III. CURRENT ENVIRONMENT

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III.1 INTRODUCTION

California Prison Health Care Services (CPHCS), acting on behalf of the California Corrections Department (CDCR) was created to house the activities of the Federal Prison Health Care Receiver. The Receivership was established by U.S. District Court Judge Thelton E. Henderson as the result of a 2001 class action lawsuit (Plata v. Schwarzenegger) brought against the State of California over the quality of medical care in the state's 33-prison system. The court found that the care was in violation of the Eighth Amendment of the U.S. Constitution, which forbids cruel and unusual punishment of the incarcerated.

The Court opinions in Plata v. Schwarzenegger, Coleman v. Schwarzenegger, Perez v. Tilton, and Armstrong v. Schwarzenegger document pervasive, fundamental organizational weaknesses and failures within the California Department of Corrections and Rehabilitation (CDCR) that undermine its ability to provide constitutionally adequate health care services. Having been given control over CDCR's medical program, the Receiver's job is to establish constitutionally adequate prison medical care as quickly as practicable, and in a way that will be sustainable after the Receiver winds down operations and responsibility for prison medical care reverts to the State. The Receiver is also required to coordinate planning and activities with the federal judicial oversight of CDCR's mental health, access to Americans with Disabilities Act services, and dental programs.

To address the shortcomings of California prison health care, the Receiver has developed a strategic plan containing a number of initiatives and projects to be accomplished by CDCR, one of which is the Access-to-Care initiative. The goal of the Access-to-Care initiative is to create a collaborative environment where custody and health care staff together guarantee that the quality of medical services accessible in California prisons meet constitutional standards while reducing avoidable morbidity and mortality. One aspect aimed at improving offenders' access to health care is the improvement of scheduling processes across institutions, disciplines, and care providers.

There is an opportunity to improve the process of scheduling and tracking health care appointments for offenders as the CDCR is in the process of procuring and implementing two large enterprise solutions: Strategic Offender Management System ("SOMS") and Business Information System ("BIS"). CDCR has launched several additional initiatives to improve the delivery of healthcare in prisons. Since neither BIS nor SOMS fulfills the scheduling needs for the prison health care system, CDCR has decided to independently procure a Health Care Scheduling System (HCSS) that will allow for enterprise-wide and integrated planning, scheduling, and tracking of health care appointments. The functionality of the HCSS will include scheduling of medical, dental and mental health care appointments within and outside of CDCR institutions. In addition, the system will be required to track key performance indicators and provide the CDCR and the courts with performance reports.

