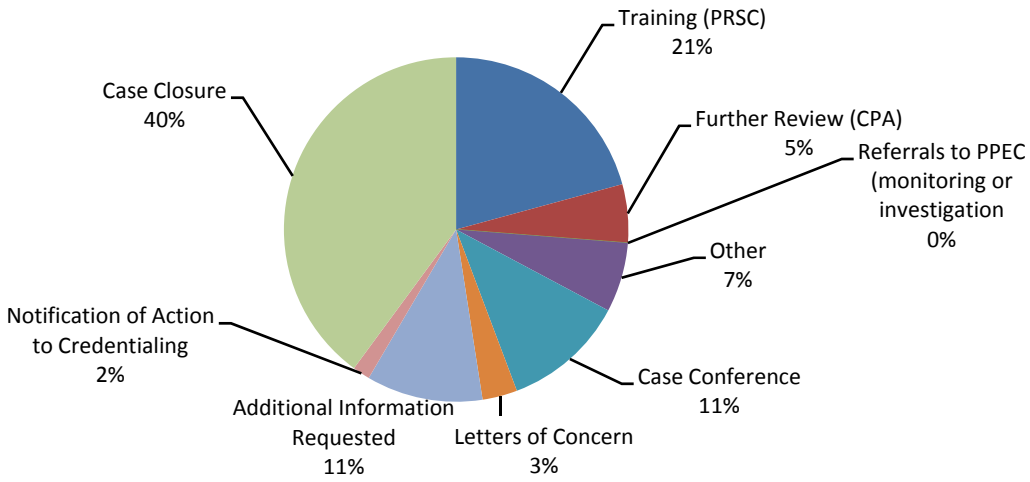


Table 10: PRSC Activity by Percentage for May 1, 2011 through August 31, 2011



Tables 7, 8, 9, and 10 Results Explanation:

The data represented pertains to licensed independent practitioners including, physicians and surgeons, psychiatrists, psychologists, dentists, nurse practitioners, physician assistants and licensed and unlicensed clinical social workers.

Case Closed is defined as licensed independent practitioners that are deemed to be practicing at an appropriate standard of care after conclusion of training/monitoring or a peer review investigation.

Training/Education/Monitoring is the manner in which providers are supported in the development of clinical competency through training/education/monitoring.

Additional Information Requested is when a provider case requires further research of the information being reviewed prior to making a determination for an appropriate action.

Case conference is requested by PRSC when institution management is to provide a case conference to all medical staff regarding the overall best practice of care provided to a specific patient-inmate.

Letters of Concern is sent to a community hospital requesting the review of care identified by PRSC.

Other may be defined as matters being deferred, referrals to other units (i.e. Utilization Management (UM) and/or Quality Management (QM)).

Notification of Action to Credentialing is notification to the Credentials Committee informing them of an action taken on a provider by PRSC or PPEC which may affect the approval of the provider's credentials.

Settlement Agreement is defined as legal agreements between CDCR CCHCS and the practitioner that ceases administrative or legal action regarding a practitioner's privileges and or employment.
Remediation Agreement are defined as legal agreements between CDCR CCHCS and the practitioner that ceases administrative or legal action regarding and requires the practitioners to complete training and monitoring as privileges are restored on a phased in basis..
Referrals to PPEC is defined as PRSC making recommendations to PPEC to initiate monitoring and/or initiate a formal peer review investigation.
Further Review (CPA) is defined as PRSC or PPEC requesting a Clinical Performance Appraisal of the provider's clinical care.
Further Review (CPA or POP) is defined as PPEC requesting a Clinical Performance Appraisal or Pattern of Practice of the provider's clinical care.
New Investigation is defined as initiation of a formal peer review investigation.
Summary Suspension is defined as the suspension of all clinical privileges in an effort to protect patient-inmate safety.
Restoration of Privileges is defined as returning the providers privileges to allow the provider to resume patient-inmate care.

Objective 4.4. Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations

Action 4.4.1. By January 2009, fully staff and complete the implementation of a Medical Oversight Unit to control and monitor medical employee investigations.

This action is completed. Progress during this reporting period is as follows:

The Medical Oversight Program (MOP) utilizes CCHCS clinicians as MOP team members to maximize the clinical resources. This approach was implemented to utilize physicians and nurses as subject matter experts in medical investigations while also directing their clinical expertise to a variety of initiatives for CCHCS.

CCHCS Clinicians, the Office of Internal Affairs (OIA), and Employment Advocacy and Prosecution Team (EAPT) continue to work collaboratively to expedite investigative decisions for medical cases. The aim of this endeavor is to ensure thorough review and investigation of allegations of misconduct related to health care delivery by institution health care staff.

MOP activations continue to review the most egregious of sentinel events. During this reporting period the MOP reviewed 130 deaths and activated on ten cases. Zero cases were transferred from Central Intake that were submitted by institutional managers; One activation was referred by the Receivership, three cases were referred by the Deputy Medical Executive, and six activations were referred through the death review process and activated by the MOP Physician and Nursing Executive Leadership. The Medical Intake Consent Calendar opened three cases for investigation, rejected seven cases for investigation, and eight cases were pending for further review at the end of this reporting period. Two Direct Actions were referred back to the hiring authority; five subjects were referred to Nursing Professional Practice Committee (NPPC) and 11 subjects were referred to the PPEC.

A graphical display of MOP outcomes for May through August 2011 is presented in Tables 11 and 12.

Table 11: MOP Activations and Referrals for May 1, 2011 through August 31, 2011

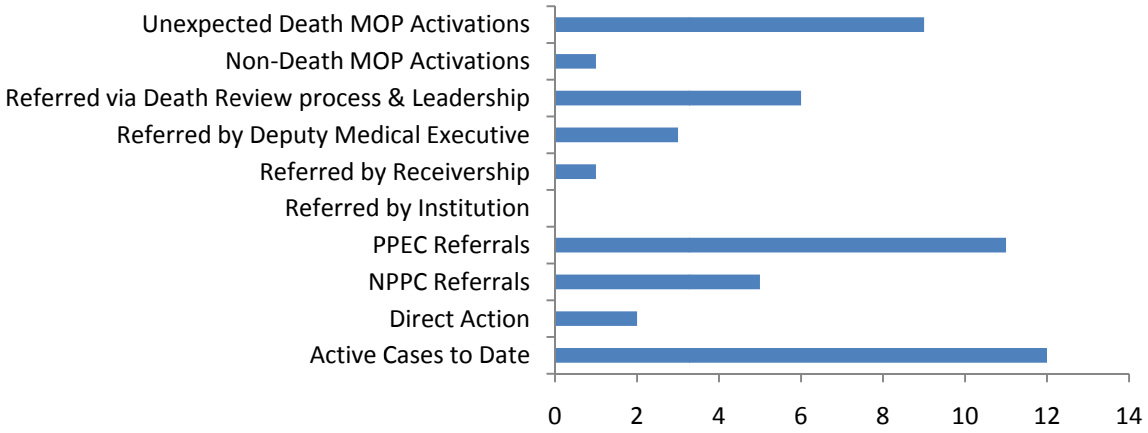


Table 11 Results Explanation:

Unexpected Death MOP Activations is a death of a patient-inmate based on the Inclusion Criteria as follows: a death of a patient-inmate who: is 40 years of age or younger with no history of a chronic medical condition; a patient-inmate with two or more TTA visits in the last week of life; who submitted two or more request for health care services in the last week of life; or the institution's heath care management staff reports possible inappropriate, absent, or untimely medical care; the institution's health care management staff directly attributes death due to asthma or a seizure condition; or the deceased returned from an off-site emergency room visit or an acute care inpatient stay within the last 14 days prior to death Medication error resulting in patient-inmate death.

Non-Death MOP Activations is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Referred via Death Review process & Leadership are cases referred to MOP through death review process and activated by the MOP Physician and Nursing Executive Leadership.

Referred by Deputy Medical Executive are cases referred to MOP by the Institutional Deputy Medical Executive.

Referred by Receivership or Referred by Institution are cases referred by those entities to MOP.

PPEC referral is made when the Medical Intake Unit suspects substandard clinical practices or clinical misconduct by a physician or mid-level provider and refers the case to the PPEC.

NPPC referral is made when the Medical Intake Unit suspects substandard clinical practices by a nurse and refers the case to the Nursing Practice Review Program.

Direct Action referral is made when the facts support the allegations of the case that are adequate to permit the hiring authority to take direct adverse action against an employee.

Active Cases to Date are cases opened for investigation and heard on the Medical Intake Calendar.

Table 12: MOP Quality Review Case Activity for May 1, 2011 through August 31, 2011

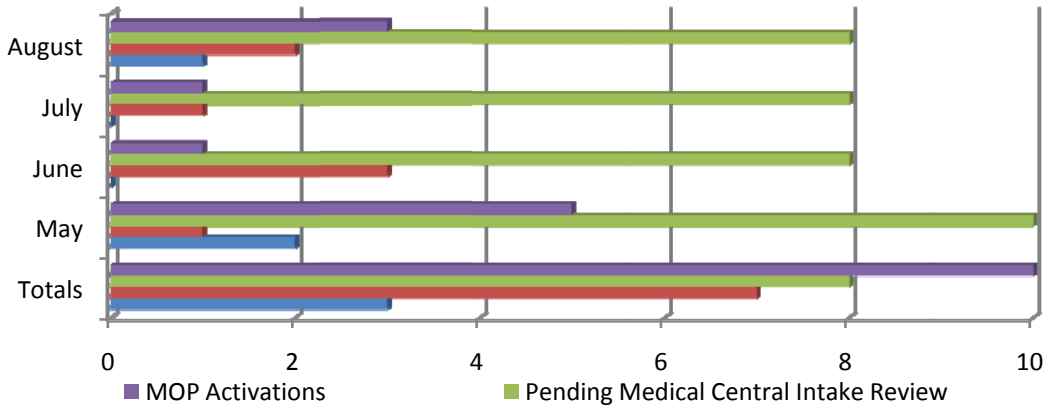


Table 12 Results Explanation:

Opened for Investigation is a formal investigation conducted by MOP.

Rejected for Investigation is when a MOP inquiry does not result in a formal investigation being opened (e.g. due to insufficient facts to support an investigation).
Pending Medical Central Intake Review is case pending Medical Central Intake review to determine whether a case will be opened for investigation or rejected.
MOP Activations are cases referred to the Medical Oversight Program that meet inclusion criteria for Activation.

Objective 4.5. Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative

Action 4.5.1. By July 2008, centralize management overall health care patient-inmate appeals, correspondence and habeas corpus petitions.

This action is completed. Activity for this reporting period is shown in Tables 13-15.

