CALIFORNIA PRISON HEALTH CARE SERVICE

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 12/1/10
CHAPTER 4B	Revision Date(s):
PRIMARY CARE PROVIDER MENTORING-PROCTORING PROGRAM AND CLINICAL PERFORMANCE APPRAISAL PROCESS PROCEDURE	Attachments: Yes ☐ No ☒

I. THE CLINICAL MENTORING-PROCTORING PROGRAM

A. The Clinical Mentoring-Proctoring Program includes the following phases:

Phase I: Initiation of three-week mentoring period upon date of hire

Phase II: Introduction of on-call duties at close of three-week mentoring period

Phase III: Transition to independent practice at four to six weeks from date of hire

Phase IV: Completion of provider clinical competency-based evaluation(s) after two months of work, and again at four months of work

Phase V: Final probationary review at six months of work

Phase VI: Ongoing mentoring-proctoring activities by supervising clinicians, including annual performance appraisals

B. Initial Three Week Mentoring-Proctoring Period for New Providers

When a Primary Care Provider (PCP) is hired, Chief Medical Executive (CME) or designee at each institution shall:

1. Confirm the new provider's start date with the Regional Clinical Support Unit CME and identify the various practice settings where he or she expects the provider to practice, such as yard clinics, the Triage and Treatment Area (TTA), the Correctional Treatment Center (CTC), or the Outpatient Housing Unit (OHU).
2. Establish and implement a three week clinical mentoring-proctoring plan, with the Clinical Support Unit (CSU) clinician's assistance, if needed, that includes scheduling the new provider to work in each clinical area for two to four days under the direction of a designated Clinical Mentor-Proctor.
3. Assign an experienced facility provider to be a Clinical Mentor-Proctor in each care delivery area to help orient the new provider to that area and to support the new provider in progressive assumption of full clinical responsibilities. Progressive assumption of full clinical responsibilities will include the following types of activities:
   - Allow the new provider to "shadow" the Clinical Mentor-Proctor while he or she evaluates and treats patient-inmates;
   - Alternate patient-inmate care between the new provider and the Clinical Mentor-Proctor; and,
   - Provide daily review of all patient-inmates seen.
4. The CME, with input from the Deputy Medical Executive (DME) and the CSU CME, shall determine if the new provider's performance has met the minimum standard of practice required to proceed to independent practice. When the new provider has successfully completed the three week clinical mentoring-proctoring period, he or she may begin independent practice.

C. Introduction to On-Call Duties

1. The new provider shall be available for the call schedule after successful completion of the mentoring-proctoring period. New providers shall be placed toward the end of the call rotation to allow them to get as much experience as possible before starting independent on-call duties.
2. During the new provider's first two independent call shifts/periods, the CME or designee will be available by telephone, at all times, or will arrange back up coverage to provide consultation and assistance.
3. The new provider shall keep a record of all calls received and shall review problems and dispositions the following day with the CME or designee. The provider's goal is to standardize on-call responses, set expectations for when an on-call provider will come into the facility, and discuss how specific problems shall be resolved.

D. Independent Practice

1. It may take the new provider four to six weeks of seeing patient-inmates independently to reach the level of proficiency equivalent to a provider experienced in correctional medicine. The CME or designee will ensure that the new provider is scheduled a reasonable number of patient-inmate visits each day, based on his or her experience and expertise. This allows the new provider time to become more familiar with correctional medical practice and to seek assistance, as needed.
2. If a provider has previously worked in a CDCR facility, the CME or designee will determine his or her mentoring needs.
3. The new provider should be located where they can easily access other providers for questions or consultation during the initial four to six weeks of independent practice.

II. PROBATIONARY PERIOD EVALUATIONS AND REPORTS

A performance review is due within ten days after the end of each one-third portion of the probationary period. Most CPHCS providers serve six-month probationary periods, with probationary reports due at two-month intervals. If it is determined that a new employee must be rejected during probation, a final probationary report may be prepared at any time during the probationary period.