For additional information see: http://www.cphcs.ca.gov/

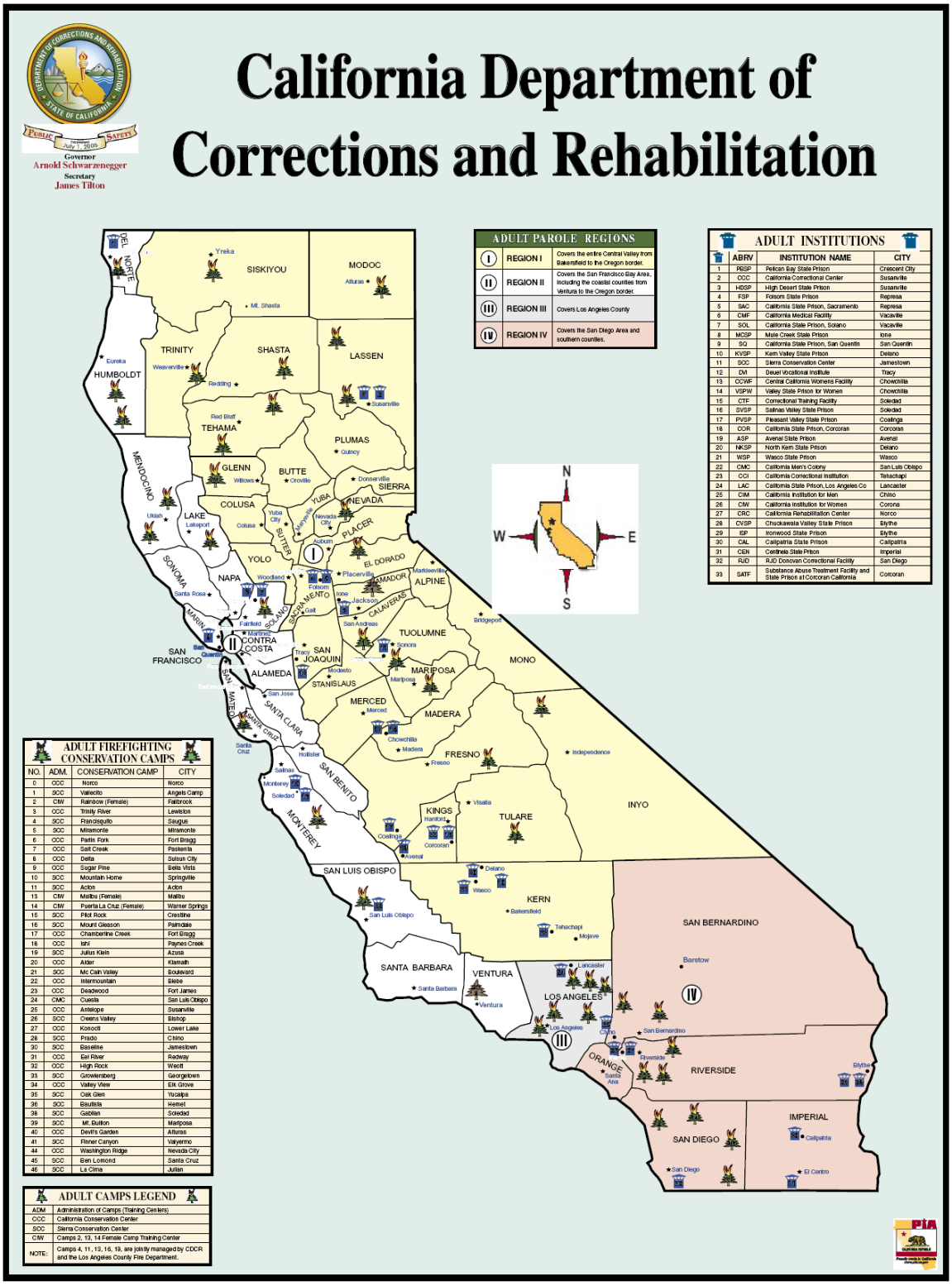
III.2 CURRENT SCHEDULING ENVIRONMENT

CDCR supervises approximately 175,000 adult offenders within the 33 adult institutions spread across the state (see Table III-1 and Figure III-1).

Table III-1. Current California Inmate Population (as of Midnight, August 31, 2008)

Institution	Population	Institution	Population
Avenal SP	6,878	Correctional Training Facility	6,435
CA Correctional Center	5,602	Deuel Vocational Institution	3,832
CA Correctional Institution	5,752	Folsom SP	4,028
CA Institution for Men	5,825	High Desert SP	4,441
CA Institution for Women	2,439	Ironwood SP	4,386
CA Medical Facility	3,110	Kern Valley SP	4,700
CA Men's Colony	6,497	Mule Creek SP	3,680
CA Rehab Center, Men	3,814	North Kern SP	5,513
CA SP Calipatria	4,372	Pelican Bay SP	3,370
CA SP Centinela	5,022	Pleasant Valley SP	5,161
CA SP Corcoran	5,735	RJ Donovan Correctional Facility	4,678
CA SP Los Angeles Co.	5,055	Salinas Valley SP	4,062
CA SP Sacramento	3,057	Sierra Conservation Center	6,118
CA SP San Quentin	5,256	Valley SP for Women	4,060
CA SP Solano	5,504	Wasco SP	5,855
CA SATF and SP - COR	7,171		
Central California Women's Facility	4,116		
Chuckawalla Valley SP	2,991		

Figure III-1. CDCR Site Map (current as of June 2006)



III.2.1 Custody Scheduling

Custody scheduling is a functional group including the processes that coordinate the scheduling of offender activities (e.g. medical appointments, adult classification committee hearings, juvenile case conferences, visits, work or program assignments, Parole Board hearings), notifies staff; sends a notice to the offender of scheduled events, and tracks whether or not the offenders appear as scheduled. Requests to schedule offenders for various events are submitted by staff or initiated by other processes (such as Transportation, Programs, Appeals, Visiting, etc.). Custody scheduling is currently performed using a series of stand alone and partially centralized systems that are complemented by manual processes. CDCR is in the process of procuring an integrated SOMS that will be used for all offender custody scheduling in the future. For further information on SOMS, refer to RFP Section IV, Proposed Future Environment, and Appendix G, Bidders' Library Contents List.