Table 13: Health Care Appeals Statewide (Institutions) - May through August 2011

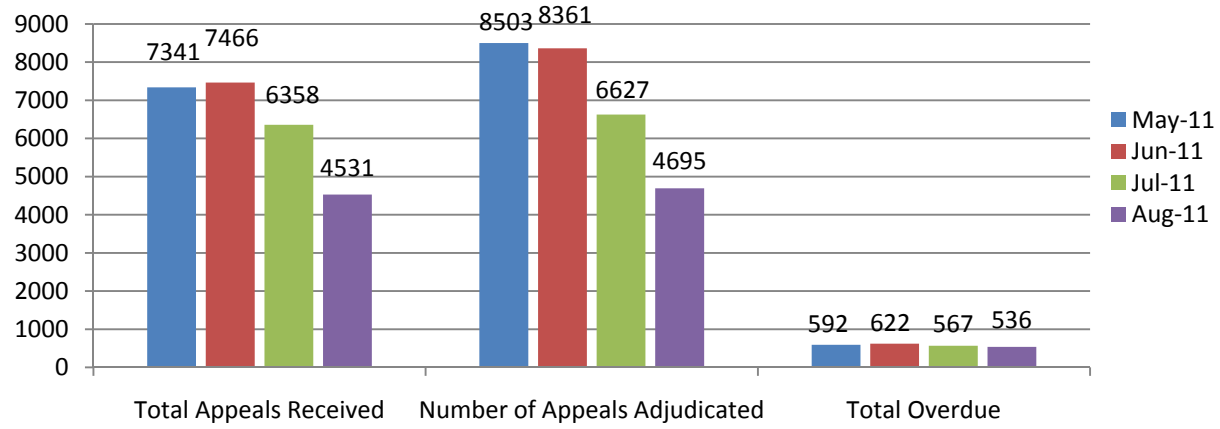


Table 14: Office of Third Level Appeals - May through August 2011

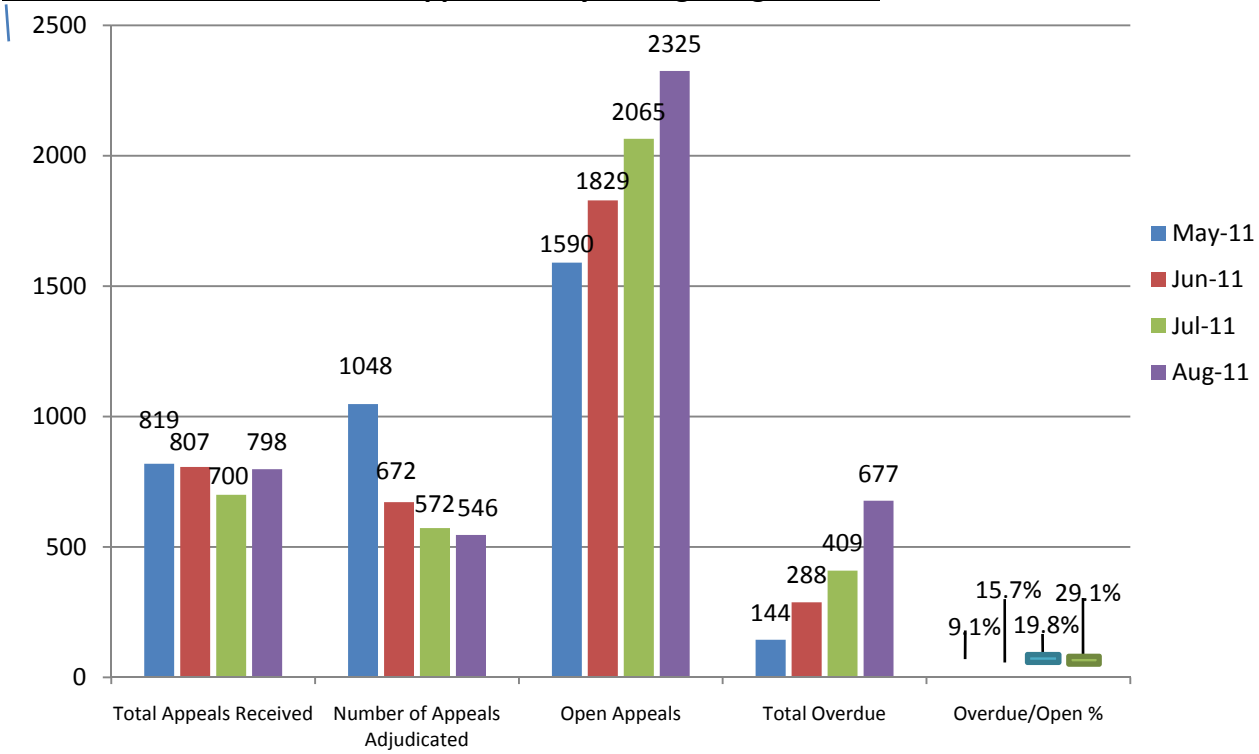
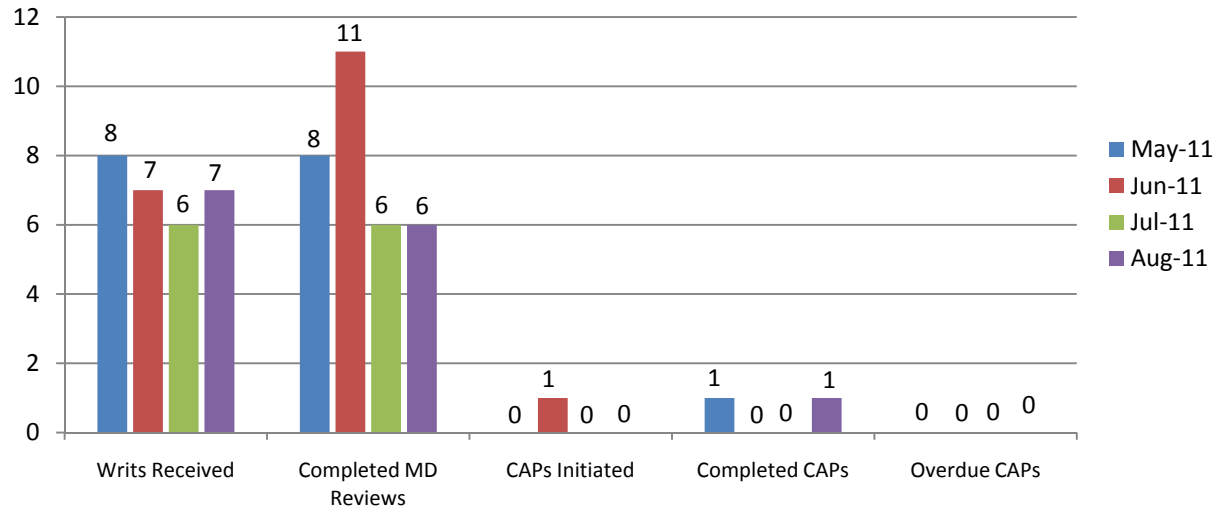


Table 15: Habeas Corpus Cases - May through August 2011



Action 4.5.2. By August 2008, a task force of stakeholders will have concluded a system-wide analysis of the statewide appeals process and will recommend improvements to the Receiver.

This action is completed.

Objective 4.6. Establish Out-of-State, Community Correctional Facilities (CCF) and Re-entry Facility Oversight Program

Action 4.6.1. By July 2008, establish administrative unit responsible for oversight of medical care given to patient-inmates housed in out-of-state, community correctional or re-entry facilities.

This action is completed. Progress during this reporting period is as follows:

The following provides an overview of the current activities Private Prison Compliance and Monitoring Unit (PPCMU) staff are involved in to ensure Corrections Corporation of America's (CCA) compliance with the Remedial Plan developed in July 2008, the Community Correctional Facilities compliance with the Inmate Medical Services Policies and Procedures, and the establishment of Geo Care Inc., as the newest out-of-state vendor responsible for housing patient-inmates.

1. CCHCS Clinical Performance Appraisals (CPAs) of CCA and GEO Care Inc. Primary Care Providers:

   CCHCS has completed two Clinical Performance Appraisals for CCA Primary Care Providers, as captured through PPCMU's monthly monitoring process. Both of the CPAs completed were annual reviews and resulted in satisfactory provider performance.

