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Office of the Inspector General

California Correctional Center

Medical Inspection Results

Cycle 4

August 2015

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CALIFORNIA CORRECTIONAL CENTER
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EXECUTIVE SUMMARY

As a result of the April 2001 *Plata v. Brown* federal court class action lawsuit, and under the authority of California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons.

To augment further the breadth and quality of the OIG's medical inspection program, for this fourth cycle of inspections the OIG added a clinical case review component and significantly enhanced the compliance portion of the inspection process from that used in prior cycles. In addition, the OIG added a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures from other State and national health care organizations and compared that data to similar results for California Correctional Center (CCC).

From March to May 2015, the OIG performed its Cycle 4 medical inspection at CCC. The inspection included in-depth reviews of 76 inmate-patient files conducted by clinicians as well as reviews of documents from 359 inmate-patient files conducted by deputy inspectors general, covering 91 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at CCC using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and 2 secondary administrative indicators. Of the 14 total indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 4 were rated by the compliance component alone. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care was *inadequate*.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	CCC Applicability
1–Access to Care	All institutions	Both case review and compliance
2–Diagnostic Services	All institutions	Both case review and compliance
3–Emergency Services	All institutions	Case review only
4–Health Information Management (Medical Records)	All institutions	Both case review and compliance
5–Health Care Environment	All institutions	Compliance only
6–Inter- and Intra-System Transfers	All institutions	Both case review and compliance
7–Pharmacy and Medication Management	All institutions	Both case review and compliance
8–Prenatal and Post-Delivery Services	Female institutions only	Not Applicable
9–Preventive Services	All institutions	Compliance only
10–Quality of Nursing Performance	All institutions	Case review only
11–Quality of Provider Performance	All institutions	Case review only
12–Reception Center Arrivals	Institutions with reception centers	Not Applicable
13–Specialized Medical Housing (OHU, CTC, SNF, Hospice)	All institutions with an OHU, CTC, SNF, or Hospice	Both case review and compliance
14–Specialty Services	All institutions	Both case review and compliance
Two Secondary Indicators (Administrative)	**All Institutions–Applicability**	**CCC Applicability**
15–Internal Monitoring, Quality Improvement, and Administrative Operations	All institutions	Compliance only
16–Job Performance, Training, Licensing, and Certifications	All institutions	Compliance only

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews, compliance testing, and population-based metrics, the OIG's overall assessment rating for CCC was *inadequate*. For the 12 primary (clinical) quality indicators applicable to CCC, the OIG found none *proficient*, three *adequate*, and nine *inadequate*. For the two secondary (administrative) quality indicators, the OIG found both were *adequate*. To determine the overall assessment for CCC, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at CCC.

Clinical Case Review and OIG Clinician Inspection Results

The OIG's clinical case reviews of a sample of patients with high medical needs found the health care services provided at CCC to be *inadequate*. Clinicians reviewed at least 1,056 patient care events. Of the 12 primary indicators applicable to CCC, 10 were evaluated by clinician case review; none were *proficient*, two were *adequate*, and eight were *inadequate.* When determining the overall adequacy of care, the OIG placed extra emphasis on the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. The opposite is not true, however; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate.

Program Strengths

- The CCC Specialty Services Department was committed and provided timely and appropriate specialty services to patients.

- Health information scanning times were found to be current without significant backlogs.

Program Weaknesses

OIG clinicians identified problems in most aspects of CCC's health care delivery system. Clinician analysis suggested that the following four core problems were likely responsible for the majority of the deficiencies and the *inadequate* rating:

- Physician understaffing: Two physicians were currently on long-term sick leave, and there remained one vacant position. In addition, providers who were currently working had been allowed to accumulate many extra leave hours, which may continue to exacerbate staffing problems in the near future. CCC's remote locale was a constant barrier to hiring well-qualified and high performing physicians. Physician understaffing was largely

responsible for the inadequate Access to Care and Quality of Provider Performance indicator ratings. Insufficient staffing created poor continuity of care, leading to further inefficient encounters because of patient unfamiliarity. The provider performance had a widespread pattern of inadequate assessment and decision-making. In addition, there was inadequate review of records, questionable chronic care performance, overdependence on specialty services, and inadequate documentation.

- Lack of a robust quality improvement program: During the clinician onsite inspection, it was apparent that only in the past few months had CCC started a few rudimentary quality improvement projects, such as a tracking system that ensured that all lab orders were completed and all lab reports were retrieved. The lack of meaningful quality improvement was reflected in the *inadequate* ratings in the *Diagnostic Services, Health Information Management,* and *Specialty Services* indicators. CCC management needs to fully commit itself to a meaningful quality improvement program.

- Poor nursing documentation, supervision, and accountability in the triage & treatment area (TTA) and outpatient housing unit (OHU): OIG clinicians found that the TTA and OHU nurses demonstrated extremely poor documentation practices. Deficiencies identified during the chart review process alone initially caused the OIG clinicians to question the basic competency of this nursing group. However, during the onsite inspection, clinician interviews clarified that the main problem was poor documentation and the lack of appropriate supervision and monitoring that allowed such errors to continue. Clinical nursing competency must be evident in thorough, correct, current, and legible nursing documentation. Poor nursing performance significantly impacted several indicators, and was largely responsible for the inadequate ratings of *Emergency Services, Inter- and Intra-System Transfers,* and *Specialized Medical Housing*. (*Quality of Nursing Performance* was primarily an evaluation of outpatient nursing performance and was not impacted by TTA and OHU nursing performance.)

- Lack of commitment to a primary care home model: OIG clinicians found during both the case review process and the onsite clinician inspection that CCC health care staff lacked a sense of individual patient ownership and responsibility. Nurses performed sick call visits in buildings physically separated from the providers. Currently, a lack of physical space prevents such a collaborative effort. Nevertheless, administrators indicated that there were no plans to integrate doctors and nurses even after the health care facilities improvement project (HCFIP) was completed. CCC's morning huddles were superficial, and only addressed acute issues faced by the on-call provider. Nursing and provider staff were not familiar enough with their patients to proactively anticipate and manage individual patient problems and needs. During the onsite inspection, in most clinics LVNs and RNs had been "floating," or temporarily assigned to areas that were outside their normal assignments. Schedulers were mostly unaware which providers each patient had been assigned to, and

they failed to make significant efforts to ensure each provider was scheduled to see patients in his or her panel. Overall, CCC health care was best described as disjointed and reactive. Unfamiliarity with patients, poor provider continuity, and a lack of ownership and responsibility were also largely responsible for many of the deficiencies found in *Quality of Provider Performance*, but were also evident in other system problems such as failure to renew expiring medications and various sick call nursing deficiencies.

- Adverse/sentinel events: There were two significant adverse/sentinel events identified during the case review of one patient (case 1). At the patient's follow-up appointment after hospitalization, there was a delay in care for a patient with possible lung cancer as the CCC provider failed to thoroughly review the patient's hospital medical records and properly diagnose the patient upon his return to the institution. During the patient's next appointment, another provider, who relied on the initial provider's assessment and did not conduct an independent review and assessment of the patient's records, made this same error. These errors caused a delay in the patient's care. Adverse events are further described within the *Medical Inspection Results* section of this report. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events.

The OIG acknowledges that CCC's patient population was generally young and healthy. At the time of case review selection, CCC's high-risk patients comprised less than 1 percent of the population, while medium-risk patients comprised less than 7 percent of the population. Less than 10 percent of the diabetic population required injectable insulin. The OIG gave appropriate consideration to the demographics of this prison when evaluating the impact of population-based metrics. With a low-risk population, there were few examples of poor outcomes. Nevertheless, the OIG case review focused primarily on health care system processes and the risk of harm to a subpopulation of patients who needed services the most. Even with this low-risk population, CCC could not provide these inmate-patients with a level of medical care that could be rated as *adequate*.

Compliance Testing Results

The OIG's compliance testing results contributed to CCC's overall rating of *inadequate*. Of the 14 total indicators of health care applicable to CCC, compliance inspectors evaluated 11. There were 91 individual compliance questions within those 11 applicable indicators that tested CCC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[1] Those 91 questions are detailed in *Appendix A—Compliance Test Results*. The institution's inspection scores for the 11 applicable indicators ranged from 52.7 percent to 92.0 percent, with the primary (clinical) indicator *Health Care Environment* receiving the lowest score, and the primary (clinical) indicator *Specialized Medical Housing* receiving the highest. For the nine primary indicators applicable to compliance testing, the OIG rated two *proficient,* four *adequate,* and three

[1] The OIG used its own clinicians to provide clinical expert guidance for testing compliance in certain areas where CCHCS policies and procedures did not specifically address an issue.

inadequate. For the two secondary indicators, which involve administrative health care functions, both were rated *adequate*.

Program Strengths

As the *Executive Summary Table* on page xi indicates, the institution's primary indicator compliance scores were in the *proficient* range for the following two indicators: *Pharmacy and Medication Management* (88.8 percent), and *Specialized Medical Housing* (92.0 percent). The following are some of the strengths identified, based on CCC's compliance scores for individual questions within all primary health care indicators:

- Nursing staff routinely reviewed patients' service requests timely and completed face-to-face visits with patients within one business day.

- Inmate-patients seen by a provider routinely received a recommended follow-up appointment within the provider's ordered time frame.

- All inmate-housing locations had Health Care Services Request forms (CDCR Form 7362) available and a standard process for submitting requests to medical staff.

- Inmate-patients received radiology and laboratory services within the required time frame.

- Providers communicated patient radiology results within the required time frame.

- Non-dictated progress notes, initial health screening forms, and Health Care Service Request forms were scanned into the eUHR within the required time frame.

- The institution's clinics followed adequate medical supply storage and management protocols, and clinics maintained emergency response bags with all essential items.

- For newly arrived inmate-patients, nursing staff properly completed the Initial Health Screening form (CDCR Form 7277) by answering all applicable questions, documenting an assessment and disposition, and signing and dating the form on the same day the inmate arrived at the institution.

- Nursing staff timely administered medications to patients with chronic care conditions, ensured that patients who transferred from one housing unit to another received their prescribed medications without interruption, and followed appropriate protocols during the preparation and administration of medications.

- The institution's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated medications; properly stored and

monitored non-narcotic medications that require refrigeration; maintained adequate controls and properly accounted for narcotic medications; and followed protocols for medication error reporting.

- The institution was prompt in offering required preventive services in the form of influenza vaccinations and colorectal cancer screenings.

- Outpatient housing unit (OHU) nursing staff completed initial assessments the same day patients were admitted to the OHU, and providers completed face-to-face encounters with inmate-patients within one calendar day of admission. In addition, providers completed subjective, objective, assessment, plan, and education progress notes within required time frames.

- The institution's OHU had a working call button system and a procedure in place to ensure that during an emergent event, medical staff can enter an inmate-patient's cell within a reasonable amount of time.

- For routine specialty services, CCC provided the services within the required time frames and providers reviewed the consultants' reports timely.

Identified strengths within the secondary indicators related to the following administrative areas:

- The institution promptly processed inmate medical appeals during the last 12 months. In addition, the institution's second-level medical appeal responses addressed all of the inmate-patients' appealed issues.

- CCC's Quality Management Committee met on a monthly basis, and took steps to validate its reported Dashboard data.

- The Emergency Medical Response Review Committee performed timely incident package reviews that included the use of all required review documents.

- Sampled nursing staff were current on training requirements, licenses, and certifications.

- Providers, the pharmacist-in-charge, and the pharmacy had current licenses and registrations.

Program Weaknesses

The institution received ratings in the *inadequate* range for the following three primary indicators: *Health Information Management (Medical Records)* (59.7 percent); *Health Care Environment* (52.7 percent); and *Inter- and Intra- System Transfers* (64.7 percent). Examples of some weaknesses identified during the OIG's testing of specific compliance questions within all the primary indicators included the following:

- Inmate-patients did not always receive timely chronic care follow-up appointments.
- Inmate-patients who were referred to a provider by nursing staff did not always receive their initial provider appointments within the required time frames.
- Inmate-patients who were discharged from a community hospital did not always receive a provider follow-up appointment within five calendar days of discharge.
- CCC providers did not always review and initial radiology and laboratory reports within the required time frames.
- The institution did not receive final pathology reports within the required time frames. In addition, providers did not always timely communicate pathology results to the inmate-patient.
- Health care documents were periodically mislabeled in patients' eUHRs.
- Clinicians' signatures on health care records were not always legible.
- The institution did not always receive a final discharge report that included all required elements for patients released from a community hospital, and providers did not always timely review the reports upon receipt.
- Clinical health care areas were not always appropriately disinfected, clean, and sanitary.
- Protocols related to proper medical equipment sterilization or disinfection were not always followed.
- Providers did not always follow universal hand hygiene precautions before or after examining patients in several of the institution's clinics.
- Clinics and exam rooms lacked essential core medical equipment and supplies for comprehensive examinations.

- The institution's medical storage areas were insufficient and the supply management process was ineffective; supplies were stored on the floor and temperature-sensitive medical supplies were stored in a non-temperature-controlled environment, which could lead to deterioration.

