STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

EMPLOYEE CONTRACT GRIEVANCE / COMPLAINT

STD. 630 (Rev. 9/2013)

BARGAINING UNIT NAME	BARGAINING UNIT NUMBER (Circle one)
Union of American Physicians and Dentists	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 **(16)** 17 18 19 20 21

Please refer to your bargaining unit's contract for specific information regarding employee grievance procedures and time frame requirements.

GRIEVANT'S NAME			HOME TELEPHONE NUMBER *(include area code)*
Class Action			
HOME ADDRESS (Number and Street)	(City)	(State)	(Zip Code)

DEPARTMENT	DIVISION OR FACILITY	SECTION, BRANCH, UNIT, ETC.
CCHCS	ALL	
POSITION CLASSIFICATION	NORMAL WORKING HOURS	WORK TELEPHONE NUMBER *(include area code)*
Physician & Surgeon		

REPRESENTATION INFORMATION (Complete if applicable)

REPRESENTATIVE'S NAME	ORGANIZATION AFFILIATION	TELEPHONE NUMBER *(include area code)*
Nereyda Rivera	Union Representative	(916)442-6977

GRIEVANCE INFORMATION

DATE OF ACTION CAUSING GRIEVANCE	DATE OF INFORMAL DISCUSSION WITH IMMEDIATE SUPERVISOR	DATE OF INFORMAL RESPONSE
Ongoing		

GRIEVANCE DESCRIPTION *(Clear, concise statement. Attach additional sheets if necessary.)*

UAPD SA-G23-06

Attachment A - CCHCS P&S Application
Attachment B - Union Survey Results (separate document)
Attachment C - UAPD Recommendations Submitted to Dr. Diana Toche and Dr. Joseph Bick Based on Union Survey Responses

SPECIFIC ARTICLE(S) AND SECTION(S) OF CONTRACT ALLEGEDLY VIOLATED

7.4 Rest Periods; 7.6 Hours of Work; 7.9 On-Call;12.6 Professional Judgment; 12.8 Working Conditions;13 Health & Safety; and any and all other relevant articles

SPECIFIC REMEDY SOUGHT

1-25 Refer to document below
26. Cease violating Articles 7, 12, 13 and any and all other relevant articles
27. Make grievants whole.

GRIEVANT'S SIGNATURE	DATE FILED
Nereyda Rivera for Physician & Surgeons	June 3, 2023

(For grievance level reviews I through IV, continue on reverse.)

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

EMPLOYEE CONTRACT GRIEVANCE / COMPLAINT

STD. 630 (Rev. 9/2013) (REVERSE)

GRIEVANCE REVIEW--LEVEL I

DATE RECEIVED	LEVEL I REVIEWER (Signature)	RESPONSE DATE
REVIEWER'S PRINTED NAME AND TITLE		TELEPHONE NUMBER *(include area code)*

LEVEL I DECISION

☐ I concur and do not appeal to the second review level	☐ I do not concur and appeal to the second review level *(State reason below)*	GRIEVANT'S SIGNATURE	DATE SIGNED

REASON FOR APPEAL

GRIEVANCE REVIEW--LEVEL II

DATE RECEIVED	LEVEL II REVIEWER (Signature)	RESPONSE DATE
☐ Decision attached	REVIEWER'S PRINTED NAME AND TITLE	

☐ I concur and do not appeal to the third review level	☐ I do not concur and appeal to the third review level *(State reason below)*	GRIEVANT'S SIGNATURE	DATE SIGNED

REASON FOR APPEAL

GRIEVANCE REVIEW--LEVEL III--DEPARTMENT DIRECTOR OR DESIGNEE

DATE RECEIVED	DIRECTOR OR DESIGNEE (Signature)	RESPONSE DATE
☐ Decision attached	REVIEWER'S PRINTED NAME AND TITLE	

☐ I concur and do not appeal to the third review level	☐ I do not concur and appeal to the third review level *(State reason below)*	GRIEVANT'S SIGNATURE	DATE SIGNED

REASON FOR APPEAL

GRIEVANCE REVIEW--LEVEL IV--DEPARTMENT OF HUMAN RESOURCES

DATE RECEIVED	DIRECTOR OR DESIGNEE (Signature)	RESPONSE DATE
☐ Decision attached	REVIEWER'S PRINTED NAME AND TITLE	

UAPD SA-G23-06
Physician & Surgeon -Class Action Grievance

Grievance Description

Current California Correctional Health Care Services (CCHCS) leadership has constructed policy and procedure and workflow practices that place patients at risk and physicians at risk both professionally and personally.