III.2.1.1 Create and Distribute Daily Master Schedule List

The adult scheduling process is formalized and involves the creation and daily distribution of a list of offenders scheduled for events. Juvenile processing is less formal and often accomplished by phone calls when the offender's presence is required. This business process involves initiating a scheduling request for an offender to appear for scheduled events at an institution, arranging for ADA needs / reasonable accommodations / effective communication, generating a master list of offenders scheduled for various activities, creating passes for the offender, and then recording outcomes. In list form:

- Initiate Scheduling Request
- Identify Scheduling Conflicts
- Generate Master List
- Identify Resources
- Generate Pass
- Distribute Master Scheduling List (Adult only)
- Issue Passes

III.2.1.2 Additions or Changes to Master Scheduling List

At times, changes or last minute additions need to be made to the master schedule. These changes could include the issuing of informal passes, as well as necessary last minute communication.

- Issue Informal Passes

III.2.1.3 Determine Outcome of Scheduled Event

All offender events must have their outcome recorded by CDCR staff.

- Record Arrival and Departure
- Reconcile Missed Appointments

III.2.1.4 Reschedule Blocks of Appointments

Blocks of appointments must be rescheduled at times for a variety of reasons, such as when offender movement is put on hold for security reasons, or when a caseworker with several offender appointments calls in sick. Movement is halted, causing scheduled appointments to be moved to a later time.

- Staff either resubmits a scheduling request or makes informal arrangements to postpone the appointment.

III.2.1.5 Create Special Activities List

Lists are created for events where numerous offenders are allowed to attend. Examples are religious services, special events, and work assignments that begin on first or third watch (e.g., kitchen, etc.). The list is distributed on a daily basis and as necessary.

- Create Special Activities List

III.2.2 Health Care Scheduling

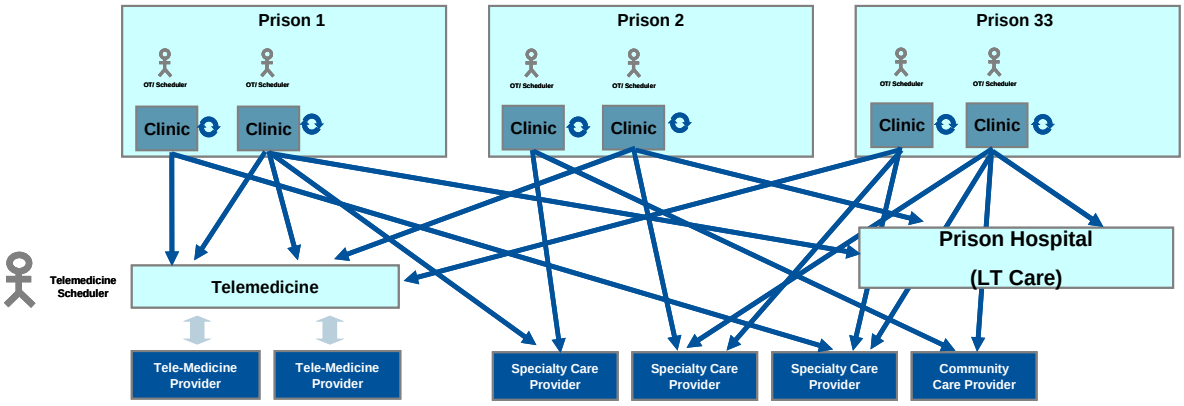
The facilities and resources available to CDCR at each institution differ, resulting in services being scheduled at the institution/clinic level (with the exception of telemedicine). See details below:

- Scheduling is primarily organized around an offender's location and managed on a clinic level.
- Prioritization of appointments is not possible today because an aggregate view of an offender's appointments is not available. Specialty Care appointments are scheduled on a priority basis.
- Multiple institutions have contracts with a single service provider, and lack coordination when scheduling appointments.
- Scheduled appointments do not "follow" an offender when transferred to another location.
- Current systems do not provide visibility across clinics.
- Scheduling processes are people dependent—schedulers have to be located at the prisons (systems are not web-enabled, institutional knowledge is required, access to paper records is required). Examples of paper records currently in use are physician orders, lab requests, and radiology requests which are used to schedule follow-ups and referrals to specialty services or diagnostic services.

Schedulers manually schedule appointments and log them into the current systems to the extent that current systems are used. Lack of integration between the multiple health care scheduling systems and insufficient knowledge regarding each offender's availability frequently lead to scheduling conflicts and missed appointments. Schedulers in the institutions use a rolling planning approach to scheduling, that is, they fill appointment slots on an ongoing basis and balance the workload as the appointment date nears. The day before the appointment, the schedule is finalized and sent to custody. This process is mostly manual today.

Figure III-2 below provides a conceptual overview of scheduling today. Each clinic has its own schedulers who schedule appointments both internally and with external Service providers.