- Several clinic restrooms did not have sufficient hand hygiene supplies, and some clinic exam rooms did not have sharps containers.

- Some clinical areas lacked an environment conducive to providing adequate medical services, affecting the clinicians' ability to ensure patients' auditory privacy. In addition, several clinical areas did not have adequate exam space or all the equipment necessary for comprehensive examinations and had confidential patient documents in areas accessible by inmate-porters.

- Inmate-patients who transferred out of CCC to another CDCR institution did not always have a supply of medications included in their transfer packages. In addition, several other inmate-patients who transferred out with an approved pending specialty service appointment did not have the service identified on their Health Care Transfer Information forms (CDCR Form 7371).

- Inmate-patients who transferred into CCC from another CDCR institution without their medications did not always receive replacement keep-on-person (KOP) medication within one calendar day of arrival.

- Some nursing staff did not have a fundamental knowledge of the required protocols to follow when a controlled substance discrepancy occurs.

- Clinical staff did not properly monitor inmate-patients who were on INH medication for tuberculosis.

- Providers did not always complete OHU patients' written history and physical exams within 72 hours of admission.

- The institution's clinical staff did not deny specialty service requests within the required time frames. In addition, a provider follow-up appointment to discuss the specialty service denial did not always occur.

The lowest scoring questions addressing secondary indicators resulted in the following administrative deficiencies:

- The institution did not follow requirements for timely reporting adverse/sentinel events or inmate-patient deaths.

- The institution did not adequately identify the status of performance objectives for all quality improvement initiatives identified in its 2014 Performance Improvement Work Plan.

- Emergency medical response drills did not always include custody staff's participation.

- The institution's supervising nurses did not always conduct adequate reviews of their nursing staff.

- Structured clinical performance appraisals were not properly or timely completed for all providers.

- CCC did not ensure that its custody managers maintained basic life support certifications.

Population-Based Metrics

Overall, CCC performed at a marginally adequate level for population-based metrics. For comprehensive diabetes care measures, CCC outperformed other State and national organizations with its high percentage of diabetics considered to be under good control and low percentage of diabetics considered to be under poor control. For diabetic monitoring, CCC outperformed all organizations except the U.S. Department of Veterans Affairs (VA), which had a slightly higher score than CCC. For blood pressure monitoring, CCC scored better than Medi-Cal, Medicaid, Medicare, and national commercial health plans (based on data obtained from health maintenance organizations), but trailed California's Kaiser Permanente and VA scores. For eye exams, CCC outperformed only the Medi-Cal, Medicaid, and commercial scores.

While the OIG found that CCC routinely offered inmate-patients the influenza vaccination and colorectal cancer screening, patients often refused the offers. With regard to those patients who actually received the influenza immunization for adults aged 18 to 64 and colorectal cancer screening for adults aged 50 through age 75, CCC scored lower than all other comparable organizations, sometimes by a large variance. For both the influenza immunizations for adults aged 65 and older and pneumococcal immunization measures, CCC received scores of zero. For both tests, CCC had only two applicable patients to sample and when tested, neither sample met the criteria to receive a passing score.

The *CCC Executive Summary Table* on the following page lists the quality indicators inspected and assessed during the clinical case reviews and objective compliance tests and provides the institution's rating in each area. The overall indicator ratings were based on a consensus decision by the OIG's clinicians and non-clinical inspectors.

CCC Executive Summary Table

Primary Indicators (Clinical)	Case Review Rating	Compliance Score	Overall Indicator Rating
Access to Care	Inadequate	81.7%	Inadequate
Diagnostic Services	Inadequate	78.6%	Inadequate
Emergency Services	Inadequate	Not Applicable	Inadequate
Health Information Management (Medical Records)	Inadequate	59.7%	Inadequate
Health Care Environment	Not Applicable	52.7%	Inadequate
Inter- and Intra-System Transfers	Inadequate	64.7%	Inadequate
Pharmacy and Medication Management	Adequate	88.8%	Adequate
Preventive Services	Not Applicable	80.6%	Adequate
Quality of Nursing Performance	Adequate	Not Applicable	Adequate
Quality of Provider Performance	Inadequate	Not Applicable	Inadequate
Specialized Medical Housing	Inadequate	92.0%	Inadequate
Specialty Services	Inadequate	79.8%	Inadequate

Note: *Prenatal and Post-Delivery Services* and *Reception Center Arrivals* indicators did not apply to this institution.

Secondary Indicators (Administrative)	Case Review Rating	Compliance Score	Overall Indicator Rating
Internal Monitoring, Quality Improvement, and Administrative Operations	Not Applicable	75.7 %	Adequate
Job Performance, Training, Licensing, and Certifications	Not Applicable	78.3%	Adequate

Compliance ratings for quality indicators are *proficient* (greater than 85.0 percent), *adequate* (75.0 percent to 85.0 percent), or *inadequate* (below 75.0 percent).

INTRODUCTION

Under the authority of California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. For this fourth cycle of inspections, the OIG augmented the breadth and quality of its inspection program used in prior cycles, adding a clinical case review component and significantly enhancing the compliance component of the program.

The California Correctional Center (CCC) was the fourth medical inspection of Cycle 4. During the current inspection process, the OIG assesses the delivery of medical care to inmate-patients for 14 primary clinical health care indicators and 2 secondary administrative health care indicators, as applicable to the institution under inspection. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

The OIG is committed to reporting on each institution's delivery of medical care to assist in identifying areas for improvement, but the federal court will ultimately determine whether any institution's medical care meets constitutional standards.

ABOUT THE INSTITUTION

The primary mission of CCC is to receive, house, and train minimum-custody inmates for placement into one of the institution's 18 conservation camps. These camps are strategically located throughout northern California to provide fire suppression crews and an organized labor force for public conservation projects and other emergency response needs to the State. The secondary mission of CCC is to provide work training and education programs for inmates who are not assigned to a conservation camp. CCC operates seven medical clinics where staff handle non-urgent requests for medical services. CCC also treats inmate-patients who need urgent or emergency care in its triage and treatment area (TTA) and treats inmate-patients requiring outpatient health services and assistance with the activities of daily living in the outpatient housing unit (OHU). Further, the institution routinely screens patients in its receiving and release (R&R) clinical area.

Based on staffing data OIG obtained from the institution in March 2015, CCC had a vacancy rate of 12 percent for primary care providers. The institution also had one nursing supervisor vacancy and 3.4 vacancies for non-supervisory nursing staff. This resulted in an overall vacancy rate of 7 percent, which is relatively low for CCC. The reduction was due in part to the institution's recent success in hiring and filling vacancies. Specifically, CCC filled 35 percent of its nursing supervisor positions and 18 percent of its non-supervisory nursing staff positions during the last 12 months.

CCC Health Care Staffing Resources—March 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	1	1%	8	11%	9.5	13%	53.9	74%	72.4	100%
Filled Positions	1	100%	7	88%	8.5	89%	50.5	94%	67	93%
Vacancies	0	0%	1	12%	1	11%	3.4	6%	5.4	7%
Recent Hires (within 12 months)	1	100%	0	0%	3	35%	9	18%	13	19%
Staff Utilized from Registry	0	0%	0	0%	0	0%	2	4%	2	3%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff under Disciplinary Review	0	0%	1*****	14%	1	12%	0	0%	2	3%
Staff on Long-term Medical Leave	0	0%	1	14%	1	12%	3	6%	5	7%

Note: CCC Health Care Staffing Resources data was not validated by the OIG.

*****According to CCC's management, this staff member has been on long-term leave since approximately September 2014.

As of August 11, 2015, the California Correctional Health Care Services (CCHCS) data showed that CCC had 3,986 inmate-patients. Within that total population, 0.1 percent of the inmate-patients were designated as high-risk Level I, and 0.5 percent designated as high-risk Level II. High-risk patients are at greater risk for poor health outcomes than average patients. They are designated High Risk if they have a high risk diagnosis, require high risk specialty consultation or medication, have multiple hospital or emergency department visits, have significant abnormal lab results, or are 65 years of age or older. High Risk II patients have one high-risk condition, and High Risk I have two or more conditions. The chart below illustrates the inmate-patient breakdown.

CCC Master Registry Data as of August 11, 2015

Risk Level	# of Inmate-Patients	Percentage
High I	5	0.1%
High II	19	0.5%
Medium	260	6.5%
Low	3,702	92.9%
Total	3,986	100%

Abbreviations Used in This Report

ACLS	Advanced Cardiovascular Life Support	**HIV**	Human Immunodeficiency Virus
AHA	American Heart Association	**HTN**	Hypertension
ASU	Administrative Segregation Unit	**INH**	Isoniazid (anti-tuberculosis medication)
BLS	Basic Life Support	**IV**	Intravenous
CBC	Complete Blood Count	**KOP**	Keep-on-Person (in taking medications)
CC	Chief Complaint	**LVN**	Licensed Vocational Nurse
CCHCS	California Correctional Health Care Services	**MAR**	Medication Administration Record
CCP	Chronic Care Program	**MRI**	Magnetic Resonance Imaging
CDCR	California Department of Corrections and Rehabilitation	**MD**	Medical Doctor
CEO	Chief Executive Officer	**NA**	Nurse Administered (in taking medications)
CHF	Congestive Heart Failure	**N/A**	Not Applicable
CME	Chief Medical Executive	**NP**	Nurse Practitioner
CMP	Comprehensive Metabolic (Chemistry) Panel	**OB**	Obstetrician
CNA	Certified Nursing Assistant	**OHU**	Outpatient Housing Unit
CNE	Chief Nurse Executive	**OIG**	Office of the Inspector General
C/O	Complains of	**P&P**	Policies and Procedures (CCHCS)
COPD	Chronic Obstructive Pulmonary Disease	**PA**	Physician Assistant
CP&S	Chief Physician and Surgeon	**PCP**	Primary Care Provider
CPR	Cardio-Pulmonary Resuscitation	**POC**	Point of Contact
CSE	Chief Support Executive	**PPD**	Purified Protein Derivative
CT	Computerized Tomography	**PRN**	As Needed (in taking medications)
CTC	Correctional Treatment Center	**RN**	Registered Nurse
DM	Diabetes Mellitus	**Rx**	Prescription
DOT	Directly Observed Therapy (in taking medications)	**SNF**	Skilled Nursing Facility
Dx	Diagnosis	**SOAPE**	Subjective, Objective, Assessment, Plan, Education
EKG	Electrocardiogram	**SOMS**	Strategic Offender Management System
ENT	Ear, Nose and Throat	**S/P**	Status post
ER	Emergency Room	**TB**	Tuberculosis
eUHR	electronic Unit Health Record	**TTA**	Triage and Treatment Area
FTF	Face-to-Face	**UA**	Urinalysis
H&P	History and Physical (reception center examination)	**UM**	Utilization Management
HIM	Health Information Management	**LPT**	Licensed Psychiatric Technician

OBJECTIVES, SCOPE, AND METHODOLOGY

In designing the medical inspection program, the OIG reviewed CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. The OIG also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the Receiver's office, CDCR, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of the OIG's inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates medical care delivery by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each State prison, the OIG identified 14 primary (clinical) and 2 secondary (administrative) quality indicators of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to inmate-patients, whereas the secondary quality indicators address the administrative functions that support a health care delivery system. The 14 primary quality indicators are *Access to Care*, *Diagnostic Services*, *Emergency Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Prenatal and Post-Delivery Services*, *Preventive Services*, *Quality of Nursing Performance*, *Quality of Provider Performance*, *Reception Center Arrivals*, *Specialized Medical Housing (OHU, CTC, SNF, Hospice)*, and *Specialty Services*. The two secondary quality indicators are *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*.

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for both of the secondary quality indicators are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

Consistent with the OIG's agreement with the Receiver, the report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of an inmate-patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential

medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

In all areas, the OIG is alert for opportunities to make appropriate recommendations for improvement. Such opportunities may be present regardless of the scoring awarded to any particular quality indicator; therefore, recommendations for improvement should not necessarily be interpreted as indicative of deficient medical care delivery.

CASE REVIEWS

The OIG has added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders. At the conclusion of Cycle 3, the federal Receiver determined that the health care provided at the institutions was not fully evaluated by the compliance tool alone, and that the compliance tool was not designed to provide comprehensive qualitative assessments. Accordingly, the OIG added case reviews in which OIG physicians and nurses evaluate selected cases in detail to determine the overall quality of health care provided to the inmate-patients. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

Because retrospective chart review is time-consuming and requires qualified health care professionals to perform it, OIG clinicians must carefully sample patients. Accordingly, the group of patients the OIG targeted for chart review carried the highest clinical risk and utilized the majority of medical services. A majority of the patients selected for retrospective chart review were classified by CCHCS as high-risk patients. The reason the OIG targeted these patients for review is twofold:

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 9 percent of the total patient population considered high-risk account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

2. Selecting this target group for chart review provides a significantly greater opportunity to evaluate all the various aspects of the health care delivery system at an institution.

Underlying the choice of high-risk patients for detailed case review are three assumptions:

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Such an analysis requires clinical expertise and is, therefore, provided by experienced correctional physicians and registered nurses.