The CME or designee shall use State Standard Form (STD) 636, Report of Performance for Probationary Employee, to assess the employee's performance during the probationary period. Through the STD 636, the CME or designee rates a new employee's performance in categories such as skill, knowledge, work habits, learning ability, relationships with people, attitude, and written and verbal communication. The CME, with input from the DME and the CSU CME, shall determine if the new provider's performance during his or her probationary period has met the minimum standard of practice required to obtain permanent civil service employment status.

Because the STD 636 is meant to be a generic tool, suitable for application to a broad array of civil service classifications, the CME or designee shall also complete the following PCP performance appraisals which allow him or her to provide structured, detailed, and clinically-relevant feedback to the new provider:

1. Primary Care Provider Core Competency-Based Evaluation
2. Primary Care Provider – 360 Degree Evaluation
3. Unit Health Record (UHR) Clinical Appraisal (UCA)

The CME or designee shall provide copies of the STD 636, the Core Competency-Based Evaluation, the PCP – 360 Degree Evaluation, the UCA, and reviewed medical records to the new provider and the CSU CME for their review.

A. Core Competency-Based Evaluation

1. At least twice during the new provider's probationary period, the CME or designee shall ensure the new provider's clinical competence and performance is assessed correctly by completing the Core Competency-Based Evaluation. The clinician's knowledge and skill shall be assessed in the following areas:
   - Patient-inmate care/outcomes
   - Medical knowledge
   - Interpersonal and communication skills
   - Professionalism
   - Practice-based learning and improvement
   - Systems-based practice
2. The CME or designee will reference the following sources while preparing the Core Competency-Based Evaluation(s):
   a. PCP – 360 Degree Evaluation
   b. UHR Clinical Appraisal (UCA)
   c. Written reports or peer review activities during the rating period - including a UCA completed by the CSU.
   d. Personal knowledge and observation.
3. The CME shall reference the Core Competency-Based Evaluation as an attachment to the STD 636.

B. Primary Care Provider - 360 Degree Evaluation

1. In conjunction with the new provider's first two probationary reports (completed within the first four months of employment) and with each annual performance appraisal, the CME or designee shall complete a PCP - 360 Degree Evaluation using input regarding the practitioner's clinical performance from each of the following institution staff:
   - The Chief Executive Officer (CEO) or designee
   - Each PCP in the institution - including the provider being evaluated
   - The Associate Warden for Health Care or designee (his or her evaluation may include input from custody staff who regularly work with the provider)
2. The CME or designee must retain each evaluation in the provider's supervisory file for no more than one year. The provider may review each PCP - 360 Degree Evaluation (evaluator's name redacted).

C. Unit Health Record (UHR) Clinical Appraisal (UCA)

1. The CME or designee will complete the UCA by reviewing a minimum of 10 UHR progress notes of patient-inmates seen by the provider at two months into the new provider's probationary period. The PCP will have a second UCA completed at four months into the new provider's probationary period, this time by a CSU clinician who will also review a minimum of 10 UHR progress notes of patient-inmates seen by the provider. The CME or designee will also complete the UCA as part of the annual performance appraisal of all PCPs.

Each patient-inmate's UHR progress note(s) will be evaluated for the following:

- Problem list/face sheets utilized and updated
- Diagnostic studies and consultations ordered in last six months were reviewed and acted on if necessary
- Preventive care items were addressed and documented
- Chronic care issues were managed appropriately in a longitudinal manner

2. The CME will use information from the UCA to complete the PCP Core Competency-Based Evaluation during the probationary period at two and four months and, for permanent employees, in conjunction with the annual performance appraisal. The UCA completed by either the CME or designee, or the CSU clinician will be maintained with the peer review documents at the institution.
3. The CME or designee will also use information from the UCA to complete the PCP Core Competency-Based Evaluation on an annual basis, as well as the STD 636 Report of Performance of Probationary Employee, and the 637 Performance Appraisal Summary for all annual evaluations of PCPs.
4. The UCA completed for either probationary or the annual appraisal by the CME or designee and/or the CSU clinician will be maintained with the peer review documents at the institution.