While CCHCS advertises a 40-hour workweek that offers work-life balance (Attachment A), the reality is that physicians are working well beyond an average 40-hour workweek. This is a contractual violation of the Bargaining Unit 16 Agreement with the State. Over 100 respondents to the attached UAPD survey answered that they regularly work beyond 40 hours per week (Attachment B) to complete the workload/workflow demands that the current CCHCS administration has constructed.

The current CCHCS administration has increased both clinical and administrative workload/workflow along with failure to provide adequate rest periods or allow time off with a dashboard mentality over workload, workflow, patient care and provider well-being. This is a violation of Article 7.4 Rest Periods of the Bargaining Unit 16 Agreement with the State of California. It is the custom and practice of the current CCHCS administration not to account for or schedule these breaks into the providers' workload.

Providers are pushed/forced to manage patients outside of the standard of care by extending follow up intervals; rushing patient encounters with reduced time frames while increasing patient load; increasing on-call workload; increasing administrative load; and decreasing the amount of available administrative time required to provide appropriate patient care. This has made it impossible to accomplish the required daily workload in an 8-hour workday. The current workload/workflow creates an unhealthy environment that cannot be sustained by providers, puts providers at risk and it is fostering a hostile work environment causing undue stress, work fatigue, burnout, and even placing patient and the care they receive at risk.

Patient care does not stop at the end of a clinical encounter nor does the time allotted to engage patients clinically allow completion of all patient care activities. The current workload with the reduced administrative time to complete daily work requirements has progressed to the point where providers are not only working over 8 hours per day, they are consistently working beyond the 40 hours per week. This is a violation of Article 7.6 Hours of Work of the Bargaining Unit 16 Agreement with the State of California.

Clinic expectations have increased to roughly seven hours per day on average thus reducing available administrative time to complete the other patient care related activities along with multiple other administrative duties/requirements in the remaining 1 hour of the typical 8-hour workday timeframe. This results in daily work load excess and is inconsistent with the duty statement and leaving inadequate time for various other required work-related elements.

The current vacancy rate for physicians is severe and impacting multiple institutions and headquarter resources. Despite this high vacancy rate, CCHCS expects physicians to complete the daily work as if

they were fully and appropriately staffed. The Administration's focus on policy, procedure and dashboard metric driven care is violating the Union contract as well as compromising provider wellbeing and patient care. There are so many metrics that they are not manageable at the clinic/patient care level and each metric/dashboard is an ever-growing unstaffed mandate.

The myriad of these metrics are then used by management against providers to demand the excessive workload/workflow processes and holds providers ultimately accountable for more metrics than anyone can keep track of, account for, and access at the point of care and day to day duties as currently constructed. Even the patient summary that is made available to be used at the point of care fails to bring all relevant metric information to the attention of the provider.

Since CCHCS implemented the Medication Assisted Treatment (MAT) program, office visits per patient have dramatically increased and the CCHCS administration has not hired providers or adjusted workflow to accommodate/absorb the additional workload. In fact, CCHCS administration has increased demands on the provider in the face of patient backlog and uses manipulation of clinic scheduling to force longer work hours in violation of the bargaining unit agreement. This excessive workload should have been anticipated by CCHCS leadership. The administration shamelessly treats the workload, metrics, and potential and or actual backlogs as the Physician's responsibility regardless of the local staffing, patient acuity, earned leave time, and/or other factors. Despite this unreasonable expectation to work more than a 40-hour workweek management continues to assign more work and ducats to physicians than can be completed in the 8-hour workday / 40-hour workweek and penalize providers with additional workload for those who utilize sick time or planned time off. Further, CCHCS has not adjust the daily workload/workflow to meet the required clinical and administrative time to complete the daily workload in the 8-hour day or 40-hour workweek.