CCA has submitted four completed Peer Reviews to the PPCMU for the same reporting period. Of the four Peer Reviews completed, one was a 60-day review, two were annual reviews, and one was a follow-up review. Aside from minor documentation issues, all providers were determined to be satisfactory by the CCA reviewer. The PPCMU will continue to monitor this process on a monthly basis.

CCHCS has completed one CPA for a GEO Care Inc. Primary Care Provider. This appraisal was an initial review and resulted in a less than satisfactory recommendation. GEO Care Inc. has appealed the CPA recommendation and a follow-up CPA will be completed during the next reporting period.

GEO Care Inc. has submitted two completed Peer Reviews to the PPCMU. Both were initial reviews and the providers were determined to be satisfactory by the GEO Care Inc. reviewer.

2. Weekly Physicians Collaborative Update on California Out-of-State Correctional Facility (COCF) Patient-Inmates:
   On average, 22 medical cases per week were discussed on the weekly CCA Physician's Collaborative Conference Call. These discussions have resulted in an average of two patient-inmates per month being returned to California for medical reasons.

   A Physician's Collaborative Conference Call was established with GEO Care Inc. physicians and the PPCMU Medical Director, beginning on May 9, 2011. On average, two medical cases were discussed weekly. There have been no patient-inmates returned to California for medical reasons. There is one pending return as of August 15, 2011.

3. CCHCS's Review of Credentialing Information of CCA and GEO Care Inc. Primary Care Provider Candidates:

   The PPCMU staff, CCHCS clinical leadership, and CCA have approved the credentialing and privileging policy. CCA implemented the approved policy in June.

   The credentialing and privileging policy from GEO Care Inc. is under review by PPCMU and CCHCS clinical staff. It is anticipated that the policy will be finalized within the next reporting period.

   Two credentialing packets were received from GEO Care Inc. and reviewed by the CCHCS Credentialing Committee. Both were approved to provide medical care to California patient-inmates housed in the GEO Care Inc. out-of-state facility.

4. Unit Health Record (UHR) Post Audits of Patient-Inmates Transferred Out-of-State:
   As a result of the CDCR population realignment, COCF will maintain the current population by back filling behind those patient-inmates that are returned to California. This action, and

the limited number of medical returns, has significantly reduced the number of transfers between CDCR institutions and COCFs.

The CCHCS nursing staff has completed an average of 168 UHR post audits per month for patient-inmates transferred to COCFs to ensure appropriate eligibility screening of transfers. May and June 2011 all patient-inmate UHRs reviewed for eligibility by the nursing staff were screened using only the Medical Classification System screening criteria. As a result of the UHR post audits, the nursing staff found all patient-inmates were appropriately identified for out-of-state placement. July and August UHR reviews are pending.

5. Establishment of Monitoring Reports:

Medical Monitoring Logs have been implemented at the GEO Care Inc., out-of-state facility as of June 9, 2011. The facility submits reports on a daily, weekly, and monthly basis.

Information Technology staff have determined that automated reporting from the Medical Monitoring Logs will not be possible due to the data collection mechanism and the data input process. Developing a program capable of capturing the volume of data submitted and producing a viable report has proven to be too staff intensive and the cost of outsourcing this is prohibitive. However, manual reports on facility compliance are in development by PPCMU staff. It is anticipated that additional information will be provided during the next reporting period.

6. COCF Compliance Audits for FY 2010/2011:

CAPs were received from the following facilities: La Palma Correctional Center (LPCC), Red Rock Correctional Center (RRCC), Tallahatchie County Correctional Facility (TCCF), and North Fork Correctional Facility (NFCF). Florence Correctional Center was not required to submit a completed CAP due to the fact that they no longer house California patient-inmates. LPCC had 17 deficiencies noted, most of which were documentation related in the areas of Chemical Contraindications, Sick Call and Diagnostic Services. All 17 items on the LPCC CAP have been closed out. RRCC had 33 deficiencies noted, in the areas of Access to Health Care Information, Emergency Services and Drills, and minor documentation issues in the areas of Sick Call and Specialty Services. Following submission of the RRCC CAPs, 11 items are still open; however, PPCMU staff is in the process of reviewing additional follow-up documentation that was recently received, which should close out the remaining deficiencies. TCCF had only four deficiencies noted, all in the area of Access to Health Care Information. All four CAP items have been closed out. NFCF had only eight minor deficiencies noted, most of which were documentation related. All NFCF CAP items have been closed out. One deficiency noted in a number of reports was failure to provide patient-inmates with their test results. CCA has since established an automated method of notifying their Licensed Independent Practitioners when results are received to ensure timely patient-inmate notification occurs. PPCMU staff continues to work closely with the out-of-state facilities to ensure all deficiencies have been adequately addressed and documented. In

addition, all previous deficiencies will be reviewed as part of the FY 2011/2012 audit process to ensure all corrective actions identified have been implemented.

7. Community Correctional Facilities (CCF) On-site Follow-up Reviews Beginning April 2011:

During this reporting period, the PPCMU completed the on-site follow-up reviews at the following CCFs: Shafter CCF, Desert View Modified CCF, Golden State Modified CCF, Central Valley Modified CCF, Female Rehabilitation Community Correctional Center, Taft CCF, Leo Chesney CCF, Claremont CCF and Delano CCF. During the follow-up review, PPCMU staff provided comprehensive training, guidance, and technical assistance to the CCF in various program areas to assist them with understanding the requirements of achieving compliance with the Inmate Medical Services Policies and Procedures. Additionally, PPCMU provided the CCFs draft policies to utilize to create their own policy or use required language from the draft policy to incorporate into their existing policies. PPCMU received CAPs from all facilities and will continue to work closely with them until all deficiencies have been adequately addressed and documented.

Due to CDCR population realignment, the following facilities were closed: Lassen CCF, Claremont CCF, and Delano CCF. Leo Chesney CCF will be closing the end of September, 2011.

8. COCF Expansion:

The North Lake Correctional Facility (NLCF) activated in May 2011, and currently houses 270 patient-inmates. Although CDCR initially approved the contract with Geo Care Inc. to house 2,500 patient-inmates, CDCR population realignment has resulted in this number being capped at its current population of 270. Additionally, the Florence Correctional Center no longer houses California patient-inmates. Therefore, the expansion of the COCF Program has been postponed until further notice.

PPCMU staff is scheduled to conduct an on-site audit of NLCF in October 2011.