Figure III-2. Conceptual view of Prison Health Care Scheduling today



III.2.3 Scheduling in Medical

III.2.3.1 Scheduling in Medical: Background

See the Introduction.

III.2.3.2 Scheduling in Medical: Current Practice

Each offender resides in a housing unit that is functionally linked with a medical clinic. Offenders requiring medical care request an appointment and are seen in the clinic. If an offender suffers from a chronic or ongoing condition that requires ongoing treatment and care, the patient-inmate may be moved to a housing location that will better enable medical staff to monitor and treat them. A Care Coordinator is responsible for an offender's treatment plan which is usually created by a Primary Care Physician (PCP). Scheduling in medical care is characterized by the following:

- Clinics are assigned housing units of offenders to provide with care (there may be more than one housing unit per clinic).
- Schedulers are assigned, and may work from a clinic or a central location.
- A Scheduler is typically in charge of scheduling appointments for multiple nurses & primary care providers (physicians, nurse practitioners, and physician assistants).
- The Scheduler owns the responsibility for scheduling appointments within the mandated time frames.
- A Scheduler may schedule different types of appointments:
- Reception Center Intake Screens
- Health Evaluations and Triages
- Primary Care Provider (PCP) visits
- Specialty Care
- Diagnostic Services

- Telemedicine
- Multiple Schedulers may schedule appointments for a particular offender at the same time and across disciplines (mental health and dental).
- Multiple Schedulers compete for a slot on the offender's calendar:
- Tracking priorities and dependencies between appointments is challenging.
- Appointments are scheduled on a priority basis.
- Specialty Care Providers have their own schedulers who may schedule follow-up visits with the Specialist, sometimes without informing the clinic or physician who initiated the initial appointment (although they are supposed to do so).
- Schedulers may schedule appointments locally (within yard or institution) or centrally (in Sacramento for Telemedicine).

III.2.4 Scheduling in Dental

III.2.4.1 Scheduling in Dental: Background

The Division of Correctional Health Care Services (DCHCS) dental program's mission is to "promote, stabilize, and maintain the oral health of all offenders incarcerated in CDCR." The mission declares further that competent professionals provide the dental services; that dental healthcare staff cares for "the greatest number of offenders within available resources"; and that the care meets professional standards and CDCR regulations. The program must also comply with all federal and state regulations stipulated in the California Code of Regulations (CCR) Title 15, the Dental Practices Act, and Dental Board of California.

The Prison Law Office (PLO) served the Dental Program with its first class action lawsuit in December 2005, *Carlos Perez v. James Tilton, et al*, contending that CDCR violated the Eighth Amendment of the United States Constitution by failing to treat serious dental needs of offenders in a timely manner, thereby causing severe and unnecessary pain and permanent damages to their oral health. To settle the lawsuit, the Dental Program filed a Stipulated Settlement Agreement along with revised policies and procedures (P&Ps) and an implementation plan to address the deficiencies. These updated P&Ps meet the minimum level of dental care necessary to fulfill the Dental Program's obligations under the Eighth Amendment. In addition to requiring the Dental Program to provide mandated dental care, the court order required the Dental Program to implement an automated dental scheduling and tracking system by March 1, 2007, and to develop and use an auditing tool to report compliance with revised policies, procedures, and court mandates. The implementation of a stand-alone Microsoft Excel spreadsheet for tracking dental treatment requests in all 33 institutions was completed as of March 1, 2007. However, this spreadsheet only tracked four (4) of the indicators required by *Perez*.

Historically, insufficient dental staffing levels combined with increased workload demands further compound mandates of the *Perez* court order. Currently, one Dentist and one Dental Assistant are assigned to screen as many as 150-200 offenders per day. Staffing issues, combined with the absence of automation in any of the dental clinics has made it difficult for dentists to keep pace with additional workload requirements of the *Perez* court order, where manually tracking clinical service delivery data has decreased the limited time available for direct patient care.