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

3. Patient charts from death reviews, sentinel events (an unexpected occurrence involving death or serious injury, or risk thereof), and hospitalizations are mostly of high-risk patients.

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

Because the selected patients utilize the broadest range of services offered by the health care system, the OIG's retrospective chart review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective chart review provides an accurate qualitative assessment of the relevant primary quality indicators as applied to the targeted subpopulation of high-risk and high-utilization patients. While this targeted subpopulation does not represent the prison population as a whole, the ability of the institution to provide adequate care to this subpopulation is a crucial and vital indicator of how the institution provides health care to its whole patient population. Simply put, if the institution's medical system does not adequately care for those patients needing the most care, then it is not fulfilling its obligations, even if it takes good care of patients with less complex medical needs.

Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of conclusions from the retrospective chart reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly-controlled diabetes, one cannot conclude that the entire diabetic population is inadequately controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes and require significant specialty interventions, one cannot conclude that the entire diabetic population is having similarly poor outcomes.

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those

services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

CASE REVIEWS SAMPLED

For CCC case reviews, OIG clinicians evaluated medical charts for 76 unique inmate-patients. Of those, 18 patients were reviewed by both nurses and physicians, totaling 94 reviews. This generated 1,056 clinical events for review (Appendix B-3). Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 23 charts, totaling 53 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 41 inmate-patients. Because of the high-risk, complex patients selected, most case reviews identified multiple chronic care diseases, and most involved review of many health care processes and programs.

The reporting format provides details on whether the encounter was adequate or had significant deficiencies. Further, the deficiencies are identified by programs and processes to help focus the institution on improvement areas. While the sample method (*Appendix B, Table B–1*) specifically pulled only four chronic care patient records (four diabetes patients), the 76 unique inmate-patients sampled included patients with 123 chronic care diagnoses, including four additional patients with diabetes (*Appendix B, Table B–2*). Many chronic care programs were evaluated with the OIG's sample selection tool because the complex and high-risk patients selected from the different categories often had multiple medical problems. While not every chronic disease or health care staff member was evaluated, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the OIG's pilot inspections have shown that most providers have been adequately reviewed. The case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing PCPs care for the less complicated, low-utilizing, and lower-risk patients. The OIG concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate *Confidential—Supplemental Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling

methodologies and counts, see *Appendix B: Sample Sets, Table B–1*; *Chronic Care Diagnoses, Table B–2*; and *Event—Program, Table B–3*, and *Case Review Sample Summary, Table B–4*.

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From March to May 2015, deputy inspectors general obtained answers to 91 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. The inspectors conducted these tests by reviewing individual inmate-patients' electronic health records and conducting an onsite inspection of CCC during the week of March 30, 2015. In total, inspectors reviewed health records for 359 inmate-patients and inspected various transactions within their records for evidence that critical events occurred. During the onsite inspection, field inspectors conducted detailed inspections of the institution's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents.

For details of the compliance results, see *Appendix A—Compliance Test Results*. For details of the OIG's compliance sampling methodology, see *Appendix C—Compliance Sampling Methodology*.

SCORING OF COMPLIANCE TESTING RESULTS

The OIG rated the institution in the following nine primary (clinical) and two secondary (administrative) quality indicators applicable to the institution for compliance testing:

- Primary indicators: *Access to Care*, *Diagnostic Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Preventive Services*, *Specialized Medical Housing*, and *Specialty Services*.

- Secondary indicators: *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*.

After compiling the answers to the 91 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient*, *adequate*, or *inadequate*.

DASHBOARD COMPARISONS

For some of the individual compliance questions, the OIG identified where similar metrics were available within the CCHCS Dashboard. The OIG compared OIG compliance test results with the institution's Dashboard and reported on that comparative data under various applicable quality indicators within the *Medical Inspection Results* section of this report.

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

The OIG derived the final rating for each quality indicator by combining the ratings from the case reviews and from the compliance testing, as applicable. When combining these ratings, the case review evaluations and the compliance testing results usually agreed, but there were instances when the rating differed for a particular quality indicator. In those instances, the inspection team assessed the quality indicator based on the collective ratings from both components. Specifically, the OIG clinicians and deputy inspectors general discussed the nature of individual exceptions found within that indicator category and considered the overall effect on the ability of patients to receive adequate medical care.

To derive an overall assessment rating for the institution's medical inspection, the OIG evaluated the various rating categories assigned to each of the quality indicators applicable to the institution, giving more weight to the rating results for the primary quality indicators, which directly relate to the health care provided to inmate-patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

The OIG identified a subset of HEDIS measures applicable to the CDCR inmate-patient population. To identify outcomes for CCC, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained CCC data from the CCHCS Master Registry. The OIG compared those results to metrics reported by other State and federal agencies.

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page ii of this report, 12 of the OIG's primary indicators were applicable to CCC. Of those 12 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 2 were rated by the compliance component alone.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to CCC. For these ten indicators, none were *proficient*, two were *adequate*, and eight were *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, one was *proficient*, 17 were *adequate*, and 12 were *inadequate*. For 1,056 events reviewed, there were 429 deficiencies, of which 98 were considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Adverse Events Identified During Case Review: Medical care is a complex dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identifies adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing conclusions regarding the institution's delivery of medical care based solely on adverse events.

There were two significant adverse events for one patient identified in the case reviews. These events were illustrative of the types of problems identified at CCC.

- In case 1, the patient was seen by a provider for follow-up after a hospitalization. The patient, who had an extensive smoking history, had been recently complaining of episodes where he had coughed up blood (hemoptysis). The CT scan from the hospital indicated the presence of a lung nodule. The provider did not thoroughly review the record to determine the severity of the hemoptysis, which several nurses had documented in the weeks prior. Because the provider only conducted a cursory review of the CT report, the provider misinterpreted the CT scan as normal. The patient was not referred to a pulmonary specialist for possible lung cancer.

- The error was duplicated at the next encounter by a different provider. This provider apparently failed to perform an independent review of the medical record and CT scan. The provider repeated the same mistaken assessment of the earlier provider who made the initial

error. When the CT scan was finally reviewed appropriately, the pulmonary consult was not ordered with a high priority. These oversight errors caused a significant delay in care. Fortunately, the lesion had not changed in size with repeat radiology examinations, suggesting a healed scar from prior infection. However, it will need two years of follow-up to exclude cancer.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to CCC. For these nine indicators, OIG inspectors rated two *proficient*, four *adequate*, and three *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

Case Review Rating:
Inadequate
Compliance Score:
81.7%

Overall Rating:
Inadequate

This indicator evaluates the institution's ability to provide inmate-patients with timely clinical appointments. Areas specific to inmate-patients' access to care are reviewed, such as initial assessments of newly arriving inmates, acute and chronic care follow-ups, face-to-face nurse appointments when an inmate-patient requests to be seen, provider referrals from nursing lines, and follow-ups after hospitalization or specialty care. Compliance testing for this indicator also evaluates whether inmate-patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Results

The Office of the Inspector General clinicians reviewed 538 provider and nursing encounters and found 30 deficiencies related to access to care, of which 18 were significant. While the vast majority of appointments were kept as scheduled, many of the deficiencies were of such magnitude that poor health care access contributed significantly to the *inadequate* rating of six clinical cases.

Provider Follow-up Appointments

Provider-ordered follow-up appointments are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care, or can even result in patients being lost to follow-up. The OIG clinicians reviewed 258 outpatient provider encounters and found 22 deficiencies, 13 of which were significant.

- In case 88, the patient was being routinely monitored for his diabetes, hypertension, and hepatitis C. The failure to carry out a provider's follow-up order resulted in the patient being lost to follow-up. He finally presented with out-of-control diabetes and a severe dental

infection requiring OHU admission, intravenous antibiotic treatment, and extraction of two teeth.

- In case 38, the patient had poorly-controlled asthma. The provider ordered a 30-day follow-up interval, which did not occur. The patient was not seen by a provider until after he had been hospitalized for chest pain (likely related to asthma) and evaluated by a pulmonary specialist.

- In cases 42 and 86, the provider ordered a follow-up appointment after reviewing abnormal labs, but the follow-up appointment did not occur. This type of access failure is a severe deficiency that greatly increases the risk of patient harm, as abnormal labs often need to be addressed by the provider during a face-to-face encounter.

RN-to-Provider Referrals

Nurses performing sick call assessments are required to refer the patient to a provider when situations arise that require a higher level of evaluation. There were 143 outpatient-nursing encounters reviewed. While only three deficiencies were identified where the provider appointment did not occur timely, two of them constituted significant deficiencies.

- In case 1, the patient saw the nurse for complaints of chest pain and shortness of breath that occurred while running. He described the feeling as being "like my chest is going to explode," and "like I'm going to pass out." The patient was ordered to have a follow-up appointment in five days, but was seen in nine days. This failure increased the medical risk for a patient who was experiencing potentially life-threatening symptoms.

- In case 42, in light of his poorly controlled diabetes, the patient wanted to be started on a type of insulin that had been working for him prior to his incarceration. The nurse referred the patient to the provider, but the appointment did not occur for six weeks, which contributed to a significant delay in care.

Provider Follow-Up After Specialty Service

Patients were generally seen by a provider to follow up on specialty services. At least 124 diagnostic and consultative specialty services were reviewed; only two deficiencies were identified, neither of which was significant.

Intra-System Transfers

Patients who were transferred into CCC and were referred by the RN to the provider were generally seen timely. Eleven transfer-in events were reviewed, of which eight patients were referred to the provider. One of the eight referred patients was not seen by a provider timely.

Follow-up After Hospitalization

Patients were almost always seen by a provider after return from a hospital or an emergency department. Twenty-nine hospital or outside emergency department events were reviewed; zero deficiencies were identified with provider follow-up in those cases.

Urgent/Emergent Care

Patients were generally seen by a PCP after being evaluated in the triage and treatment area (TTA). At least 37 urgent/emergent encounters were reviewed; zero deficiencies were identified.

Specialized Medical Housing

Patients in the OHU (outpatient housing unit) were generally seen by a provider frequently and well within the 14-day minimum policy requirement. There were 26 OHU admissions with 80 OHU provider encounters reviewed. As discussed below, two deficiencies were identified, both of which were significant.

- In case 19, the patient had severe right leg pain, low-grade fever, and cellulitis. The patient had an ultrasound examination at an outside community hospital, but was not seen by a provider for another 15 days.

- In case 1, the patient was kept in the OHU overnight following discharge from a local community hospital. While a provider wrote admission and discharge orders, the patient was not actually seen by a provider for the OHU stay.

Specialty Access

Access to specialty services is discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

OIG clinicians interviewed CCC staff regarding the majority of access deficiencies identified in case review. The majority of the deficiencies were due to lack of provider availability. CCC currently has one open physician vacancy. Two additional physicians are currently on long-term sick leave. Most provider staff have accumulated large leave balances in excess of several months that will eventually be used to take time off work, which will cause additional staffing challenges.

Scheduling errors were another reason for missed appointments. In addition, several cases were identified where custody staff returned patients to their housing units before being seen by the provider because they had been waiting for a significant length of time (typically more than four hours). In the past few months, CCC has embarked on a quality improvement initiative for scheduling with extensive training in the scheduling system (MedSATS) in an effort to reduce scheduling errors and improve scheduling efficiency.

Clinician Summary: *Access to Care*

Access to care appears to be a significant problem at CCC. Although the total numbers of deficiencies in this category were small, the relative impact was quite large. In particular, there were serious problems with provider-ordered follow-up appointments following outpatient encounters or abnormal labs. These problems played a significant role in the inadequacy rating of six case reviews. Additionally, there were occasional lapses in access for nurse-to-provider referrals, intra-system transfers, and OHU follow-ups that were potentially dangerous. The most significant reason for the poor *Access to Care* rating is the lack of provider availability, though small improvements in scheduling efficiency and custody performance would likely improve the rating.

Compliance Testing Results

The institution received an overall score of 81.7 percent in the *Access to Care* indicator, scoring well in some areas, as described below:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all five housing units inspected, receiving a score of 100 percent for this test (MIT 1.101).

- All eight inmate-patients who were referred to and seen by a PCP, and for whom the PCP determined a follow-up appointment was necessary (100 percent), received a timely follow-up visit within the PCP's ordered time frame (MIT 1.006).

- Inspectors sampled 32 Health Care Services Request forms (CDCR Form 7362) submitted by inmate-patients across all facility clinics. As documented on the service request form, for all but one patient (97 percent), nursing staff reviewed the request form on the same day it was received. The nurse neglected to sign the service request form for one patient (MIT 1.003). Similarly, nursing staff completed a timely face-to-face patient encounter with all but one of the patients sampled (97 percent). Inspectors were unable to locate an encounter form in the eUHR for one patient, and the nurse had not documented the encounter on the service request form (MIT 1.004).

The institution scored within the *adequate* range for the following tests:

- Inmate-patients who transferred into CCC from other institutions and were referred to a PCP for a routine appointment based on nursing staff's initial health care screening were not always seen timely by a PCP. Of the 27 patients sampled, 21 (78 percent) received a timely appointment. Four patients were seen from one to 15 days late, and two other patients were seen 37 and 85 days late, respectively (MIT 1.002).