Goal 5: Establish Medical Support / Allied Health Infrastructure

Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program

During this reporting period, implementation of the Pharmacy Services Road Map to Excellence continues to make progress. Progress during this reporting period is detailed below.

Action 5.1.1. Continue developing the drug formulary for the most commonly prescribed medications.

This action is ongoing. Progress during this reporting period is as follows:

The CDCR Pharmacy and Therapeutics Committee (P&T) continues its monthly meetings to review utilization trends, actively manage the formulary, and review and approve pharmacy policies and procedures. During these meetings, the committee members reviewed monthly reports including the pharmacy dashboard, monthly metrics summary, and medication error reports. The P&T Committee is presently engaging with a cost-effective effort. The P&T Committee is actively considering therapeutic equivalent products in an effort toward cost effective care. Since January 2011, the committee has initiated 6 therapeutic-equivalent substitutions in order to effectuate cost-effective medication therapy. CCHCS pharmacy services has an agreement with the school of pharmacy at the University of California in San Diego, where faculty and senior pharmacy students are collaborating by introducing evidence to inform the Committee's decision for the therapeutic interchange questions. This collaboration has started an evidence review effort within mental health pharmacotherapy.

The Committee published a pocket formulary. The physicians requested that a paper formulary be printed and updated that each can have in their pocket. Many prescribers do not have blackberries to access the electronic formulary and going to the computer to view the formulary sometimes does not fit with their workflow. The formulary has been updated and printed in a pocket format for the physicians and nurses.

Action 5.1.2. By March 2010, improve pharmacy policies and practices at each institution and complete the roll-out of the GuardianRx® system.

This action is completed. Progress during this reporting period is as follows:

The roll-out of the GuardianRx System is completed with 28 out of the 33 pharmacies migrating the Guardian Rx System to a more stable health care network.

The P&T Committee continued to actively review and revise pharmacy policies and procedures as needed. The 2011 revisions have started.

Action 5.1.3. By May 2010, establish a central-fill pharmacy.

This action is completed. Progress during this reporting period is as follows:

The Central Pharmacy automation and computer systems have been debugged and CCHCS has entered into a maintenance and operations phase with the Cornerstone Automated Systems, Incorporated (the manufacturer of the equipment) in June 2011. As such, implementation of the central distribution model has re-established in July 2011 and High Desert State Prison (HDSP) and CCC are now supported by the Central Pharmacy. The present plan is to support the facilities by dispensing and delivering Keep-on-Person (KOP) prescriptions. In the month of August 2011, three additional pharmacies will be supported by the Central Pharmacy. They are: CIW, CIM and the CRC. By the end of December 2011, the Central Pharmacy will dispense and deliver KOP prescriptions to 16 prison pharmacies throughout the state.

The Central Pharmacy has implemented a centralized order entry service since January 2011. The concept was instituted to establish mutual support from the Central Pharmacy located in Sacramento to assist the institution pharmacies that had to depend on unreliable and expensive registry labor. This service started quietly with the first five early-adopters (Ironwood State Prison, Chuckawalla Valley State Prison, RJD, HDSP and California Correctional Institution). Today, this small service has grown to support 12 institutions' pharmacies. Since this centralized order entry team is more efficient, the service is also able to provide support for the pharmacies that require assistance due to unplanned events, such as power outages at the local prison.

Objective 5.2. Establish Standardized Health Records Practice

Implementation of the Health Information Management/Health Records remediation road map continues to move forward to achieve improved patient-inmate health records management based on evidence-based practices and increased cost-efficiency. Progress continues and is detailed below.

Action 5.2.1. By November 2009, create a roadmap for achieving an effective management system that ensures standardized health records practice in all institutions.

This action has been completed. Progress during this reporting period is as follows:

CCHCS completed the implementation of an enterprise-wide electronic Unit Health Record (eUHR) with the roll-out to the men's institutions on July 19, 2011.

The Health Records Readiness Team (HRRT) continues to monitor activities at all institutions to ensure that local health records units follow the recommendations that were made as a result of the pre-implementation assessment, as well as with policies and procedures that were updated with the eUHR implementation. Mentors remain at the institutions in support of the scanning operation and are also available to provide one-on-one training for health care providers desiring additional guidance in the use of the eUHR. In addition, several of the trainers were retained following the completion of scheduled classroom training at the institutions; those trainers have been scheduled to revisit institutions that were identified for additional support based on lower than average classroom training participation rates as well as if additional training was requested.

The CCHCS IT infrastructure team completed all required construction activities at all institutions, to ensure access to the eUHR application. Further, deployment of workstations, tablet PCs and printers was completed for all critical-need access points. Additional workstations will be deployed as institutions complete planned remodeling or relocation of staff.

Efforts continue to be focused on plans for the new 3rd storage bay at the Health Records Center (HRC) to receive the 150,000+ paper UHRs that will eventually be transferred from the institutions for long-term storage; transfers are tentatively scheduled to begin nine to 12 months after the eUHR implementation. HRC managers have begun hiring the staff that will be needed to accommodate the scanning of health records for Parole Violators Returning to Custody and Re-commitments. The scanning center will also be responsible for scanning on-demand scanning requests, Release of Information Requests, Mentally Disturbed Offenders, and other health records requests, while ensuring compliance with federal and state privacy laws.

Objective 5.3. Establish Effective Imaging/Radiology and Laboratory Services

Action 5.3.1. By August 2008, decide upon strategy to improve medical records, radiology and laboratory services after receiving recommendations from consultants.

This action is ongoing. Progress during the reporting period is as follows:

Imaging/Radiology Services

CCHCS has hired a Clinical Executive of Medical Imaging Services. This position will lead Radiology and Imaging Services through the completion of the Remediation plan and transitioning to operations that meet the requirements of the federal courts including patient-inmate care, regulatory compliance, and an improved work environment for CDCR/CCHCS staff.

During this reporting period, CCHCS completed its effort to implement contracts for professional services, mobile imaging services, and equipment maintenance services. With revised contracts containing updated verbiage and Service Level Agreements, Radiology has better report turnaround times, consistent on-site mobile services (CR, MRI, Ultrasound), and fewer equipment downtimes. This has resulted in better access to care for patient-inmates and fewer patient-inmate backlogs. Allied Health Services (AHS) is currently pursuing a contract for an Offsite Radiology Supervisor to meet regulatory requirements.