III.2.4.2 Scheduling in Dental: Current Practice

As in Medical Care, each offender is linked to a dental clinic according to their housing unit. After an offender's reception and intake into their assigned institution, offenders receive dental care upon their request and according to their dental needs. Recall or regular on-going dental examinations are scheduled for all offenders depending upon their age, with every offender being seen by a Dentist every one or two years. Offenders can request a dental appointment in the same manner they would ask to see a medical doctor. Offenders needing special dental care or removable dental prosthetics are also serviced through their assigned dental clinic. Scheduling in Dental is characterized by:

- Clinics are assigned housing units of offender to provide care to (there may be more than one housing unit per clinic).
- Schedulers are assigned to a clinic and may physically work there.
    - A Scheduler is typically in charge of scheduling appointments for multiple Dental Providers.
    - The Scheduler owns the responsibility for scheduling appointments within the mandated time frames.
- A Scheduler may schedule different types of appointments:
    - Routine visits
    - Specialty Care
    - Follow-up Visits
    - Diagnostic Services
- Scheduling in Dental is guided by the Dental Placement Code (DPC) assigned to an offender after each dental encounter
    - DPC codes are reviewed and reissued after each encounter with a Dentist and are recorded on a CHRONO form.
    - DPC codes trigger a need for follow-appointments within specific mandated time frames, depending on the code issued.
- Specialty Care Providers may be scheduled as on-site appointments (within the prison dental clinic) or off-site (within the community)
    - Specialty Care Providers may have their own schedulers who schedule follow-up visits to the dental clinic or dentist who originally referred an offender to specialty care.
- An offender's Dental Provider is responsible to decide if follow-up appointments are necessary.

Continuity of care is to be maintained when an offender is transferred within an institution and among institutions. For transferring offenders, dental appointments are scheduled based upon an offender's priority code, medical condition, last dental examination, and if they are coming from a reception center.

III.2.5 Scheduling in Mental Health

III.2.5.1 Scheduling in Mental Health: Background

The Mental Health Program's mission is to provide timely, cost-effective mental health services that seek to optimize the level of individual functioning of seriously mentally disordered offenders in the least restrictive environment. The Program's Mental Health Services Delivery System (MHSDS) utilizes a variety of professional clinical, custody, and support staff to provide the best available quality of care to seriously mentally disordered offenders.

The MHSDS is a decentralized, system-wide concept using standardized evaluation and treatment. MHSDS provides state-wide screening for all incoming offenders at Reception Centers (RCs) and initiates direct transfers from the RCs to mainline facilities with treatment programs for further evaluation and/or treatment if needed. The MHSDS also utilizes case management techniques as it attempts to manage the majority of mentally disordered offenders in the general population and provide for their access to care as the need arises.

Outpatient care is provided in an array of treatment levels and modalities, presently including one day treatment programs and an array of outpatient clinic level of care (LOC) programs. The MHSDS seeks to provide a continuum of inpatient care from its contractual relationship with Department of Mental Health (DMH) for acute and intermediate and a short-term crisis inpatient care program within CDCR institutions. The program must also comply with California statutes and regulations, particularly those stipulated in the CCR Title 15 and Title 22, and those in Business and Professions Code along with the rulings of the various state licensing boards for each of the health care professions and vocational entities licensed by the State.

III.2.5.2 Scheduling in Mental Health: Current Practice

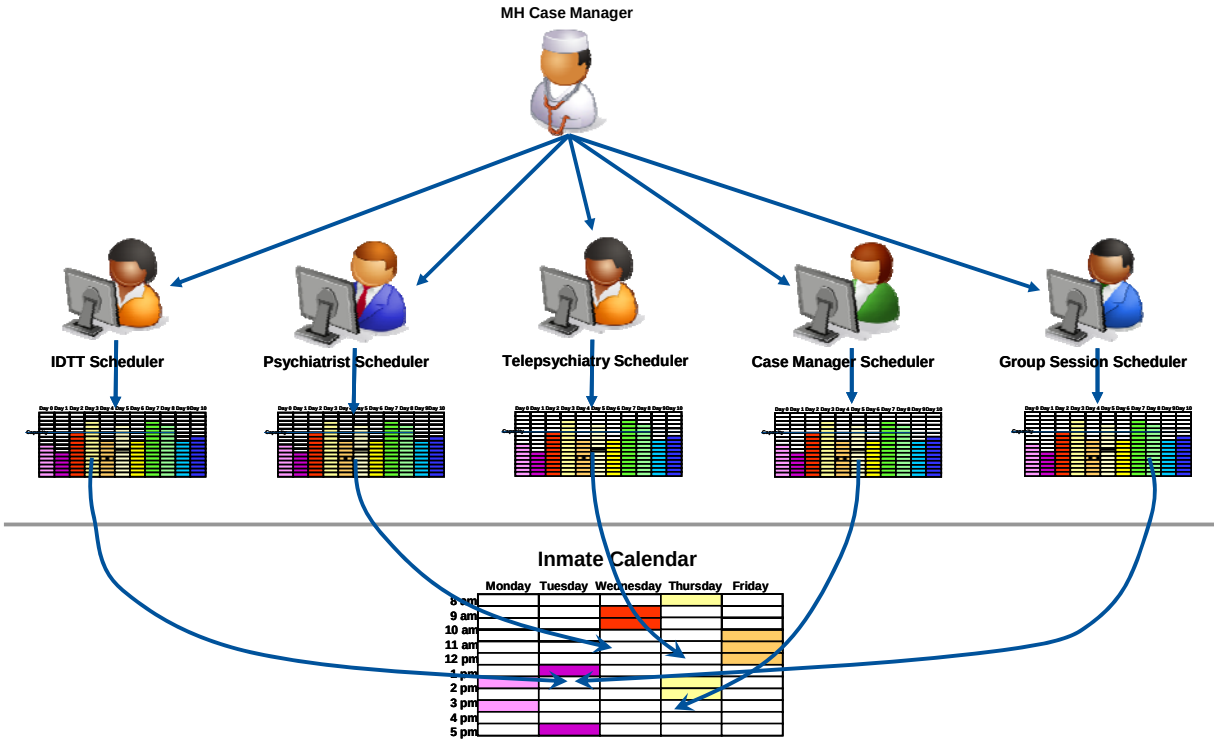
In contrast to Medical and Dental Care, Mental Health Care assigns a case manager to each offender who is a mental health patient. The Case Manager is responsible for an offender's treatment plan which is usually created by an Interdisciplinary Treatment Team (IDTT). Scheduling in Mental Health Care is characterized by the following:

- A Case Manager has a caseload of multiple offenders.
- Schedulers are assigned to Case Managers and Clinicians.
- A Scheduler is typically in charge of scheduling appointments for multiple Clinicians.
- The Scheduler owns the responsibility for scheduling appointments within the mandated time frames.
- A Case Manager may have multiple Schedulers who schedule different types of appointments:
- IDTT
- Case Manager
- Psychiatrist
- Group Therapy
- Individual Therapy
- Diagnostic Services

- Telemedicine
- Multiple Schedulers may schedule appointments for one particular offender at the same time and across multiple disciplines.
- Multiple Schedulers compete for a slot on the offender's calendar:
- Tracking priorities and dependencies between appointments is challenging.
- Appointments are scheduled on a priority basis.
- Psychiatrists have their own schedulers who may schedule follow-up visits without informing the Clinician or Case Manager who initiated the initial appointment.
- Schedulers may schedule appointments locally (within yard or institution) or centrally (in Sacramento for Telemedicine).

Figure III-3 provides a conceptual view of scheduling in Mental Health Care.

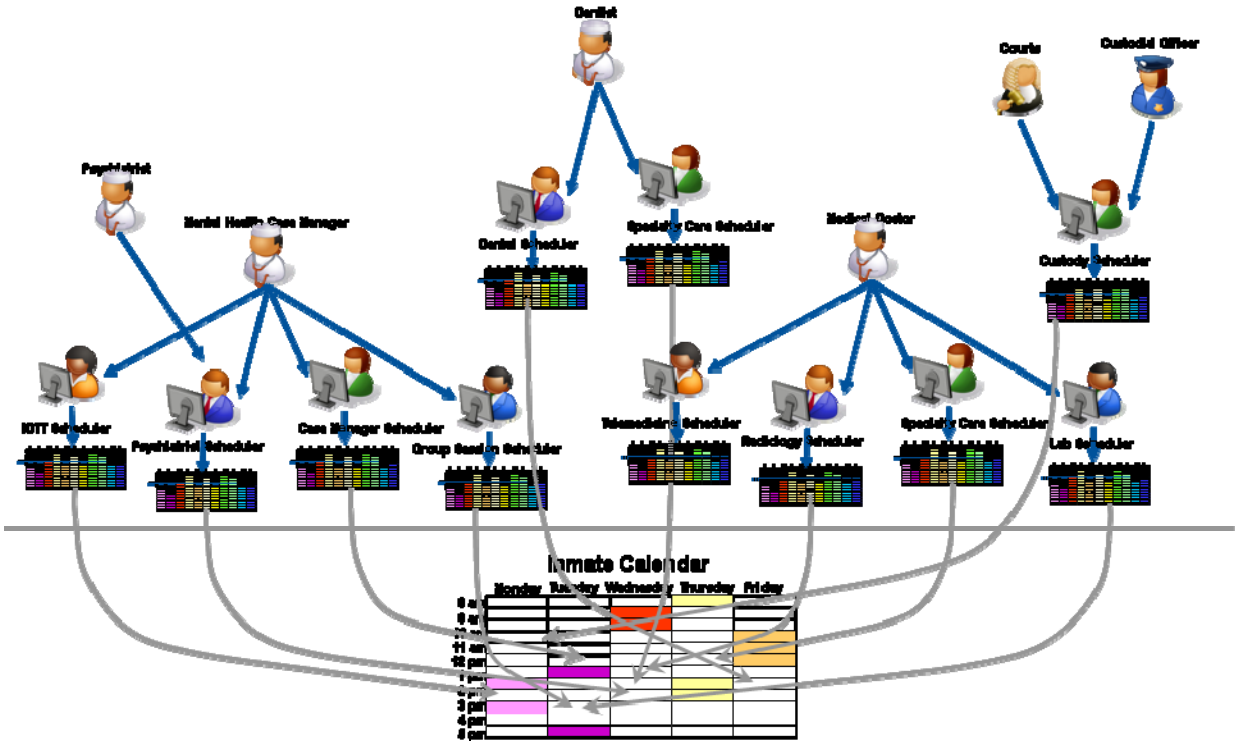
Figure III-3. Conceptual view of scheduling in Mental Health Care