Another example that has manifested from the current workflow process involves population management meetings and nursing co-consultations where providers are asked and required to write orders on patients without good faith exams. This contributes to the exponentially increasing workload and negates professional judgment. This is a violation of Article 12.6 Professional Judgment.

Physicians are being assigned an excessive workload on a daily basis and does not balance the amount of work between clinical patient hours and associated administrative requirements to complete all the tasks that are needed in a typical day/workweek. Physician On Call (POC) workload has also increased dramatically, beyond the scope of urgent/emergent provider support, given current policies and procedures adding to the overall workload. This is a violation of Article 7.9 On-Call/ Call Back Assignment.

Following is a partial list of problematic areas and **requested remedies** to address the current problematic workload and workflow issues that have resulted in the violation of the contract agreement and created the current unhealthy, non-sustainable provider work environment.

1. Inadequate administrative time to address the increasing volume of Learning Management System (LMS) training. Employees are having to complete these tasks after regular work hours and weekends.

   Remedy #1: Schedule adequate administrative time with specific scheduling time dedicated to required elements such as LMS or required tasks.

2. Actual patient care time often differs from scheduled visits. This time is not accounted for and often encroaches into administrative time and other activities. For example, meetings, required Continuing Medical Education (CME) and an 8-hour workday.

   Remedy #2: Allow rescheduling of non-urgent visits when ducated times cannot be met.

3. Inadequate time to attend required in-service/Continuing Medical Education (CME) conferences due to patient care demands encroaching on scheduled CME time.

   Remedy #3: These should be scheduled prior to scheduled patient appointments and/or on a designated afternoon (i.e. on a designated day where patient care is truncated to allow adequate time to complete patient care and administrative tasks associated with that day's workload).

4. Patient ducats are not adjusted for Statewide meetings.

   Remedy #4: These meetings should be scheduled prior to scheduled patient appointments and/or on a designated afternoon (i.e. on a designated day where patient care is truncated to allow adequate time to complete patient care and administrative tasks associated with that day's workload).

5. Staff meetings are scheduled outside of/extend beyond regular work hours.

   Remedy #5: Schedule staff meetings within the 8-hour day and pay them for the additional required work time.

6. Inadequate time to attend required Daily huddle/s. Some institutions have a roll call prior to clinic huddle.

   Remedy #6: Incorporate the daily huddle and any other required meeting prior to huddle into the 8-hour scheduled workday.

7. Inadequate administrative time to adequately address patient labs.

   Remedy #7: Schedule adequate administrative time to adequately address patient labs.

8. Inadequate administrative time to address the volume for specialty consult reviews.

   Remedy #8: Specialty providers should have access to the medical record and place their own orders. Schedule adequate administrative time for physicians to appropriately review and consider recommendations.

9. Inadequate administrative time to adequately address the medication refills/ Provider Hub.

   Remedy #9: Schedule adequate administrative time to appropriately address refills/Provider Hub.

10. Inadequate administrative time to address the volume of messages from various staff.

    Remedy #10: Refine policy to appropriately triage messages to be handled at the lowest possible level.

11. Inadequate clinic/patient care time to address the volume of Co-consultations with nursing.

    Remedy #11: Schedule adequate time for co-consultation as defined in the Health Care DOM.

12. Inadequate administrative time to address the volume of CERNER messages

    Remedy #12: Refine policy to appropriately triage to be handled at the lowest possible level and increase administrative time to address these messages.

13. Inadequate administrative time to address the volume of Outlook messages.

    Remedy #13: Adequate time to address Outlook messages. Outlook messages should be business related only. All patient care related messages should be sent within the medical record. There should be no duplicated messages, chain messages, or excessive cc lists.