- Inspectors also sampled 30 inmate-patients who had received a specialty service and found that 25 of them (83 percent) received a timely follow-up appointment with a PCP. Four

exceptions related to patients' high-priority specialty service follow-up appointments that ranged from one to ten days late. One other exception related to a patient's routine specialty service follow-up appointment that was held timely but in which the provider did not discuss the specialty service results with the patient (MIT 1.008).

The institution scored within the *inadequate* range and needs significant improvement in the following areas:

- Of the nine sampled inmate-patients who had been discharged from a community hospital, only four (44 percent) received or were offered a follow-up appointment with a PCP within five days of discharge. Four of the inmate-patients were seen from one to three days late, and one was seen nine days late (MIT 1.007).

- The OIG reviewed recent appointments for 30 inmate-patients with one or more chronic care conditions and found that only 19 (63 percent) received timely follow-up appointments. In fact, six of the follow-up appointments were held two or more months late, and four appointments did not occur at all (MIT 1.001).

- For 18 of the Health Care Service Request forms sampled where the nursing staff referred the inmate-patient for a PCP appointment, only 13 of the patients (72 percent) received a timely appointment. For three patients, the routine appointments occurred from two to six days late, and for one other patient, inspectors found no evidence that the routine appointment occurred at all. Another inmate-patient received a timely appointment, but the condition for which the nurse referred the inmate-patient to be seen was not discussed by the PCP (MIT 1.005).

CCHCS Dashboard Comparative Data

The Dashboard uses the average of nine medical access performance measures to calculate the score for access to medical services. The OIG compared similar CCC compliance scores with that Dashboard average score.

As noted in the table below, the OIG test results were based on a review of current documents as well as documents dating up to 14 months back; CCC's March Dashboard data reflected only the institution's February 2015 results. Regardless of the disparity in the sampling review period, both the Dashboard's and the OIG's scores were in the *adequate* range overall.

Access to Care—CCC Dashboard and OIG Compliance Results

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Scheduling & Access to Care: Medical Services March 2015	*Access to Care* (1.001, 1.004, 1.005, 1.007) *Diagnostic Services* (2.001, 2.004) *Specialty Services* (14.001, 14.003) March 2014–April 2015
83%	**82%**

Note: The CCHCS Dashboard data includes access to care for inmate-patients returning from CDCR inpatient housing units and emergency departments. The OIG does not specifically test follow-up appointments for these patients.

Recommendations

- The California Correctional Center and CCHCS should work collaboratively to fill vacant positions with high-quality physician staff and quickly resolve issues with non-productive providers who are on extended leave.

- The institution's management should monitor excessive accumulated time off, and if necessary mitigate any impact on future *Access to Care*. CCC can gain further efficiency through the reduction of scheduling errors. Collaboration with custody is necessary to prevent lost appointments due to the custody practice of returning patients back to housing due to excessive wait time.

- CCC's quality management team should review the occasional lapses in access to care identified in RN to provider referrals, intra-system transfers, and OHU provider access to determine if further training or process improvement is necessary to prevent their recurrence.

- The institution must take steps to ensure that providers conduct timely appointments for inmate-patients who transfer into CCC and those who receive RN referrals to see a provider.

- When inmate-patients receive a specialty service, providers should conduct a follow-up appointment within 3 business days for an urgent service or 14 days for a routine service.

- CCC providers must conduct a follow-up visit within five calendar days for all inmate-patients who are discharged from a community hospital, or sooner if ordered by a clinician.

- The institution should ensure that inmate-patients who suffer from chronic care conditions receive routine follow-up appointments within the required time frame, as dictated by the patient's chronic condition and the provider's follow-up orders.

- Inmate-patients who are referred to a provider after a nurse encounter must receive the provider visit within the nurse's ordered time frame.

DIAGNOSTIC SERVICES

Case Review Rating:
Inadequate
Compliance Score:
78.6%

Overall Rating:
Inadequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to inmate-patients, whether the primary care provider (PCP) timely reviewed the results, and whether the results were communicated to the inmate-patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the PCP timely reviewed and communicated the pathology results to the inmate-patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic test(s) ordered and the clinical response to the results.

Case Review Results

Office of the Inspector General clinicians reviewed 147 diagnostic-related events and found 82 deficiencies, 20 of which were considered significant. Of those 82 deficiencies, 73 were related to health information management and 9 related to the non-completion of ordered tests. Within health information management, test reports that were never retrieved or reviewed were considered just as severe of a problem as tests that were not completed as ordered.

When diagnostic services were successfully completed, they were performed timely. When reports were available, they were mostly reviewed timely by a provider. Patients were notified of the test

results quickly. Pathology reports were rarely encountered during case review, but those that were reviewed were generally retrieved and reviewed timely. No deficiencies were found with regard to completion of x-ray services.

In multiple cases, laboratory tests (predominately blood tests) were not performed when ordered by a provider. Case review found nine deficiencies across seven patients for whom diagnostic studies were ordered but were not processed.[2]

- Diagnostic tests ordered but not performed were found in cases 3, 37, 41, 46, 56, 86, and 88. These deficiencies were considered very significant.

In addition to the general unreliability of completing diagnostic laboratory tests, CCC also had significant problems with health information management related to those services.

- Diagnostic tests for the case reviews were sometimes processed; however, the reports were never retrieved, reviewed by a provider, or even placed in the medical record. This severe deficiency was found in cases 1, 23, 37, 39, 44, and 88, and was even repeated on separate occasions in cases 23 and 44.

- Electrocardiogram (EKG) results often were not communicated back to the patient. This deficiency was found in cases 1, 2, 41, 44, 46, 48, and 88.

- Pulmonary function testing (PFT) was reviewed in cases 1 and 35, but the patient was not notified of the test result in either case.

- Delays in provider review of diagnostic reports were uncommon but were identified in cases 1, 4, 5, 16, 39, 46, 58, and 59. Most of these delays were minor and inconsequential, but significant delays in the review of reports were identified in cases 1, 4, and 39.

- Illegible initials or signatures on diagnostic reports were found throughout the inspection.

- Diagnostic reports examined throughout the inspection failed to include a date on which they were reviewed.

Because of the high number of improperly processed laboratory orders and failures to retrieve completed diagnostic reports, diagnostic testing at CCC is considered unreliable overall by the OIG. These failures are the major reasons for this indicator's *inadequate* rating.

[2] These findings may seem contradictory to the compliance findings in MIT 2.001 and MIT 2.004 due to testing methodology. Compliance testing begins with the completed test and tests backward, whereas case review begins with the physician order and tests forward.

Clinician Onsite Inspection

During the onsite inspection, CCC's laboratory personnel were interviewed. The staff identified problems with the completion and retrieval of laboratory tests that had occurred in prior months. The inspection identified factors that contributed to the problems, which included staffing difficulties as well as laboratory provider service issues. A lack of a tracking system allowed some lab test results not to be followed up on. In response to these identified issues, laboratory personnel have implemented a tracking system to ensure that all ordered tests are completed and all reports are retrieved. During the onsite inspection, leadership at the institution communicated to the OIG clinicians that these deficiencies have improved with the new tracking system. CCC's recent focus on quality improvement bodes well for subsequent medical inspections in the area of *Diagnostic Services.*

Compliance Testing Results

The institution received an overall score of 78.6 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below.

Radiology Services

- OIG inspectors found that for all ten of the radiology services sampled (100 percent), the service was timely performed and the test results were timely communicated to the inmate-patient (MIT 2.001, 2.003). However, providers initialed and dated the radiology report to evidence that they had timely reviewed the final radiology results report within two business days of receipt for only four of those ten patients (40 percent) (MIT 2.002). For five patients, the provider did not initial and date the report at all; for one other patient, the provider did not review the report results timely.

Laboratory Services

- Nine of ten laboratory services orders sampled (90 percent) were performed timely. The one exception was a routine laboratory services order for which the diagnostic test results were provided five days late (MIT 2.004). However, only seven of those ten diagnostic test result reports (70 percent) showed evidence that the provider reviewed the report within two business days of receipt. For two of the reports, the provider initialed the report but did not date it; one other report as not initialed at all (MIT 2.005). In addition, providers timely communicated test results to the patient for eight of the ten samples (80 percent). For two patients, the provider communicated the laboratory test results one day late (MIT 2.006).

Pathology Services

- The institution received and documented the final pathology report in the eUHR for only seven of ten inmate-patients sampled (70 percent), and the provider timely reviewed the pathology results for six of those seven patients (86 percent). One provider initialed the final report but failed to date it (MIT 2.007, 2008). Further, providers communicated the final pathology results to only five of those seven inmate-patients (71 percent). For two patients, the provider communicated the pathology results one and two days late, respectively (MIT 2.009).

Recommendations

- The institution's recently implemented quality control process should be extended to ensure that all diagnostic tests (laboratory, x-ray, EKG, and PFT) are consistently processed, and that providers retrieve and review the reports, communicate the results back to the patient, and place the report into the medical record. Specifically, CCC providers need to communicate laboratory and pathology test results to the inmate-patient within two business days of receiving the results, through either a Form 7293 or a face-to-face encounter.

- Providers with illegible initials or signatures should use their name stamps and document the date on each diagnostic report after it has been reviewed. Providers must review radiology and laboratory reports within two business days of receipt.

- Providers should track their requests for pathology services and follow-up when final pathology reports are not timely received from outside entities.

EMERGENCY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on a patient's emergency situation, clinical condition, and need for higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice.

The OIG evaluates this quality indicator entirely through clinicians' reviews of case files. There is no separate compliance testing component associated with this indicator.

Case Review Results

The OIG clinicians reviewed over 70 urgent/emergent events and found 39 deficiencies, mainly in the area of nursing care. These minor deficiencies did not significantly affect patient care. In general, CCC performed well with emergency response times, BLS care (no CPR events occurred during the review), and 9-1-1 call activation times. Overall, despite the deficiencies noted, the case reviews showed that patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed.

Provider Performance—Emergency Services

The triage and treatment area (TTA) provider generally saw patients timely and made adequate assessments. Triage decisions were sound, and patients were sent to the appropriate levels of care. The OIG identified two deficiencies with emergency provider care; neither was considered significant. The quality of provider care in the *Emergency Services* indicator was good.

Nursing Performance—Emergency Services

Emergency services nursing deficiencies often related to inadequate documentation. According to the American Nurses Association (2010), nursing documentation entries must be accurate, valid, complete, authenticated (truthful), dated and timed, and legible, and they must contain standardized terminology. One of the essential principles of basic nursing practice is that anything not documented is considered not done. Based on these important standards, the OIG clinicians found the TTA nursing documentation incomplete, disorganized, and illegible, with little evidence that adequate nursing care was provided. Extremely poor nursing documentation resulted in an *inadequate* rating for this section. The following cases were examples of these case review findings:

- Case 1 involved a patient with chest pain. The medical responder documented that the onset of pain was three days ago, but the TTA RN documented the onset as only three hours. The TTA RN did not document the number of nitroglycerin pills the patient had already taken, the number of pills administered in the TTA, the time that the EKG was completed, or the intravenous line infusion rate. The patient later told the physician in the community hospital emergency department that he had taken two nitroglycerin pills on his own, and was given one more while in the CCC TTA prior to coming to the hospital.

- In case 2, the patient complained of chest pain. The LVN medical responder documented the pain level was "7" on a 1 to 10 severity scale (7/10), radiating, and with onset at 6:00 p.m. The TTA RN documented the pain level was 6/10, with radiation to the left arm, and with onset at 5:00 p.m. The LVN medical responder did not document any vital signs or the oxygen saturation level for this patient. In fact, vital signs were not documented until 32

minutes after clinical staff received notification of this symptomatic patient. In addition, the RN did not document the time oxygen was initiated.

- In case 5, the patient sustained head trauma during an altercation. The TTA RN did not document the type or nature of the head injury. The nurse's handwriting was illegible.

- In case 35, the patient complained of neck pain after an altercation. The TTA RN did not document a timeline of nursing assessments and interventions. The nurse failed to document the timeline for provider notification and monitoring of neurological checks for the patient, with cervical spine precautions. The nurse's handwriting was illegible.

- In case 38, the patient complained of shortness of breath. The medical responder did not document an initial assessment of respiratory status. The TTA RN also did not document assessment of respiratory status after administering a breathing treatment nor reassess the patient's vital signs nor document a clear timeline of nursing assessments and interventions. The nurse's handwriting was illegible.

- In case 39, the patient presented with a rapid pulse, shortness of breath at rest, and pain with deep breaths. The RN delayed administering oxygen for almost one hour after arrival in the TTA. After the initial assessment of symptoms, the RN did not document a subjective reassessment of the patient's breathing or pain status although the RN did regularly reassess the respiratory rate and oxygen saturation level. The RN did not document a clear timeline of other nursing assessments and interventions or patient status for the three-hour TTA encounter; specifically, the RN failed to document the time of the EKG, PCP notification, and ambulance arrival.