III.2.6 Challenges

The main challenges of the current environment arise from the fact that multiple schedulers across disciplines – including custody – schedule activities and appointments for an offender without having insight into the offender's calendar. Figure III-4 below illustrates this challenge—which is aggravated by the fact that the various schedulers operate completely independent with little coordination among them.

Figure III-4. Conceptual view of scheduling appointments for an offender



The current situation causes the following business problems:

- Scheduling Conflicts
- Missed Appointments
- Non-Compliance with Mandated Standards & Deadlines
- Location-based Episodic Care
- Inconsistent Access to Hospitals & Specialty Care
- Multiple & Duplicate Requests for Health Care Services

Table III-5 below details the contributing factors to the business problems described above.

Table III-5. Business Problems, Causes and Contributing Factors

Business Problem	Cause and Contributing Factors
Scheduling Conflicts – Untimely access to care and non-compliance	• Multiple schedulers, multiple systems, and a lack of overall offender schedule visibility causes scheduling conflicts • There is no over-arching mechanism for prioritizing appointments • Current systems do not allow for pro-active resolution of scheduling conflicts
Missed Appointments – Potential under-utilization of staff & facilities and increased risk to offenders	• Prisoner location is not always known by a scheduler (may have moved to an other location without notification) • Appointments do not "follow" an offender when transferred • Prisoner refusals or forgetfulness • Event caused schedule changes (lock downs, staff training, etc.)
Compliance with Mandated Standards & Deadlines	• Error-prone manual processes for tracking deadlines • Insufficient communication regarding offender movements • Lack of scheduling capabilities • Reliance on medical admin. staff and schedulers to track and manage compliance without a system in place • No clear accountability for monitoring and ensuring deadlines are met
Location-based Episodic Care – Creates redundancy of treatments and procedures	• Lack of coordinated treatment across disciplines & institutions • Lack of continuity of care after transfer (no visibility into upcoming or previous appointments) • Medical staff do not always have access to medical history • Often redundant procedures performed at receiving institutions
Inconsistent Access to Hospitals and Specialty Care	• Utilization Management is not always linked to case information or medical history • Resource planning cannot be conducted due to the lack of visibility into resources available (beds, nurses, etc.), making future compliance difficult to predict • Excessive wait-time for some inpatient care due to resource misallocation (short term beds used for long term care, etc.)
Multiple and Duplicate Requests for Health Care Services	• Inmates have limited access to see the status of appointments/requests • The offender population tends to be in poorer health than civilian population • Inmates sometimes use sick calls as a mean to draw attention, seek communication, and for other non-health care related reasons

III.2.7 Business Processes

Many CDCR and DCHCS business processes involve scheduling. Across medical, dental, and mental health care scheduling is a key component of the 13 processes listed below. For a more complete description of CDCR business processes and accompanying process flow diagrams, please refer to the Bidder's Library.