14. Inadequate clinic time to address the volume of orders requested by nursing.

    Remedy #14: Schedule adequate clinic time to address patient care related nursing requests and enable nursing to propose orders to physicians for requested tests.

15. Inadequate administrative time to review InterQual and justify criteria for approval of RFS requests.

    Remedy #15: Provide adequate time to review InterQual criteria and complete request for services.

16. Inadequate administrative time to contact specialists/ respond to E-Consultations for discussion of patient care.

    Remedy #16: Provide adequate time to allow for discussion with the specialists when needed.

17. Poorly organized population management meetings often create administrative work for the provider beyond the meeting.

    Remedy #17: Allow adequate time to allow providers to address population management elements outside the population management meeting. Make the meetings more efficient and effective such that the work can be completed during the meeting timeframe.

18. Inadequate administrative time to complete Physician On-Call (POC) documentation and on-call reports.

    Remedy #18: Allow adequate time following call to complete documentation and on-call reports.

19. Inadequate administrative time to adequately address the volume of MAT non-adherence messages.

    Remedy #19: Allow adequate administrative time to address MAT messages. Develop policies and procedures to manage non-adherent patients.

20. The volume of ISUDT/MAT patients compromises the availability of clinic time for other scheduled visits.

    Remedy #20: Adjust the provider staffing ratio to account for the increased volume of patient visits.

21. Inadequate time to allow meaningful visits for patients in the ISUDT/MAT program.

    Remedy #21: Limit bundling of MAT visits with other chronic care problems so there is adequate time to create a motivational based interview and address elements of MAT care and non-adherence.

22. Providers are not provided and/or scheduled time to take their two 15-minute breaks.

    Remedy #22: Schedule a 15-minute break during each four hours of the workshift.

23. Providers are given an unreasonable workload that cannot be completed in a 40-hour workweek.

    Remedy #23: Immediately reduce workload such that it can be completed in a 40-hour workweek consistent with the BU16 contract. Adjust clinic time to a reasonable amount such that the administrative time can be protected with reasonable expectations to complete daily activities within the 8-hour day. Schedule the administrative time commensurate with duty statements and an adequate amount of time be provided to address the workload on a daily basis.

24. CCHCS Leadership failed to address and respond in a meaningful fashion to the UAPD recommendations dated January 20, 2023 such that issues were allowed to continue.

    Remedy #24: Address timely and professionally the issues and the Union recommendations (Attachment C) previously identified and those delineated in the UAPD survey (Attachment B)

25. Current management has created a policy and procedure that places providers and patients at risk.

    Remedy #25: Elevate this grievance to the Federal Receiver, Clark Kelso, for a corrected action plan to improve unsatisfactory conditions.

Current policy and procedure and administrative direction does not allow physicians to practice in a manner that allows them to exercise their professional judgment. This is a violation of Article 12.6 Professional Judgment.

Management does not provide a supportive environment for physicians to be successful in their position. Instead, management fosters a hostile work environment that penalizes the employee for management's failure to provide reasonable expectations, resources, nursing support, appropriate staffing needed to be successful, and practice in a community level standard of care, address all available metrics at point of care, and meet the elements of the current Health Care DOM and Title 15. This is a violation of Article 12.8 Working Conditions of the BU16 Agreement with the State.

The excessive workload and current administrative approach have created a hostile work environment with an unreasonable volume of work in an unsupportive, unhealthy, punitive, and stressful work environment that violates Article 13 Health and Safety of the contract. This not only affects the providers, but also places patients at risk.

ATTACHMENT A

CCHCS P&S Application

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Physician & Surgeon (IM/FP)

Job Number: 6061071
Location: Pelican Bay State Prison - Crescent City
Department Name: California Correctional Health Care Services
Region: Northern California
Time Base/FT/PT: Full Time
Closing Date/FFD: Until Filled

Physician & Surgeon (IM/FP)
$302,424 - $317,556 annual (Time-Limited Board Certified)
$287,268 - $301,656 annual (Lifetime Board Certified)
$272,184 - $285,804 annual (Pre-Board Certified)

Are you looking to practice medicine and maintain a positive work-life balance? A career with California Correctional Health Care Services (CCHCS) allows you to focus on providing quality care without the burdens of managing insurance paperwork or maintaining a private practice while committing to providing optimal care, promoting patients' successful reintegration into society, and reducing recidivism.