Film filing at the institutions has achieved standardization at all 33 institutions. The effort to centralize parolee film files has kicked off for seven sites that were identified as having critical space issues for storing films. These films are being transported to the Health Records Center (HRC) and stored in existing shelving. Once additional space is allocated and shelving installed, the effort will expand to the remaining 26 institutions so that all parolee film files are stored centrally as a standard. This will assist with site film filing as well as provide a coordinated, central model for managing parolee recidivism to either state or county institutions.

Replacement of medical equipment that was scheduled and funded for FY 2010/2011 was completed on time and within budget. All 22 devices targeted for procurement were purchased and are on track to meet full installment and acceptance milestone timelines. The remaining devices that were targeted for procurement in FY 2011/2012 are currently being evaluated to determine priority. The criteria for prioritization includes existing equipment condition, site population type and exam volumes.

Workflow, forms, policies and metrics continue to be implemented based on the PPO contract that includes mobile services and professional services (interpretation). Several nuances have made it difficult to provide a statewide model for all institutions. These include compliance requirements related to women's health (mammography) and the disparate interpretive group that supports mobile services.

Mobile pad construction was not completed according to expectations. AHS is now determining how to provide funding to complete this project in FY 2011/2012.

Three clinical information systems have been procured to support the workflow of imaging, one for dental services and two for radiology:

- The procurement of the Dental Imaging System was completed FY 2010/2011 with build, pilot, and implementation scheduled for FY 2011/2012.

- Radiology Information System (RIS) was procured and is in the project planning and development phase with implementation scheduled over the next 16 months. This system will provide for patient-inmate information management within the Radiology program.

- Picture Archival and Communication System (PACS) was procured and is in the project planning and development phase with implementation scheduled over the next 16 months. PACS will provide for the storing, management, transmission, sharing and archiving of images across the enterprise.

Laboratory Services

The transition to Quest Diagnostics (Quest) as the sole provider of off-site clinical laboratory services for all CDCR institutions is complete. All 33 institutions have been trained and are using Quest's Care360 web-based application to view results, print bar code specimen labels, and manage patient-inmate clinical laboratory results. In addition, 27 of the 33 institutions have been trained or are scheduled for training for electronic test requisitioning at institutions using the Care360 system. Full implementation of electronic test requisitioning will be implemented by October 1, 2011.

Recruitment to fill the position of Chief of Laboratory Services was completed on June 28, 2011.

Laboratory Services has coordinated with Medical Services and Quest to customize several clinical laboratory test panels to better meet the needs of CCHCS physician providers in the institutions.

Laboratory Services has also coordinated with Medical Services to establish clinical laboratory support at Quest, for dialysis program activities in institutions offering these services, and Coccidioidomycosis and tuberculosis testing strategies for providers in all institutions.

Laboratory Services is defining specifications for procurement of clinical laboratory equipment, reagents, and maintenance to improve testing quality and reduce costs.

Objective 5.4. Establish Clinical Information Systems

Action 5.4.1. By September 2009, establish a clinical data repository available to all institutions as the foundation for all other health information technology systems.

This action is completed. Progress during this reporting period is as follows:

The CDR project completed Launch 1.0 in 2010 to 12 institutions. The launch made available data for custody, disability, pharmacy, and laboratory information capabilities. During the course of the deployment, data anomalies were discovered. This led to analysis about the root causes of the unexpected results and the Data Validation and Integrity (DVI) sub-project was initiated. During this time user logons were suspended.

The current plan is to prepare for Launch 2.0 which will include the above capabilities and a component of the Clinical Documentation sub-project called "Problem Lists." Launch 2.0 includes user access to other health care systems including Electronic Unit Health Record (eUHR) and Mental Health Tracking System (MHTS). Beginning in October 2011, Launch 2.0 is expected to be available to the first 12 institutions and deployment to the remaining 21 will begin. While Launch 2.0 is being deployed to all 33 institutions, the project team will prepare for the next version release.

The next version release is targeted for the spring of 2012 and will feature enhanced GuardianRx data and enhanced Quest lab data. This release will make automated clinical forms, graphical displays, and work processes available to Primary Care, Dental Health, Nursing, and OB/GYN. The release will enable enhanced sharing or health care information by geographically dispersed health care providers.

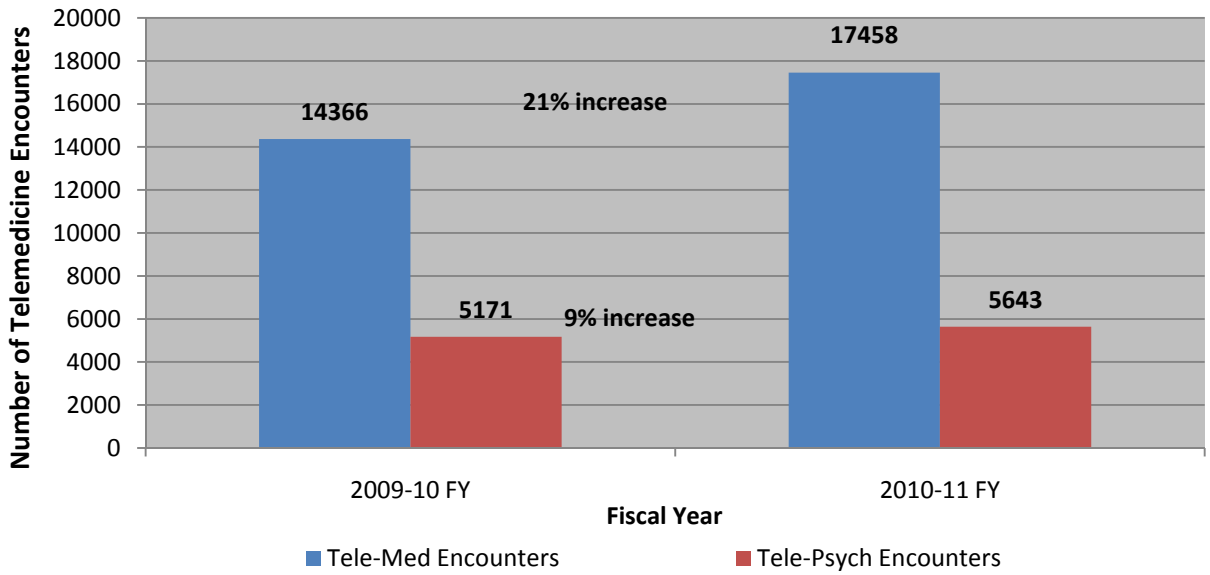
Objective 5.5. Expand and Improve Telemedicine Capabilities

Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure.