- In case 42, the patient was seen for an allergic reaction; he developed rash and hives after eating peanut butter. The TTA RN failed to clearly document the time the patient arrived and departed from the TTA, the route and location of the administered medications (Benadryl and Solumedrol), and the patient's tolerance of and response to treatment.

- Also in case 42, at a different TTA encounter, the patient was seen for a shoulder injury sustained during a riot on the yard. He was found to have very high finger-stick blood glucose of 439. The RN administered 10 units of regular insulin as ordered by the PCP, but failed to recheck the blood glucose level or advocate for the patient to be monitored for a period of time in the TTA or OHU. Instead, the patient was released to housing without having his blood glucose level rechecked.

Patient Care Environment

Two isolated deficiencies were identified during the case review, but no pattern was identified. However, the following deficiencies can be used for quality improvement purposes:

- In case 3, a patient experiencing chest pain had a 15-minute delay between onset of the incident and notification of health care staff. The first responder did not assess or document vital signs. The Emergency Medical Response Review Committee (EMRRC) did not address the medical concerns during incident review.

- In case 1, custody staff failed to document ambulance sally port entry and exit times.

Onsite Clinician Inspection/Patient Care Environment

During the onsite visit, OIG clinicians found the patient care environment in the TTA to be adequate with two patient bays. The TTA and the OHU are side by side and share nursing staff, often with nurses freely "floating" between the two areas to assist with patient care during busy times and when otherwise needed. On first watch, there are two RNs in the TTA, one serving as medical responder rover, and one LVN covering the OHU with backup supervision by the TTA RN. During second watch, one RN and one LVN are in the OHU and two RNs (one as rover) are in the TTA. On third watch, there are two TTA RNs (one as rover), one LVN in the OHU, and the RN house supervisor. Interviews with both the TTA and the OHU RNs demonstrated a close working relationship and readily available supportive backup that occurs between the two units when needed. Nursing staff also expressed their appreciation of good working relationships with providers and custody staff.

Clinician Summary: Emergency Services

Problems with nursing documentation were so severe that the OIG clinicians could not score this indicator with a passing rating despite good performance by providers, who saw patients timely and made good triage decisions. Good provider performance could not override the inadequate performance of the TTA nurses. Therefore, the overall clinical case rating for this indicator is *inadequate*.

Recommendations

Nursing documentation should be improved by implementing the following:

- Require supervisors to ensure that TTA nurses produce accurate and legible documentation. Nursing notes should contain complete nursing assessments and all medical interventions, including the exact time they were performed.

- Require that nursing documentation include timely assessment and reassessment of the patient's status, the patient's responses to medical intervention, and all contacts or notifications made on the patient's behalf. Since the OHU and TTA share nursing staff, similar concerns and recommendations are also addressed in the *Specialized Medical Housing* indicator.

CCC should take the following actions to further improve the quality of nursing documentation:

- Audit the frequency and quality of nursing assessments, interventions, and documentation.
- Develop TTA-specific nursing expectations and ensure all nurses are trained.
- Ensure the times of all custody and ambulance notifications, arrivals, and departures are recorded.
- Ensure patients are regularly assessed and their care is documented up to their departure.
- Ensure EMRRC data is accurately represented.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
59.7%

Overall Rating:
Inadequate

Health information management is a crucial link in the delivery of medical care. Medical personnel require accurate information in order to make sound judgments and decisions. This indicator examines whether the institution adequately manages its health care information. This includes determining whether the information is correctly labeled and organized and available in the electronic Unit Health Record (eUHR); whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the inmate-patient's eUHR; whether records routed to and signed off on by clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

Case Review Results

Hospital Records

- Most hospital records were eventually retrieved, reviewed, and scanned into the eUHR. However, of the 27 hospitalizations or emergency department events reviewed, only 10 events were retrieved, reviewed, and timely scanned.

- The most severe deficiencies occurred when hospital records, especially discharge summaries, were not retrieved and were missing from the eUHR. These types of records contain the most vital information for the continuity of care between inpatient and outpatient settings. In cases 1, 4, and 44, discharge summaries were not retrieved or found in the eUHR.

- Similarly, hospital records retrieved late could place a patient at elevated medical risk. Late record retrieval increases the risk that those records are not available for the PCP to review at the time of the hospital follow-up appointment. This deficiency occurred in cases 18, 35, 38, and 40.

- Many hospital records were not properly initialed by a provider to indicate they were appropriately reviewed. This deficiency occurred in cases 18, 19, 37, and 38.

- Many hospital records were not dated by a provider to document when the report had been reviewed. This deficiency occurred in cases 3, 17, 18, 19, 37, and 38.

Scanning Performance

- Most delays in scanning were due to provider delays in document review. Once reviewed by a provider, all reports were generally scanned within an adequate time frame.

- Mistakes were identified in the document scanning process (mislabeled or misfiled documents). Erroneously scanned documents can greatly hinder providers' ability to find relevant clinical information. In addition, if a provider takes action for one patient based on another patient's report, there is potentially severe consequences. Case reviewers found mislabeled documents in the eUHR in cases 4, 19, and 85. Misfiled documents (filed in the wrong chart) were found in cases 19 and 40.

Specialty Services Reports

- OIG clinicians found significant problems in the retrieval and review of specialty reports. These findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

- OIG clinicians found significant problems in the retrieval and review of diagnostic reports. These findings are discussed in detail in the *Diagnostic Services* indicator. Furthermore, EKG and pulmonary function tests (PFT) results were often not communicated back to the patient.

Legibility

- Illegible progress notes, signatures, or initials were found throughout the review from some of the physician providers. Illegible progress notes pose a significant medical risk to patients, especially when other staff must review past medical care or when a patient is transferred to a different care team.

- Providers often neglected to document a date on a report after it was reviewed. This was found throughout the inspection.

Clinician Summary: Health Information Management

CCC had several health information management processes in place that need improvement. While most hospital records were retrieved, many were retrieved late. Significant problems with diagnostic and specialty reports were also found, as discussed further in their respective indicators. While scanning times (after delayed provider review) were adequate, scanning accuracy (i.e. correctly labeled and filed) was not acceptable. In addition, providers did not consistently initial and date the reports they reviewed. Because of the multitude of problems with report handling at CCC, this indicator was rated *inadequate*.

Compliance Testing Results

The institution received an overall score of 59.7 percent in the *Health Information Management (Medical Records)* indicator and needs to improve in the following areas:

- The institution scored 0 percent in its labeling and filing of documents scanned into inmate-patients' electronic Unit Health Records. The most common errors were medication administration records (MARs) labeled with the incorrect month and various health care documents labeled with an incorrect document type (MIT 4.006).

- Only 9 of 32 samples of various medical documents (28 percent), such as hospital discharge reports, initial health screening forms, certain medication records, and specialty service reports, showed compliance with clinical staff having legibly documented their names on the forms (MIT 4.007).

- The OIG reviewed hospital discharge records for nine sampled inmate-patients who were sent or admitted to the hospital. The community hospital discharge records were complete and had been timely reviewed by a CCC provider for only six of the nine patients (67 percent). For two patients, the discharge report did not include all required elements; one report did not include the patient's discharge medications and another did not include the patient's date of discharge. For another patient, there was no evidence that a CCC provider had reviewed the hospital discharge report (MIT 4.008).

- Community hospital discharge reports or treatment records were not always scanned into the inmate-patient's eUHR within three calendar days of the hospital discharge. Seven of the nine sampled reports (78 percent) were timely scanned. However, reports for two patients were scanned 3 and 55 days late (MIT 4.004).

- The OIG also tested specialty services reports and MARs to determine if the institution timely scanned the documents into the eUHR. Fifteen of 20 sampled specialty reports (75 percent) and 15 of 20 sampled MARs (75 percent) were timely scanned. Five specialty reports were scanned one or two days late, and five MARs were scanned from one to ten days late (MIT 4.003, 4.005).

The institution performed well in its scanning of the following health care documents:

- Miscellaneous non-dictated documents, including providers' progress notes and inmate-patients' initial health screening forms and requests for health care services, were scanned timely. Specifically, inspectors found that 19 of the 20 documents sampled (95 percent) were appropriately scanned into the patient's eUHR within three calendar days of the inmate-patient's encounter. For one patient, a provider's progress note was scanned two days late (MIT 4.001).

CCHCS Dashboard Comparative Data

As shown below, for two of the three applicable comparative measures, the OIG's compliance results for CCC were inconsistent with the March 2015 CCC Dashboard results. The OIG test results were based on a review of current documents as well as documents dating up to nine months back; CCC's March Dashboard data reflected only the institution's February 2015 results. Given these variable time frames, the OIG's compliance scores were only consistent with CCC's Dashboard results for miscellaneous non-dictated documents. For specialty documents and community hospital documents, CCC's Dashboard results were much higher than the OIG's results. For dictated documents, the OIG did not identify any comparable documents during the sample test period from which to make a comparison.

Health Information Management— CCC Dashboard and OIG Compliance Results

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Non-Dictated Medical Documents March 2015	*Health Information Management* (4.001) Non-Dictated Medical Documents July 2014–March 2015
94%	**95%**

Note: The Dashboard results were obtained from the Non-Dictated Documents Drilldown data for "Medical Documents 3 Days."

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Dictated Documents March 2015	*Health Information Management* (4.002) Dictated Documents March 2015 (No dictated documents)
N/A for CCC	**N/A for CCC**

Note: The Dashboard results were obtained from the Dictated Documents Drilldown data for "Medical Dictated Documents 5 Days."

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Specialty Notes March 2015	*Health Information Management* (4.003) Specialty Documents July 2014–December 2014
91%	**75%**

Note: The Dashboard measure includes specialty notes from dental, optometry, and physical therapy appointments, which the OIG omits from its sample.

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Community Hospital Records March 2015	*Health Information Management* (4.004) Community Hospital Discharge Documents August 2014–January 2015
100%	**78%**

Recommendations

- The California Correctional Center should improve its performance in the retrieval and review of hospital, specialty, and diagnostic reports. Providers should demonstrate that reports are timely reviewed by consistently and legibly initialing and dating each report reviewed. The OIG encourages all clinical staff to utilize a name stamp to enhance legibility.

- Providers should review community hospital discharge reports within three calendar days of a patient's discharge. The report and any addendum must include information regarding the admission date, discharge date, nature of events, diagnosis, and discharge medications (if applicable).

- Quality control measures should be strengthened to help ensure the accuracy of health care documents scanned and labeled in the eUHR.

- The institution must ensure that staff scans hospital discharge reports, specialty reports, and MARs into the eUHR within the required time frames.

HEALTH CARE ENVIRONMENT

This indicator addresses the general operational aspects of the institution's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for inmate-patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. For most institutions, rating of this component is based entirely on the compliance testing results from the visual observations inspectors make during their onsite visit at the institution.

Case Review Rating:
Not Applicable
Compliance Score:
52.7%

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an overall score of 52.7 percent in the *Health Care Environment* indicator, and needs to improve in 9 of the 11 test areas, as described below:

- The OIG examined nine clinics at CCC and found that none of the clinics (0 percent) were appropriately disinfected, clean, or sanitary. At all nine clinics, cleaning logs indicated the clinics were not regularly cleaned. The Prison Industry Authority (PIA) supervisor stated that modified programs at the institution negatively affected PIA's ability to clean the clinics properly. Inspectors also found two clinics that had visible dirt and dust on the floor (MIT 5.101).

- Inspectors found that the medical supply management process did not adequately support the needs of the medical health care program. Specifically, in one Conex box storing medical supplies (see Figure 1), temperature sensitive medical supplies such as talcum powder and bandages were stored in the non-temperature-controlled environment, which could lead to premature deterioration. In addition, other medical supplies were found stored directly on the unsanitary ground. As a result, CCC scored 0 percent for this test (MIT 5.106).

Figure 1: Conex box with supplies on the ground

- The OIG inspected exam rooms in the nine clinics to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. Inspectors found that only two of the nine clinics (22 percent) complied with this test; one or more exam rooms in the remaining seven clinics had deficiencies. In three clinics, exam rooms had disorganized supply storage and supply cabinets and medication carts that were not properly labeled. Two clinics had insufficient space in exam areas to conduct a comprehensive examination. In one clinic's exam room, the placement of the exam table did not allow inmate-patients to lie in a fully extended supine position on the table (see Figure 2). The M Yard clinic exam area measured only 89 square feet, which did not allow for unhindered movement within the room and provided insufficient space to place an exam table. Also, the B Yard clinic and the R&R clinic had exam areas that lacked auditory and visual privacy during examinations. Two other clinics were storing confidential medical records designated for destruction in exam rooms that were accessible by inmates (MIT 5.110).

Figure 2: Non-supine exam table without disposable paper

- Clinical health care staff at only four of eight applicable clinics (50 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. Three clinics did not properly log equipment sterilization, and one other clinic did not have paper for the exam table (MIT 5.102).

- When the OIG examined the nine clinics to verify that adequate hygiene supplies were available and sinks were operable, inspectors found operable sinks and sufficient hygiene supplies in only six of the clinics (67 percent). In three clinics, inmate-patient restrooms did not have hand soap or towels (MIT 5.103).