We currently have opportunities at Pelican Bay State Prison in the charming town of Crescent City. Nestled near the Oregon border, this area is surrounded by ancient redwoods, pristine rivers, and the rugged Pacific coast. Whether you're looking for outdoor adventure, restorative time amid nature, or a small-town lifestyle for your family, this may be just the spot to take advantage of your newfound work-life balance with CCHCS.

Here, in a supportive and collaborative environment, you will:

- Enjoy a practical patient panel (approximately 10 – 12 patients per day)
- Deliver basic primary care to our diverse patient population
- Provide education to patients related to chronic disease management

CCHCS offers a competitive compensation package, including:

- 40-hour workweek (affords you true work-life balance)
- Generous paid time off and holiday schedule
- State of California retirement that vests in 5 years (visit CalPERS.ca.gov for retirement formulas)
- Robust 401(k) and 457 savings plans (tax defer up to $41,000 - $68,000 per year)
- Paid Insurance, license, and DEA renewal
- Paid CME, with paid time off to attend
- Visa sponsorship opportunities
- Relocation assistance for those new to state service
- And much more

Take the first step in joining our team and submit your CV to CentralizedHiringUnit@cdcr.ca.gov.

Candidates new to CCHCS are required to submit to a background investigation process utilizing Live Scan Fingerprinting, and Tuberculosis (TB) testing prior to appointment followed by department annual TB testing/evaluation thereafter.

Pursuant to the Public Health Order (State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement) issued by the California Department of Public Health and the directive (Mandatory COVID 19 Vaccines and Testing for Institution Staff) issued by the Department of Corrections & Rehabilitation (CDCR), all staff assigned to all staff assigned to this institution are required to show evidence of full vaccination for COVID-19, absent an approved reasonable medical or religious accommodation precluding them from vaccination. In addition, employees regularly assigned to work in the health care areas or posts within this assigned institution shall provide evidence of full vaccination for COVID-19, absent an approved reasonable medical or religious accommodation precluding them from vaccination.

Pursuant to the Public Health Orders (Guidance for the Use of Face Coverings and State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement) issued by the California Department of Public Health and the directive Mandatory COVID 19 Vaccines and Testing for Institution Staff issued by the Department of Corrections & Rehabilitation (CDCR), all staff assigned to this post/position may be required to show evidence of full vaccination and booster for COVID-19, absent an approved reasonable medical or religious accommodation precluding them from vaccination.

Please review the appropriate bulletin/assessment on the **Bulletin Page** for the Minimum Qualifications and, if qualified, complete the Assessment according to the instructions.

How To Apply: You may apply for this position by clicking "Apply Now" on the top or bottom of this page.

"CCHCS uses E-Verify in its hiring practices to achieve a lawful workforce. For more information about E-Verify, please go to **www.e-verify.gov**".

EOE

ATTACHMENT B

Union Survey Results

A separate document in the same email

ATTACHMENT C

List of UAPD Recommendations

UAPD Recommendations to CCHCS
CCHCS Physician Workload and Satisfaction Survey
From Meeting on January 20, 2023

1. Workload adjustment such that there is adequate clinical and administrative time to complete work in an 8-hour day.

An overwhelming majority of physicians are working well beyond the 40-hour workweek which is a violation of the BU16 Agreement. Processes are not efficient from the physician perspective.

Given that this is inconsistent with CDCR advertising for P and S positions and given that it is a clear violation of contract this is a top priority of the membership.

Ensure adequate administrative time to complete all work within an 8 hour time frame.

It is critical that all BU 16 contract violations be addressed.

The workload has become a significant enough issue that the survey indicates many providers have considered leaving CDCR and would not recommend a friend to work for CDCR.