This action is completed. Progress during this reporting period is as follows:

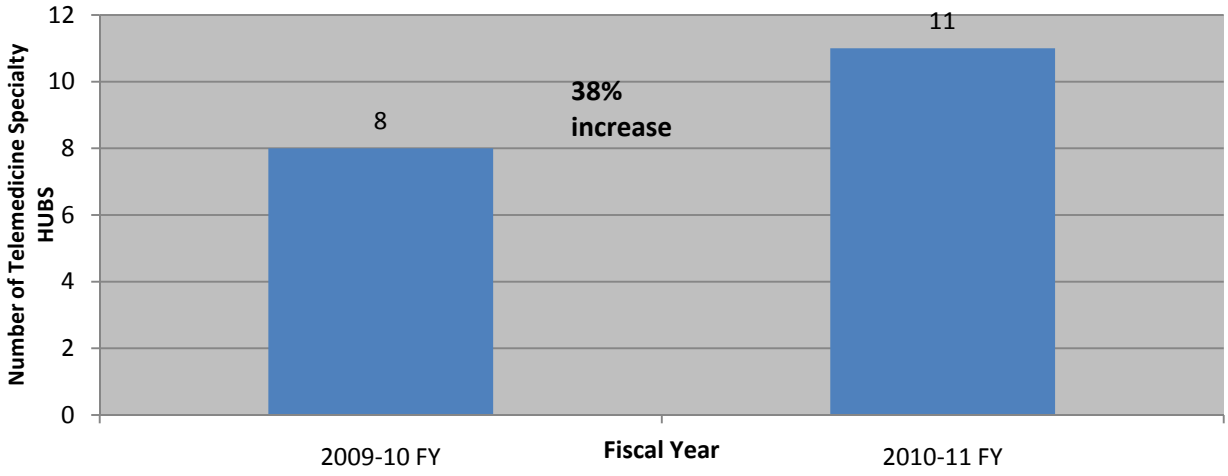
Statewide medical encounters increased by 21% from FY 2009/2010 to 2010/2011. Statewide mental health encounters increased by 9% from FY 2009/2010 to 2010/2011. This activity is shown in Table 16.

Table 16: Telemedicine Encounter Increase



HUBs expanded by 38% from FY 2009/2010 to 2010/2011. HUBs offered in Southern California: JFK Hospital, Alvarado Hospital, Tri Cities Medical Center, Pioneer Occupational Health Center and Riverside County Regional Medical Center. Central California: Colonial Medical Group at Mercy Medical Center in Bakersfield, Preferred Physicians Alliance at San Joaquin Community Hospital and San Joaquin General Hospital. Northern California: University of California, Davis. Three additional HUBs are pending. Telemedicine Specialty HUB Increase is shown in Table 17.

Table 17: Telemedicine Specialty HUB Increase



ISDN to IP Conversion: 100% completion of network upgrades to all thirty-three institutions.

Store and Forward: MedWeb is a HIPAA compliant, web-based Store-and-Forward transport vehicle to move patient-inmate information from the institutional telemedicine site to the participating provider HUB sites for clinics. Three pilot institutions and one pilot provider HUB site are currently operational. The remaining eight provider HUB sites and twenty institutional telemedicine sites will be operational end of the first quarter, FY 2011/2012, and the remaining ten institutional telemedicine sites will be operational during the second quarter, FY 2011/2012.

Equipment Deployment and Upgrades: CCHCS continues to roll out endpoints and peripherals to meet institutional needs. Increased availability of equipment ensures that telemedicine equipment is not a barrier to telemedicine expansion.

Primary Care: 100% transition of Primary Care pilot to program offering.

CEO Telemedicine Strategic Plans for FY 2011/2012: CEOs from all thirty-three institutions submitted their strategic plans to expand their use of Telemedicine.

Goal 6: Provide for Necessary Clinical, Administrative and Housing Facilities

Objective 6.1. Upgrade administrative and clinical facilities at each of CDCR's thirty-three prison locations to provide patient-inmates with appropriate access to care.

Progress on this objective continues to be impacted. CDCR is working with the Department of Finance (DOF) to finalize the project approval packages (30-Day Letters) for submittal to the Joint Legislative Budget Committee (JLBC). Once approved by the JLBC, projects will be scheduled for the soonest Public Works Board (PWB) available to receive project approval.

Action 6.1.1. By January 2010, completed assessment and planning for upgraded administrative and clinical facilities at each of CDCR's thirty-three institutions.

This action item is ongoing. Progress during this reporting period is as follows:

CMF and SOL project approvals did not occur at the July 2011 PWB meeting. CDCR continues to respond to numerous questions from DOF in order to secure release of the 30-Day Letter to the JLBC. Currently, the soonest PWB available to consider action for the first two projects (CMF and SOL) is October 2011. Submission of 30-Day Letters for the remaining projects will be delayed pending clarification/comments from DOF for the CMF/SOL projects.

Action 6.1.2. By January 2012, complete construction of upgraded administrative and clinical facilities at each of CDCR's thirty-three institutions.

This action item is ongoing. Progress during this reporting period is as follows:

Progress on this objective is impacted by the delay of project approvals. The design, bid, and construction phases for projects at each of the 33 institutions will begin once PWB project approvals and Pooled Money Investment Board (PMIB) loan approvals have been obtained. The typical duration is two to three years from PMIB loan approval.

Objective 6.2. Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs.

The Receiver and CDCR have developed a bed plan that provides medical and mental health facilities for the projected patient-inmate population through 2013. The approved plan envisions one new facility of 1,722 beds and the use of three former Division of Juvenile Justice (DJJ) facilities, which would be converted to accommodate inmates with medical and mental health conditions.

Action 6.2.1. Complete pre-planning activities on all sites as quickly as possible.

This action item is ongoing. Progress during this reporting period is as follows:

A scope change relative to the placement of buildings and to improve operational coordination between the DJJ DeWitt Nelson Correctional Facility and the California Health Care Facility (CHCF) was approved by PWB in August 2011. The Request for Qualification process to select a

Design-Build firm has been completed and three firms were selected to receive the Request for Proposal. The JLBC requested that further information relative to bed needs after Realignment be provided to them before a contract is awarded.