- When the OIG tested the nine clinics' common areas and exam rooms to determine if essential core medical equipment and supplies were present, inspectors found that only five of the clinics (56 percent) were in compliance. Exam rooms in two clinics did not have a biohazard waste bag or receptacle, and one clinic's exam room table had no disposable paper (see Figure 2). Missing items in clinic common areas included Snellen eye charts with permanent distant markers, refrigerators, and glucometer strips. The R&R clinic did not have a nebulization unit, a peak flow meter and tips, or an oto-ophthalmoscope. In addition, neither the M Yard clinic nor the R&R clinic had an exam table (MIT 5.108).

- OIG inspectors observed clinicians' encounters with inmate-patients in eight of the institution's clinics and found that clinicians followed good hand hygiene practices in five clinics (63 percent). Inspectors observed physicians in two clinics who did not properly sanitize their hands before and after patient contact. In another clinic, inspectors observed a clinician and a phlebotomist who did not properly sanitize their hands when changing gloves between patient encounters (MIT 5.104).

- OIG inspectors found six of nine clinics (67 percent) followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. Three clinics had exam rooms with no sharps container (MIT 5.105).

- The institution's common areas at six of nine clinics (67 percent) had an adequate environment conducive to providing medical services. However, common areas in two clinics did not have adequate auditory privacy; one clinic's vital sign triage area was next to the holding cell for patients waiting for their own appointments; another clinic had three nurse triage stations adjacent to each other (see Figure 3). In addition, as seen in Figure 4, there was no waiting area within one other clinic; inmates had to wait outside without adequate protection from inclement weather (MIT 5.109).

Figure 3: No auditory privacy

Figure 4: No protection from inclement weather

The institution performed well in the two areas below:

- In all seven of the clinics where emergency response bags were stored (100 percent), inspectors found that the bags were inspected daily and inventoried monthly, and that they contained all essential items (MIT 5.111).

- Inspectors found that eight of the nine clinics (89 percent) followed adequate protocols for managing and storing bulk medical supplies. However, one clinic had a dirty and disorganized bulk supply storage room, as seen in Figure 5 (MIT 5.107).

Figure 5: Disorganized storage

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure is maintained in a manner that supports health care management's ability to provide timely and adequate health care. This question is not scored and is only collected and reported for informational purposes. Health care management expressed no significant concerns to OIG inspectors during interviews. Further, management indicated that, while the current infrastructure does present some limitations, health care staff work together to mitigate those limitations and none of the infrastructure problems impact the institution's ability to provide adequate health care. The institution does have four significant infrastructure projects underway, including a renovation of the A and B Yard clinics, expansion of the C Yard clinic, a new primary care clinic for the minimum support facility, and the renovation and expansion of the central health services facility. The institution has the following multi-year projects planned for construction from September 2015 to May 2017 (MIT 5.999).

Project A: Renovation of Facilities A and B primary care clinics—renovation area of approximately 4,407 sq. ft.

Project B: Renovation and expansion of Facility C primary care clinic—renovation area of approximately 1,074 sq. ft. and single-story expansion of 880 sq. ft.

Project C: New Minimum Support Facility primary care clinic—single-story stand-alone building of approximately 3,068 sq. ft.

Project D: Renovation and expansion of Central Health Services facility—renovation area of approximately 8,191 sq. ft., and two single-story buildings, expansion of approximately 2,292 sq. ft.

Recommendations

- The institution should work with the PIA to develop a system that ensures clinics are regularly cleaned, even during modified programs. When cleaning clinics, the PIA must ensure that all clinic restrooms are stocked with an adequate quantity of hand soap and disposable towels.

- CCC must ensure that all medical supply storage locations, including Conex boxes, have proper temperature-controlled environments suitable for the item being stored. CCC should also implement policies and procedures that prohibit the storage of medical supplies directly on the ground.

- CCC management must ensure that all clinics include the following items either in the clinic common area or in an exam room: a Snellen eye chart with a permanent distant marker, a refrigerator, glucometer strips, a nebulization unit, a peak flow meter and tips, an oto-ophthalmoscope, and an exam table.

- Institution staff must ensure that clinic common areas maintain auditory and visual privacy for patients being examined or triaged in those areas, and that outdoor clinic waiting areas provide inmate-patients with protection from inclement weather.

- CCC management must ensure that all clinics have exam areas with adequate space, necessary equipment, and sufficient room to conduct comprehensive patient examinations.

- Clinic exam rooms should include the following: supply cabinets and medication carts organized with properly labeled items, a supply of exam table paper, a sharps disposal container, and either bio-hazard bags or a bio-hazard receptacle. Measures should also be implemented to ensure auditory and visual privacy for patients, and security of inmate-patient records so they are not accessible by other inmates.

- Clinical staff must maintain logs to ensure all invasive reusable equipment items are properly sterilized. Clinicians should follow proper hand hygiene protocols at all times, including sanitizing hands before and after contact with an inmate-patient and between glove changes.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Inadequate
Compliance Score:
64.7%

Overall Rating:
Inadequate

This indicator focuses on the management of inmate-patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments (including tuberculosis screening), initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For inmate-patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of CCC to another CDCR facility.

Case Review Results

Forty events were reviewed related to *Inter- and Intra-System Transfers*, involving transfers to and from other CDCR facilities and community hospitals. OIG clinicians reviewed 13 events for inmates transferring out to other CDCR institutions and 11 events for inmates transferring in from

other CDCR institutions. In addition, the OIG reviewed 16 hospitalization events, each of which resulted in a transfer back to the institution. In general, the transfer processes to and from other CDCR institutions were adequate, with the majority of transferring inmates receiving timely continuity of health care services. Unfortunately, significant problems were found with the handling of transfers back from a community hospital. The OIG identified problems similar to those in the *Emergency Services* and *Specialized Medical Housing* indicators, which ultimately resulted in an *inadequate* rating for this indicator.[3]

Transfers In

CCC handled patient transfers from other CDCR institutions well. The receiving nurse properly reviewed incoming patients' transfer forms and referred the patients for appropriate medical services. Only one deficiency was identified in this process, related to *Access to Care*.

- In case 5, the receiving RN referred a patient for a provider follow-up regarding abnormal labs to occur within 14 days. The appointment did not occur until almost five weeks later.

Transfers Out

Deficiencies found with inmates transferring out of CCC were largely due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information form (CDCR Form 7371).

- In case 24, the RN did not document the pending specialty services request (RFS or referral for service) for a routine lumbar spine MRI for chronic lower back pain. This omission occurred despite the RN having access to the information, as the RFS was scanned into the eUHR almost three weeks prior to the transfer out.

- In case 26, the CDCR Form 7371 transfer form was completed seven days before the patient actually transferred out. Transfer forms completed this early risk not documenting current changes in the patient's status and management. The RN did not document the patient's history of intermittent asthma, the RFS for colonoscopy and esophagogastroduodenoscopy, or the patient's refusal of treatment.

- In case 59, the RN filled out a new CDCR Form 7371 for the inmate-patient that failed to include the pending chronic care and telemedicine wound care appointments that had been documented on the previous CDCR Form 7371 dated four days prior.

[3] The OIG case review rating is applicable only to CCC's existing, nursing-only inter- and intra-system transfer processes. The rating is not applicable to the CCHCS systemwide transfer process, which the OIG has significant concerns with and which is discussed in this section.

Hospitalizations

Patients returning from hospitalizations are some of the highest risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer of care. OIG clinicians found significant problems with CCC's hospital return transfer process, specifically nursing performance, medication continuity, and the retrieval and review of hospital records.

The majority of hospital-return patients at CCC were processed by the TTA RN and admitted or placed on "hold" status in the OHU. In general, the assessments by the TTA and OHU RNs after a patient's return from an outside medical facility were inadequate and illegible. The TTA and OHU RNs generally checked the box indicating review of hospital discharge recommendations, and sometimes obtained physician orders to implement the plan of care.

- In case 2, the patient with cervical spinal fractures was admitted as a "hold" in the OHU per orders from the primary care provider (PCP) upon return from the hospital. The TTA and OHU RNs listed "pain control and monitoring" as the reason for OHU admission but failed to address any pain management medications. The OHU RN indicated that there were "no limitations" in mobility or function, despite the fact that the patient was required to wear a cervical neck collar at all times, without exception. The nurse's handwriting was illegible.

- In case 3, the patient returned from a four-day hospital admission for increased platelet count (thrombocytosis) and non-cardiac chest pain. The TTA RN indicated that orders had been obtained from the PCP and noted "see Medication Reconciliation." However, neither written medication orders by the PCP nor verbal telephone orders taken by the RN were found in the eUHR. The patient later received medications without post-hospitalization medication orders.

- In case 4, the patient returned from a community hospital after undergoing an appendectomy for acute appendicitis. The OHU RN documented that the patient had three abdominal incisions but did not describe the specific location on the abdomen and did not assess the condition of the wounds, their type, or the appearance of the wound dressing.

- In case 5, the patient returned from a community hospital with diagnoses of trauma assault, fractured thoracic spine, concussion, and scalp hematomas. The TTA RN circled the head and face area on the body graph but did not adequately document a description or location of the injuries. The RN noted that the patient was only "oriented x1" (oriented only to person) and "slow to respond," but failed to reassess the patient's neurological status. Approximately six hours later, the first watch RN in the OHU noted that the patient was "oriented x4" (to person, date, place, and situation) with slow responses. The handwriting of both the TTA and the OHU RN was illegible.

- In case 17, the patient returned from a community hospital with the diagnosis of a fractured jaw. The TTA RN documented the nursing assessment for a different patient in this patient's medical record. During the onsite visit, the Supervising RN explained this documentation error occurred due to two patients arriving in the TTA at the same time.

- In case 35, the patient returned from community hospital admission with the diagnosis of concussion, and complained of headache (pain level 8 on scale of 1 to 10). The RN documented that the patient had no complaints in the nursing discharge progress notes and referred to an assessment completed earlier. The RN did not document any administration of pain medication or any other treatment or intervention. Again, the nurse's handwriting was illegible.

In addition to poor nursing performance, another major problem identified was that TTA RNs did not follow a medication reconciliation process at the time of a patient's return from outside medical services. The lack of a medication reconciliation process can lead to significant errors in post-hospital medication continuity. This is further discussed in the *Pharmacy and Medication Management* indicator.

There were also significant problems found with the retrieval and review of hospital records. These types of information transfer problems increase the risk for lapses in care. These problems are further discussed in the *Health Information Management* indicator. After return from hospitalization, patients were usually seen by a provider, although not always within five days.

Systemwide Transfer Challenges

In reviewing *Inter- and Intra-System Transfers*, the OIG acknowledges systemwide challenges common to all institutions regarding pending specialty services referrals and reports and the potential for delay in needed follow-up and services. Nurses are responsible for accurately communicating pertinent information, identifying health care conditions that need treatment and monitoring, and facilitating continuity of care during the transfer process. While this is sufficient for most CDCR inmate-patients, it has not been adequate for patients with complex medical conditions or patients referred for complex specialty care. Often, the CDCR Form 7371 transfer forms are initiated by nurses who are not familiar with the patient's care or are not part of the primary care team. In addition, providers are often left out of the transfer process altogether, and patients are transferred without the provider's knowledge. Without a sending and receiving provider, the risk for lapses in care increase significantly. The OIG understands CCHCS is currently working to revise the transfer policy with its Patient Management Care Coordination Initiative and looks forward to reviewing that new policy once it is finalized.

Clinician Summary: Inter- and Intra-System Transfers

Case review found that patients transferring into CCC received adequate transfer care. However, current performance limitations in provider availability (see *Access to Care*) impact this area. With regard to transfers out to another CDCR institution, CCC nurses do not consistently document relevant clinical information on the CDCR Form 7371 transfer document. There were significant problems found with the return from hospital transfer process, including problems with nursing documentation, medication continuity, and the retrieval and review of hospital records. With all factors taken into account, the rating for this indicator is *inadequate.*

Compliance Testing Results

California Correctional Center obtained an *inadequate* score of 64.7 percent in the *Inter- and Intra-System Transfers* indicator, scoring at or below 50 percent in three of the five tests, as described below:

- The OIG tested ten inmate-patients who transferred out of CCC to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). Inspectors found that staff had identified the scheduled appointment(s) on the transfer forms of only four of the ten patients sampled (40 percent) (MIT 6.004).

- The institution scored 50 percent when the OIG tested four inmate-patients who transferred out of the institution during the onsite inspection to determine whether their transfer packages included required medications and related documentation. Two of the inmate-patients tested had their keep-on-person (KOP) medication with their personal property and not in their transfer packages, preventing them from timely accessing their medications. Although a total of ten inmates transferred out of the institution on the testing day, the sample was limited because medications had been prescribed for only four of them (MIT 6.101).

- Only four of the 30 inmate-patients the OIG sampled who transferred into CCC from another CDCR institution had an existing medication order upon arrival. Of those four patients, inspectors found that only two (50 percent) received their medication without interruption. One patient's prescribed KOP medication was not dispensed until two weeks after his arrival at CCC, even though nursing staff clearly noted on the Initial Health Screening form (CDCR Form 7277) that the medication did not arrive with the inmate-patient and a medication refill was necessary. Another patient received his directly observed therapy medication one day late (MIT 6.003).