III. NEW PROVIDER IMPROVEMENT PLAN

The CME or designee, with input from the DME and CSU CME, shall determine if the new provider has met the minimum expectations of his or her job and, if he or she has not, implement an improvement plan designed to provide additional education and training which allows the provider to meet standards of practice during their probationary period. The CME or designee in collaboration with the CSU clinician, if needed, shall also perform an assessment of the outcome of any improvement plan.

If the provider does not adapt well to the institutional medical setting or the provider is unable to successfully complete the improvement plan, the CME or designee will discuss these findings with the CSU clinician, the Chief Physician and Surgeon (C P&S), the CSU CME, and the DME. The CME or designee shall also determine an appropriate action(s), including: limiting clinical privileges, requiring continued education and training, intensifying mentoring-proctoring programs, increasing the level of clinical practices monitoring, or recommending rejection during probation.

IV. ANNUAL PERFORMANCE APPRAISAL

The CME or designee will complete an annual performance review for each permanent civil service provider under his or her supervision. The CME will use State Standard Form 637, Performance Appraisal Summary of Past Job Performance of Permanent Employees (STD Form 637) to assess the employee's performance on an annual basis. The CME or designee will also complete the UCA, the PCP-360 Evaluation, and the Core Competency-Based Evaluation as part of the annual performance appraisal.

The CME or designee will attach the Core Competency-Based Evaluation to the STD Form 637 and provide copies of the STD Form 637, the Core Competency-Based Evaluation, the UCA, and reviewed medical records to the PCP and the CSU CME.

V. CLINICAL SUPPORT RESPONSIBILIES

A. Deputy Medical Executive (DME):

Assist the CME and the CSU CME as needed in any PCP performance appraisal related issues including when progressive discipline including termination is recommended.

B. Clinical Support Unit Chief Medical Officer:

1. Assign a CSU clinician to review each annual UCA, including a review of at least 30% of the UHR records reviewed, independent of the UCA prepared by the CME or designee, for each permanent civil service provider.
2. Ensure that the CSU clinician performs a UCA on each new provider within the first four months of the probationary period.
3. Consult on any provider improvement plan.
4. Consult with the CME or designee regarding the granting of independent practice following the provider's mentoring-proctoring period.
5. Consult with the CSU clinician, the local institution management, and the DME regarding implementing any progressive discipline during the provider's probationary period.
6. Communicate relevant PCP performance issues to the DME, the Peer Review Subcommittee, and the Professional Practices Executive Committee, and to the Danger Determiner when appropriate.

C. CSU Clinician Assigned to the Institution:

1. Train and mentor the CME or designee in conducting the UCAs at the institution.
2. Consult with the CME or designee at assigned institutions, CSU clinician, the CSU CME, and the DME on any progressive discipline during the provider's probationary period.
3. Assist the CME or designee at assigned institutions, as needed, in preparing a mentoring-proctoring plan.
4. Evaluate each annual UCA, including an assessment of at least 30% of the UHR records reviewed, independent of the UCA prepared by the CME or designee, for each permanent civil service provider. If the CSU clinician does not agree with a finding in the UCA prepared by the CME or designee, he or she shall document his/her findings and attach it to the UCA, return it to the CME or designee for further review and report on their findings to the CSU CME for further action if any.
5. Complete a UCA for each new provider during the first four months of his or her probationary period either independently or in collaboration with the CME or designee and share it with the new provider, the institution clinical manager(s), and the CSU CME. The DME should be involved if, at any time, there are concerns about the new provider's performance.
6. Implement and assess the outcome of any improvement plan.
7. Ensure that a copy of all completed UCAs are forwarded to the CSU CME in the applicable region for review and determination of further action, if any, and to ensure that patient-inmate care concerns are reported and tracked appropriately using existing mechanisms established with the Peer Review Sub-Committee (PRSC), the Professional Practices Executive Committee (PPEC), and danger determinations.