The JLBC denied the DJJ Estrella Correctional Facility (Estrella) project on April 6, 2011. The DJJ Herman G. Stark (Stark) project was disapproved by the JLBC on September 15, 2010. Alternatives for Stark and Estrella are still being explored.

Action 6.2.2. By February 2009, begin construction at first site.

This action item is ongoing. Progress during this reporting period is as follows:

Contractor O. C. Jones & Sons, Inc. is on schedule to have demolition and abatement work completed by September 30, 2011. The Notice to Proceed (NTP) was issued to Hensel Phelps/Granite Joint Venture (JV) on June 30, 2011 for Design/Build Package #1 (Site Work and Non-Secure Support Buildings). They began earth moving activities on August 2, 2011. Field work and design are being completed concurrently and are on schedule. The JV of Clark/McCarthy was awarded Design-Build Package #2 (Housing, Kitchen, and health care support buildings) and the NTP was issued on August 2, 2011. The CHCF is on schedule for full occupancy by December 2013.

Action 6.2.3. By July 2013, complete execution of phased construction program.

This action item is ongoing. Progress during this reporting period is as follows:

Occupancy for Herman G. Stark and Estrella Correctional Facility remain delayed beyond the scheduled completion date.

Objective 6.3. Complete Construction at San Quentin State Prison

Action 6.3.1. By December 2008, complete all construction except for the Central Health Services Facility.

This action is completed.

Action 6.3.2. By April 2010, complete construction of the Central Health Services Facility.

This action is completed.

Section 4: Additional Successes Achieved by the Receiver

A. Office of the Inspector General – Update on the Medical Inspections of California's 33 Adult Prisons

To evaluate and monitor the progress of medical care delivery to inmates at each prison, the Receiver requested that the California OIG conduct an objective, clinically appropriate, and metric-oriented medical inspection program. To fulfill this request, the Inspector General assigns a score to each prison based on multiple metrics to derive an overall rating of zero to 100%. Although only the federal court may determine whether a constitutional standard for medical care has been met, the Receiver's scoring criteria for adherence to medical policies and procedures establish the minimum score for moderate adherence to that standard to be 75%. Scores below 75% denote low adherence, while those above 85% reflect high adherence.

Using this tool, the Inspector General has rated California's 33 adult institutions for the first cycle of inspections (September 2008 – June 2010) at 72.9%, on average. HDSP scored lowest, at 62.4%, and FSP received the highest score, at 83.2%. The Inspector General found that nearly all prisons were not effective in ensuring that inmates receive their medications. In addition, prisons were generally not effective at ensuring that inmates are seen or provided services for routine, urgent, and emergency medical needs according to timelines set by CCHCS policy. However, the Inspector General did find that prisons generally performed well in areas involving duties performed by nurses, and continuity of care.

Second cycle inspections began September 2010 and OIG has completed 25 inspections as of August 31, 2011 and issued 11 final inspection reports. Summary results of these final reports show that eight of the 11 institutions achieved a score of 75% or higher placing them in the moderate adherence area. Sierra Conservation Camp achieved the highest score of 87.5% placing them in the high adherence category. CCWF scored 0.4% lower in its second review receiving a score of 77.5% which continues to place them in moderate adherence. With 11 finalized inspections reports, the overall statewide average for the second cycle inspections is 77.6%.

Section 5: Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals

While the Receivership continues to make progress in many key areas to achieve the goal of providing a constitutional level of health care within California's adult correctional system, the State's fiscal crisis has and will likely have continued impact on CCHCS, as it has on many state government operations. While this impact is difficult to define and measure, this Tri-Annual Report identified programmatic areas in which timelines have been adjusted and the reasons for change. While blame for these failures cannot be placed solely on fiscal challenges, there is little doubt that budget cuts and mandates have contributed to these setbacks.

The budget forecast coupled with California's low financial rating will present challenges for all in 2011 and the years that follow. However, the Receiver continues to utilize all available resources to ensure that the goals and objectives within the Turnaround Plan of Action are achieved and will continue to strive in these efforts to fulfill the Vision and Mission.

Section 6: An Accounting of Expenditures for the Reporting Period

A. Expenses

The total net operating and capital expenses of the Office of the Receiver for the year ended June 2011 were $2,550,500 and ($8,664,269) respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 10.

For the two months ending August 31, 2011 the net operating and capital expenses were $346,777 and $0.00 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 11.

B. Revenues

For the months of May and June 2011, the Receiver requested transfers of $400,825 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 2010/2011 to the CPR from the State of California is $2,577,205.

On July 28, 2011 the receiver requested a transfer of $125,000.00 respectively from the State to the CPR to replenish the operating fund of the office of the Receiver for the first month of the FY 2011/2012.

All funds were received in a timely manner.

Section 7: Other Matters Deemed Appropriate for Judicial Review

A. Coordination with Other Lawsuits

During the reporting period, regular meetings between the four courts, *Plata, Coleman, Perez,* and *Armstrong* (Coordination Group) class actions have continued. Coordination Group meetings were held on June 6th, July 27th, and September 7th. Progress has continued during this reporting period and captured in meeting minutes.

B. 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 12 is a summary of the contracts the Receiver awarded during this reporting period, including a brief description of the contracts, which projects the contracts pertain to, and the method the Receiver utilized to award the contracts (i.e., expedited formal bid, urgent informal bid, sole source).

C. Consultant Staff Engaged by the Receiver

In accordance with Section III, Paragraph B, of the Court's Order Appointing Receiver, dated February 14, 2006; the Receiver has engaged the following consultant:

- The Receiver entered into a consulting services agreement with Stephen B. Levine, MD, to provide expert witness services in litigation.

Section 8: Conclusion

Two-thirds of the institutions have now been visited by OIG as part of the second cycle of inspections, and OIG has released final scores for 15 institutions. For those 15 institutions, the average overall score is 77.74% which is 6.07% higher than the overall average for the first cycle of inspections. Fourteen of the institution scores are higher, and the only score that was not higher dropped a mere 0.4% points from 77.9% to 77.5%. Based on the preliminary results for the additional 7 institutions that have been inspected, it appears likely that the overall average will climb to around 79%. The trend of scores is unmistakably upwards. This demonstrates without question that our combined efforts over the last two years to improve the quality of medical care within California's prisons are being reflected in the OIG scores. It is notable that these improvements have occurred at precisely the same time that we have very substantially reduced the overall costs of the medical program. We are clearly moving in the right direction both on quality and costs.

TABLE OF APPENDICES