The institution performed well in the following tests:

- California Correctional Center received a score of 93 percent when the OIG tested 30 inmate-patients who transferred into CCC from another CDCR institution to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. Nursing staff timely completed the assessment for 28 of the patients sampled but neglected to answer all screening questions for two others (MIT 6.001).

- The OIG also reviewed the Initial Health Screening document (CDCR Form 7277) for 30 inmate-patients who transferred into CCC from another CDCR institution to determine if nursing staff completed the assessment and disposition sections of the form on the same day staff completed an initial screening of the patient. Inspectors found that nursing staff properly completed the documents for 27 of the patients sampled (90 percent). For two patients, nursing staff either failed to sign the document or failed to date it; for a third patient, the nurse failed to sign the document and failed to answer all questions on the document (MIT 6.002).

Recommendations for CCC

- With regard to hospitalizations, CCC can improve the return process for medication continuity. The OIG strongly recommends a formal medication reconciliation process and suggests the creation of a special hospital return medication order that discontinues all prior outpatient medications and specifies the medication, dose, route, frequency, duration, and start time for each new prescription. When given verbally, nurses can be expected to verify each prescription in detail via read-back with the ordering physician. These orders can be audited to ensure completeness by both physicians and nurses.

- Pre-hospitalization medication administration records should be removed from the medication binder, or pre-hospital medications should be clearly marked as discontinued when patients transfer out. Since the same nurses who staff the TTA and OHU are responsible for the majority of hospital returns, the same nursing recommendations from the *Emergency Services* and *Specialized Medical Housing* indicators apply to this indicator as well. The utilization management nurse should create a tracking system that includes the proper retrieval, review, and scanning of all hospital records, especially the discharge summary.

- CCC should train staff to ensure patients transferring out of the facility have pending and scheduled specialty services appointments properly identified on the Health Care Transfer Information form (CDCR Form 7371). For nurses who complete these forms, formal training along with audits and competency testing should be considered.

- Nursing staff should ensure that inmate-patients who transfer out of CCC to another CDCR institution have a supply of their prescribed medication(s) placed in their transfer package.

- Nursing staff should ensure that pending specialty service appointments are documented on the transferred-out patient's Health Care Transfer Information form (CDCR Form 7371).

- For inmate-patients who transfer into CCC, nursing staff should verify whether the patient arrived with all prescribed medications and ensure that those patients who did not arrive with their medications receive them without interruption.

Recommendations for CCHCS

With regard to systemwide transfers (not specific to CCC), the majority of patients who do not have complex medical conditions or who do not require complex specialty care would be well served by the existing nursing-only transfer process. However, CCHCS should create a process to identify patients who require special transfer handling that includes the following steps:

- Those patients should not be allowed to transfer without physician involvement, as a nursing-only transfer process is insufficient.

- The transfer process should include a clear disposition, including the specific yard to which the patient is being transferred and the primary care physician who will be directly responsible for the patient's continued care.

- The transferring physician should dictate or type a transfer summary to be communicated to the accepting physician prior to transfer. Transfer should only occur after the accepting physician has reviewed the summary, has had an opportunity to discuss the case with the sending physician, and has formally accepted the transfer.

- The transfer process comprehensively incorporates key utilization management information.

The OIG understands that these recommendations would place a significant logistical and staffing burden on both sending and receiving institutions, and that these measures are not practiced in the outpatient community generally. However, the volume and transfer rate within CDCR is much higher than that in the outpatient community and needs to be accounted for when designing an adequate transfer system. The OIG understands CCHCS is currently working to revise the transfer policy with its Patient Management Care Coordination Initiative and looks forward to reviewing that new policy once it is finalized.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
88.8%

Overall Rating:
Adequate

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Because effective medication management is affected by numerous entities across various departments, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the PCP prescriber, staff, and patient.

Based on results from prior inspections, the OIG has found that the most accurate evaluation of this indicator is derived largely from a detailed analysis of the OIG compliance scores in addition to the clinical case reviews. The case reviews often add specific examples of the findings revealed by the compliance scores and identify problems in other processes that may not be evident when viewed solely from a compliance standpoint.

Case Review Results

The OIG clinicians evaluated pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and was heavily relied on for the overall rating for this indicator.

New Prescriptions

The case reviews found that for the majority of cases, patients received their medications timely and as prescribed. However, there were occasional cases where prescriptions were not processed correctly:

- In case 39, the pharmacy did not receive a new prescription ordered on November 20, 2014, due to a computer or network failure. This resulted in the order not being processed until the error was discovered by the provider on November 26, 2014.

- In case 56, there was a four-day delay in delivering a chronic care medication order.

Post-Hospitalization Medication Continuity

Most patients received appropriate medications upon return from a community hospital. However, there were several problems with medication continuity following hospitalization identified during both the chart review and the OIG clinician onsite inspection.

- CCC medications were not automatically discontinued upon a patient's admission to an inpatient facility.

- CCC did not perform formal medication reconciliation upon a patient's return from a hospital. Medications that had been prescribed prior to hospitalization were automatically continued after hospitalization, even when were no longer appropriate for the patient. CCC depended on an informal medication reconciliation, where the receiving nurse or provider would "eyeball" the discharge medications and compared them with the active orders.

- The lack of an automatic stop order combined with a lack of a formal medication reconciliation process posed a significant patient safety risk and oversight error. In addition, without a reconciliation process, the receiving RN or provider could not be certain that the patient had an adequate supply of medication upon return from the hospital.

In addition to the process deficiencies identified above, the following problems were identified in case review:

- In case 3, the patient returned from a hospital admission, and the LVN administered hydroxyurea (a medication to reduce an elevated blood platelet number) on the evening of return. However, the eUHR lacked PCP orders for starting new or resuming previous medication orders. This indicated a lack of even informal medication reconciliation upon the patient's return from the hospital.

- In case 29, upon return from the emergency department, the PCP prescribed antibiotic therapy. However, the medications were not administered until the following day, resulting in a lapse in antibiotic treatment.

- In case 37, the patient returned from the hospital with recommendations to start new medications for newly diagnosed ulcerative colitis. However, there was a four-day delay in administering these medications. The onsite pharmacist cited the non-formulary status as a reason for the delay, and maintained that CCC remained within compliance with policy. However, from a patient care perspective, the delay was unacceptable for receiving critical medications, regardless of policy adherence.

Chronic Care Medication Continuity

The majority of patients reviewed received their chronic care medications without interruption. However, a few cases suggested some problems with chronic care medication continuity.

- In case 55, the patient's atenolol expired, which resulted in a break in continuity during the month of December 2014.

- In case 57, the patient's prescription for Xarelto (blood thinner) expired, which resulted in a lapse in medication continuity and delay in care.

- In case 86, the patient's prescriptions for glipizide and simvastatin expired resulting in a lapse in chronic care medication continuity during the months of November and December 2014. In addition, the patient's prescription for glipizide was allowed to expire on April 2, 2015. There was also a lapse in chronic care medication continuity for the patient's simvastatin prescription during the month of March 2015, despite a current order.

The above deficiencies led to further inquiry by the OIG clinicians during their onsite inspection. The cause of most of these deficiencies was a failure in the renewal process, when medications were allowed to expire without being properly reviewed and renewed.

Intra-System Transfer-In Medication Continuity

Medication continuity was maintained in all transfer-in cases reviewed.

Medication Administration

For the majority of cases reviewed, patients received their medications timely and as prescribed. However, there were a few cases where medication errors occurred:

- In case 57, on October 6, 2014, the patient received two doses of rivaroxaban (blood thinner), when he was supposed to have received only one. One LVN administered a 15 mg dose, and another LVN administered a 20 mg dose.

- In case 57, on December 9, 2014, the nurse administered a dose of rivaroxaban, even though the prescription had expired on December 8, 2014.

- In case 2, the provider ordered one-half bottle of magnesium citrate "now at clinic" and one-half bottle as needed "tonight." The clinic LVN did not document the time or the administration of the "now" medication order, but the evening dose was given per documentation in the MAR.

Medication Follow-up

Case review revealed no problems with timely notification when patients missed medications.

Onsite Clinician Inspection

During the onsite visit, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. Nursing instruction and monitoring of the knowledge and skills regarding medications and medication administration is a strength at CCC. The nursing instructor and nursing administrators at CCC have implemented various educational and training strategies with ongoing sessions that are required for all nursing staff and managers regarding medication safety, skills practice, and continuity of care.

Clinician Summary: Pharmacy and Medication Management

Despite the problems identified above, the majority of reviewed medication events were performed without problems. However, OIG clinicians are particularly concerned about CCC's post-hospitalization medication process and its lack of sufficient safeguards. In addition, there are intermittent but recurrent breakdowns in the medication renewal process of expiring medications. Although these concerns are significant, they were not enough to completely override the fact that the majority of pharmacy transactions occurred without problems at CCC. Overall, pharmacy and medication administration performance is rated *adequate*.

Compliance Testing Results

The institution received a *proficient* score of 88.8 percent overall for the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

For this sub-indicator, the institution scored an average of 87 percent and performed particularly well in the following areas:

- Nursing staff timely dispensed chronic care medications to 24 of the 26 inmate-patients sampled, scoring 92 percent for this test. Two patients did not receive supplies of their keep-on-person (KOP) medications within the required time frame (MIT 7.001).

- When the OIG sampled 23 CCC inmate-patients who had transferred from one housing unit to another, inspectors found that 21 of the patients (91 percent) received their prescribed medications without interruption. Two patients did not receive their medication at the proper dosing interval (MIT 7.005).

- The OIG found that the institution timely administered or delivered new medication orders to 26 of the 30 patients sampled (87 percent). For one patient, there was no evidence that he received a prescribed injection; for two patients, there was incomplete documentation evidencing when their KOP medications were received; one other patient received his KOP medication 20 days late (MIT 7.002).

The institution could improve in the following medication administration area:

- The institution timely provided hospital discharge medications to seven of nine patients sampled who had returned from a community hospital (78 percent). Two patients received their discharge medications two days late (MIT 7.003).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution scored an average of 81 percent. For the following two tests, CCC scored 100 percent:

- Inspectors observed nursing staff following appropriate administrative controls during medication preparation at all six of the sampled medication and preparation administration locations (MIT 7.105). In addition, at four sampled medication preparation and administration locations, inspectors observed nursing staff following appropriate administrative controls when distributing medications to inmate-patients (MIT 7.106).

The institution scored within the *adequate* range for the three tests below:

- The institution properly stored non-narcotic medications that do not require refrigeration at 10 of the 12 applicable clinics and medication line storage locations sampled (83 percent). In two clinics, topical medications were stored in the same cart drawer as internal medication, with no divider to separate the two different types of medications (MIT 7.102).

- Nursing staff at four of the five medication preparation and administration locations (80 percent) followed proper hand hygiene contamination control protocols during the medication preparation and administration processes. At one location's medication line (pill line), the LVN did not sanitize hands prior to initially putting gloves on or between subsequent glove changes (MIT 7.104).

- When OIG tested eight clinics and medication pill line locations to determine if non-narcotic medications that required refrigeration were stored properly, inspectors found that six locations (75 percent) were in compliance. At two clinic locations, the refrigerator and freezer temperature logs showed multiple entries documenting temperatures outside of the required ranges during February and March 2015 (MIT 7.103).

The institution needs improvement in the following area:

- The OIG interviewed nursing staff and inspected narcotic storage areas at four applicable pill line locations. Inspectors found no exceptions at two of the four locations (50 percent). At the other two pill line locations, the licensed vocational nurses interviewed were not fully aware of key standard procedures to follow when a controlled substance discrepancy occurs (MIT 7.101).

Pharmacy Protocols

For this sub-indicator, the institution scored an average of 99 percent, scoring 100 percent in all but one test, as indicated below:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated medications; properly stored and monitored non-narcotic medications that require refrigeration; and maintained adequate controls and properly accounted for narcotic medications. The institution scored 100 percent in each of these areas (MIT 7.107, 7.108, 7.109, 7.110).
- The institution's pharmacist-in-charge (PIC) properly processed 24 of the 25 medication error reports tested (96 percent). However, for one medication error report, the PIC completed the follow-up review 11 days late. After obtaining additional information about the error, the PIC ultimately upgraded it to a higher severity level (level 4), which met the threshold requiring the PIC to report the error to CCHCS. Because of the PIC's untimely follow-up review, this level 4 error was also not timely reported to CCHCS (MIT 7.111).

Non-Scored Tests

In addition to the OIG's testing of reported medication errors, inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only. At CCC, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG tested inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP asthma rescue inhalers and nitroglycerin medications. All four applicable inmates interviewed indicated they had possession of their asthmatic inhalers (MIT 7.999).

CCHCS Dashboard Comparative Data

Medication Administration

The Dashboard uses performance measures from the Medication Administration Process Improvement Program (MAPIP) audit tool to calculate the average score for its Medication Administration measure. The OIG compared similar CCC compliance scores with the Dashboard results.