- Reception Center Intake
- Care Coordination / Case Mgt.
- Routine Care
- Chronic Care
- Requests for Service
- Specialty Care
  - Inpatient
  - Outpatient
- Telemedicine
- Pharmacy Services
- Emergency Services
- Education Programs
- Diagnostic Services
  - Imaging
  - Laboratory
- Release

III.3 CURRENT TECHNOLOGY ENVIRONMENT

Scheduling health care appointments in California prisons today is done individually by each institution using separate stand alone systems for medical, dental and mental health care. The three scheduling systems currently used are homegrown applications that have been developed to schedule and track health care appointments and deliver the performance metrics needed to comply with rules imposed by the courts. Medical care uses the offender Medical Scheduling and Tracking System (IMSATS), mental health uses the Mental Health Tracking System (MHTS), and dental has employed the Dental Tracking System (DTS). Not all institutions have implemented the current systems. Among institutions that have implemented the systems, individual customization has occurred. The systems are not integrated at either an institution or enterprise level. Many of these systems also receive periodic downloads from custody-based systems such as the Offender Based Information System (OBIS), the Distributed Data Processing System (DDPS), and Disability and Effective Communication System (DECS).Table III-2 details the component databases of the current scheduling system and the environments in which they operate.

Table III-2. Current Databases in use at CDCR

System	Description	Application Software, Database	Hardware, Operating System
IMSATS	■ Schedule and appointment data are entered into the system for tracking and reporting purposes. ■ Scheduling is done as a manual process with the results entered into the system. ■ Receives offender info periodically from a DDPS download.	• Access	• Windows Desktop PC
MHTS	■ The Mental Health Tracking System was developed to provide CDCR Mental Health with the case management functionality needed to synchronize the detailed treatment planning and care for CA offenders. ■ The Mental Health Tracking System software system allows data entry staff to enter appointments for their assigned clinicians and produce a daily ducat list. The ducat list is hand carried or submitted by fax to the Inmate Assignment Office approximately two days prior to the scheduled appointment date. ■ At most locations, the Mental Health Clinic staff is on the DMS distribution list. If not, they obtain a copy of the DMS in order to confirm that the appointments they requested were in fact scheduled and in order to identify offenders who have had a housing change that may preempt or delay their scheduled appointment. ■ It is common for offenders to not arrive at all for their scheduled appointment or to arrive at vastly differing times, which leads to appointment conflicts and wasted preparation and clinical time. ■ Some higher level-of-care programs do not actually “schedule” or issue ducats for appointments in advance. In these programs, clinician scheduling involves blocking out various time periods for seeing patients and the “appointment” information is entered retroactively. ■ There are 33 versions currently being run by institutions, which are manually updated on a periodic basis. ■ MHTS receives a daily download from DDPS (reflecting changes in the previous 24 hours).	• Access	• Windows Desktop PC (currently transitioned to central SQL server)

System	Description	Application Software, Database	Hardware, Operating System
DTS	■ The Dental Tracking System is designed to track all dental-related reporting requirements and ensure court mandates are met. ■ The System is the most recent to be put in place, and has been rolled out to less than 1/4th of the institutions ■ The roll-out has been slow due to required interface customization with other systems (e.g., DDPS).	• Access	• Windows Desktop PC
OBIS	■ OBIS maintains offender sentence/parole revocation data, location, time collection and sentence calculation, holds/wants/detainers, and DNA collection information. ■ OBIS resides centrally at the Department of Technology Services (DTS) data center, where all institutions, parole offices, and CDCR's Central Office or Headquarters (HQ) staff access it. CDCR's EIS maintains OBIS. ■ Input to the OBIS system is through key data entry. There are no interfaces or data uploads into OBIS. OBIS performs scheduled batch jobs to extract information for use by other CDCR systems and external agencies. ■ Developed in 1976	• ADABAS	• IBM Mainframe
DDPS	■ DDPS provides offender information to the CDCR and DCHCS. DDPS provides a daily update of offenders at each institution. ■ DDPS is made up of 10 different integrated applications. Each institution and CDCR's HQ runs its own set of these DDPS applications. ■ All institutions send data to the common database at CDCR's Central Office; however each institution has separate databases at its locations. CDCR's EIS maintains DDPS.	• Turbo Image	• HP 3000, 34 separate servers (1 per institution and 1 at Headquarters)

System	Description	Application Software, Database	Hardware, Operating System
DECS	■ DECS provides a single, state-wide repository of Americans with Disabilities Act/Effective Communication (ADA/EC) information. ■ DECS was developed in response to the permanent injunction which requires CDCR to ensure offenders' due-process rights by identifying and accommodating their disability and effective-communication special needs in a timely manner throughout the offender's time with CDCR.	• SQL, web based front end.	• Centralized Windows Server

III.3.1 Current Information Technology (IT) Staffing and Organization

The current IT staffing and organization resides within CDCR and will not be used within the new environment.

III.3.2 Current Enterprise Information Technology Standards

The current IT technology standards apply to the CDCR environment and will not be used within the new environment.