2. One of the primary concerns outlined in the survey is a disconnect between PCPs and upper-level management. We have meetings with our Chief Physician and Surgeons and to a varying degree with CMEs but above that there is no communication. This leads to mistrust. A significant number of respondents indicated CDCR/CCHS is not moving in a positive, physician supportive direction under the current leadership (Q18). Based on the above, respondents also indicated they would support a vote of no confidence.
Recommendations:

- Foster regular meetings between the CEO/DME and providers for meaningful feedback and process improvement. Providers need to be included in planning and role out of new programs with value placed on our input.
- Regular institutional and statewide meetings/committees that allow physicians active involvement in processes.
-
- Create a statewide and institutional Committees that include Rank and file Physicians to discuss policies and procedures before they are implemented. Minimum of 5 rank and file Physicians to be selected by the Union
- Train and/or replace current leadership to promote a supportive and collaborative work environment.

3. Significant concerns related to the MAT program. Specifically, this program does not adequately address misuse, abuse, and diversion. There is a global disrespect and lack of integrity from the perspective in the field. This is covered in comments by providers.

- Recommend a clear pathway to identify misuse, abuse, and diversion.
- Hold patients accountable for the standards set in their MAT agreement.
- Providers need adequate training to interpret and act upon unexpected urine toxicologies.
- All patients need to be in counseling or CBI or ISUDT classes with no exceptions. MAT has significantly increased the work for providers without additional providers being hired. Providers have concerns with the prevalence of Suboxone on the yard and the real possibility that it is causing more harm than good.

4. Patient care documentation templates (example: standardized dot phrases, checklists) for all chronic care diseases/conditions/MAT appointments, RFS checklist for common requests.

This would improve provider to provider communication when patient's transfer service. This would also improve OIG inspections for compliance to patient care standards.

If we have dashboard requirements available at the time of patient visit we can try to address them in an efficient fashion. Dashboard requirements may not be a priority at every visit. Patient care MUST come first but this will maximize our opportunities to address necessary items at the time of the visit.

5. Patient care related metrics need to be organized such that they are useful and can be used at point-of-care.

The current patient summary is incomplete. All relevant matrix flags to a particular patient need to be visible at time of visit.

6. Facilitating teamwork to have an efficient - effective RFS process that works to correct and move an RFS and patient care forward.

Both the utilization review nurse and the physician reviewer have access to the medical record and details that would allow for better patient centered care decisions.

Consider reviewing all RFS denials at physician meetings for process and care improvements. Denials must have specifics as to which criteria were not met and why the RFS was denied. Have an effective appeal process.

The current process creates tension between physician and supervisor. They do not provide alternate solutions with the denials.

The CME and UM RN need to be advocates for processing the RFS not an adversary to the PCPs efforts for patient care.

7. All credentialed physicians HQ and institutions would be much more effective leaders if they were required to maintain active patient care clinical engagement.

For example HQ and CME physicians should be involved with direct patient care at least ½ day per week (2 days per month) and CPS should have at least one full day per week to better understand and relate to the clinicians and product of patient care for incarcerated patients they serve.

8. POC must not be so frequent as to preclude reasonable rest and reasonable personal time. Administrative time (4 hours) following POC to complete documentation needs.

Current POC is overworking the physicians. It is not safe. The physician has a full shift, then POC, then comes back for another full shift the next day.

9 . Review all questions in the survey and provide meaningful responses to each. In addition please review and consider all comments in your responses. Engage providers statewide for solutions and discuss items at a **statewide provider/physician conference.**

10. The time needed to engage the patient must be protected. Limit administrative bundling of appointments as this becomes unwieldy at the point of care. Involve physicians in scheduling endeavors.

11. Consider cultivating a work environment where patient care is the priority over dashboard management.The survey respondents clearly indicate that staff and providers are being pressured to change RFS priorities f/u dates, etc. to keep the dashboard green and that this places physician licenses at risk and does not allow HQ to identify problematic process that could be corrected