As noted in the table below, the OIG test results were based on a review of current documents as well as documents dating up to nine months back; CCC's March Dashboard data reflected only the institution's February 2015 results. Using these variable time frames, the Dashboard's score is 14 percentage points higher than the OIG's score of 86 percent. However, both scores fall into the *proficient* range overall.

Pharmacy and Medication Management—
CCC Dashboard and OIG Compliance Results

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Medication Management: Medication Administration March 2015	Medication Administration (7.001, 7.002) (Chronic Care & New Meds) *Preventive Services* (9.001) (Administering INH Medication) July 2014 – March 2015
100%	**86%**

Note: The Dashboard results were obtained from the Medication Administration Drilldown data for Chronic Care Meds—Medical, New Outpatient Orders—Medical, and Administration—TB Medications. Variances may exist because CCHCS includes medication administration of KOP medications only for the first two drilldown measures, while the OIG tests KOP, DOT, and nurse-administered (NA) medication administration.

Recommendations

- The institution should institute automatic medication stop orders for any patient who has left the institution for more than 24 hours (including hospital send-outs). A medication reconciliation process is required, involving, at a minimum, the re-ordering of all medications for patients returning after discharge from an outside hospital. The OIG recommends a formal medication reconciliation process where discharge medications are routinely reconciled with the medications the patient had been on prior to leaving the facility.

- Hospital discharge medication orders should be required to have a start date specified to ensure that the pharmacy and nursing staff provide proper medication continuity. The institution should also ensure that inmate-patients who return from a community hospital receive their discharge medications within one calendar day.

- The institution's health care administration should perform an in-depth review to identify why expiring medications are not always renewed timely to avoid breaks in medication continuity. With the pharmacy's readily available expiring medication report, medication continuity should not be difficult to maintain.

- At pill line locations, nursing staff need to segregate topical medications from oral medications by clearly separating the medication's storage locations.

- In clinics, medication pill lines, and pharmacy locations, CCC staff should ensure that refrigerators and freezers are maintained at the appropriate temperatures.

- The institution's nursing staff, especially LVNs, should receive periodic training on proper protocols for reporting narcotic medication discrepancies and hand hygiene during medication preparation and administration.

PREVENTIVE SERVICES

This indicator assesses whether various preventive medical services are offered or provided to inmate-patients. These include cancer screenings, tuberculosis screenings, and influenza and chronic care immunizations. This indicator also assesses whether certain institutions take preventive actions to relocate inmate-patients identified as being at higher risk for contracting coccidioidomycosis (valley fever).

Case Review Rating:
Not Applicable
Compliance Score:
80.6%

Overall Rating:
Adequate

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator, with an overall score of 80.6 percent. The institution scored 80 percent or higher in five of the six tests. The stronger areas are described below:

- All 30 inmate-patients sampled who were subject to annual colon cancer screening (100 percent) received or were offered a fecal occult blood test (FOBT) within the last year or had a normal colonoscopy within the last ten years (MIT 9.005).

- The institution scored 97 percent in the area of annual influenza vaccinations. The OIG sampled 30 inmate-patients to determine if they were offered annual influenza vaccinations, and only one inmate-patient was not offered the vaccine during the most recent flu season (MIT 9.004).

- The institution scored in the *adequate* range for administering anti-tuberculosis medications (INH) to inmate-patients with tuberculosis. Twenty-four of 30 patients sampled (80 percent) received their INH medication at the ordered dosing intervals. Five patients did not receive all required doses for one or more weeks during a three-month test period. For one other patient, inspectors could not find any evidence in the eUHR that the patient either received or refused his INH medication during one of three months tested (MIT 9.001).

- The OIG found that 24 of 30 inmate-patients sampled (80 percent) received proper tuberculosis (TB) screenings within the last year. Four exceptions were due to nursing staff failing to complete patients' TB screening documentation or because required TB test results were read by an LVN, rather than by an RN, PHN, or PCP. One other exception was due to nursing staff not reading a patient's TB test results within 72 hours. In addition, one inmate-patient did not receive a TB screening within the past 12 months (MIT 9.003).

- The OIG tests whether inmate-patients who suffer from a chronic care condition are offered vaccinations for influenza, pneumonia, and hepatitis. At CCC, 16 of the 20 patients sampled (80 percent) received all recommended vaccinations at the required interval. Three patients were not offered their recommended Pneumovax immunizations; one patient was not offered his recommended hepatitis vaccinations (MIT 9.008).

The institution scored quite low in the following key preventive services test:

- When the OIG reviewed the institution's monthly monitoring of 30 sampled patients who received INH, the institution was in compliance for only 14 of those patients (47 percent). The most common problem was that medical staff did not scan tuberculosis monitoring documents into the eUHR on a monthly or weekly (if ordered by a provider) basis, but instead waited until the end of the treatment period, which in some cases was many months later (MIT 9.002).

CCHCS Dashboard Comparative Data

Both the Dashboard and the OIG found a *proficient* level of compliance for colon cancer screening, with the OIG showing a higher level of compliance (by 11 percentage points) than the Dashboard score of 89 percent.

Preventive Services—CCC Dashboard and OIG Compliance Results

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Colon Cancer Screening March 2015	Colon Cancer Screening (9.005) March 2015
89%	**100%**

Recommendations

- The institution must ensure that all inmate-patients receive their tuberculosis INH medication at the required dosing interval, or properly document why the medication was not given.

- CCC also needs to ensure that monthly tuberculosis monitoring for patients taking INH is completed and that documents are scanned into the eUHR on a monthly basis to ensure medical staff have access to each patient's most current information.

- The institution needs to follow CCHCS policy for annual tuberculosis screening by ensuring an RN, PHN, or provider reads the tuberculosis skin test results for each inmate-patient. If LVNs participate in the tuberculosis screening, they can review the patient for signs and symptoms, and administer the tuberculosis test, but they cannot read the test results.

- CCC must ensure that inmate-patients who suffer from certain chronic care conditions are offered all of their recommended vaccinations. If the inmate-patient is already immune to the disease for which the vaccination is intended to prevent, staff must document this fact.

QUALITY OF NURSING PERFORMANCE

***Case Review Rating**:*
Adequate
***Compliance Score**:*
Not Applicable

Overall Rating:
Adequate

This indicator is a qualitative evaluation of nursing services performed entirely by OIG nursing clinicians within the case review process, and, therefore, does not have a score under the compliance-testing component. The OIG nurses conduct case reviews that include face-to-face encounters related to nursing sick call requests identified on the Health Care Services Request Form (CDCR Form 7362), urgent walk-in visits, referrals for medical services by custody staff, RN case management, RN utilization management, clinical encounters by Licensed Vocational Nurses (LVNs) and Licensed Psychiatric Technicians (LPTs), and any other nursing service performed on an outpatient basis. The OIG case review also includes activities and processes performed by nursing staff that are not considered direct patient encounters, such as the initial receipt and review of CDCR Form 7362 service requests and follow-up with primary care providers and other staff on behalf of the patient. Key focus areas for evaluation of outpatient nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions including patient education and referrals, and documentation that is accurate, thorough, and legible. Nursing services provided in the outpatient housing unit (OHU), correctional treatment center (CTC), or other inpatient units are reported under *Specialized Medical Housing*. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported under *Emergency Services*.

Case Review Results

The OIG RN clinicians evaluated 141 outpatient nursing encounters for CCC, almost all of which were for nursing sick call requests. Of the 38 deficiencies found, most were unlikely to contribute to patient harm. Sick call nurses generally made appropriate primary care provider (PCP) contact and referrals and coordinated primary care services with the PCP. Documentation of nursing assessments and interventions by some sick call RNs was illegible.

Nursing Sick Call

Overall, outpatient nursing performance related to sick call requests was adequate. Nurses generally reviewed sick call requests appropriately, triaged sick call patients adequately, saw patients quickly, and made proper assessments, interventions, and dispositions. The pattern of deficiencies identified fell into two broad categories: nursing assessment and intervention, and nursing documentation. The majority of the nursing assessment and intervention deficiencies were due to inadequate subjective or objective physical assessment for complaints of medical symptoms, and failure to conduct a face-to-face assessment visit. The majority of the documentation deficiencies were for incomplete documentation per requirements established by CCHCS nursing protocols in the Inmate Medical Services Program Policies and Procedures.

Nursing Assessment Deficiencies

The majority of nursing encounters demonstrated an adequate assessment, and most of the deficiencies found were not likely to have caused harm. However, several cases were more serious in nature due to an increased potential for adverse outcomes or unnecessary delays in needed health care services in the outpatient clinics. The following cases are cited for purposes of quality improvement in nursing services.

Referrals without nursing assessment:

- In case 57, the patient complained of continued problems with moles on his face and requested to see a doctor about mole removal. The RN failed to conduct a face-to-face assessment, but noted the patient had a PCP appointment in two days and the issue would be discussed at that time. This occurred again about one week later for the same complaint on another sick call request.

- In case 23, the RN failed to provide a face-to-face assessment or patient interview after receiving three requests for a medication refill within 12 days. The RN did not assess the patient regarding a medication the patient stated was not working. Additionally, there was no documentation of actions taken by medication nurses about the forwarded requests.

Initiating appropriate PCP referrals and consultation contacts:

- In case 57, custody staff requested the RN assess a patient involved in an accident. The patient was taking Xarelto (blood thinner) at the time. The patient had a bruised, reddened area to his left hip, with dried blood, redness, scratches, and abrasions to both hands. Although the patient was otherwise asymptomatic and subsequently released to custody staff, the RN should have contacted the PCP regarding the potential need for PCP referral.

- In case 66, the patient complained of frequent urination. The RN made a routine referral to the PCP, and should have made an urgent referral for evaluation of a possible urinary tract infection. The PCP visit occurred 14 days after the face-to-face assessment.

Inadequate assessments and intervention:

- The patient in case 35 submitted a Health Care Services Request (CDCR Form 7362) just two days after a hospital discharge for concussion. He had severe headaches and increased pain to the right side of his face. Due to the nature of the hospitalization and the service request complaint, an RN should have assessed this patient on the same day the request was reviewed. The patient ultimately refused the RN assessment that occurred one day later and chose to wait for the PCP visit scheduled for two days later.

- In case 46, the patient complained of acute low back pain. The nursing plan of care was "activity as tolerated," Tylenol and ibuprofen as needed, and a follow-up nurse visit in 72 hours if symptoms persisted. There was no PCP referral. The RN did not obtain a complete subjective history about the acute back pain or specifically that the patient had fallen off his top bunk.

- In case 56, the patient submitted a CDCR Form 7362 for the complaint of a sore throat and cold and flu symptoms for the previous two days. The patient had a dressing to his left ear after a surgical tympanoplasty performed approximately three weeks prior. The patient had been instructed to use cotton balls to keep the ear canal dry during showers. However, the RN did not remove the left ear packing to assess for signs of an ear infection.

- The patient in case 63 complained of an earache, a lump under his chin, and pain behind and below both ears and under his chin. The RN did not address the lump under the chin during the sick call visit. Three days later, the sick call RN assessed the patient for the second complaint of quarter-sized lump under his chin for the past two weeks, referred the patient to the PCP, and subsequently started the patient on an antibiotic regimen for an infection. The first sick call RN should have referred the patient to the PCP.

- Inadequate nursing assessments and interventions per the CCHCS nursing protocols were also found in cases 71, 76, and 79.

Nursing Documentation Deficiencies

Overall, the nursing documentation deficiencies were rare and unlikely to cause patient harm. However, the following examples demonstrate documentation deficiencies from CCHCS nursing policy and protocols and have been included for quality improvement.

- The patient in case 58 had a face-to-face RN sick call visit, requesting to see an eye doctor. Although the RN completed a visual acuity assessment and referred the patient to an eye doctor, the RN did not document subjective assessments, vital signs, weight, and review of current medications.

- Incomplete documentation occurred in cases 1 and 68. The documentation lacked subjective and objective assessments, assessment conclusion (nursing diagnosis per North American Nursing Diagnosis Association (NANDA) taxonomy), and signatures or titles as required by CCHCS nursing protocols.

Care Management

Care management nurses at the institutions routinely conduct periodic face-to-face assessment visits with chronic care patients. These nurses track status and results of diagnostic tests and monitor health care needs based on the patients' chronic conditions. Because CCC had a low population of

patients with chronic conditions, care management nursing services were not evident from the case reviews.

Medication Administration

Medication administration was generally timely and reliable. The onsite inspection noted that although the clinic LVNs participated in the primary care morning huddles, the medication line LVNs were not present during the huddles. See the *Pharmacy and Medication Management* and *Emergency Services* indicators for specific findings.

Emergency Care

See *Emergency Services* indicator for specific findings.

Inter- and Intra-System Transfers

Although there were few major nursing issues found in the cases reviewed, various deficiencies emerged in nursing services related to incomplete documentation of specialty appointments for inmates transferring out of CCC. The OIG found significant issues related to incomplete assessments and illegible nursing documentation for patients returning from hospital discharge. Since the same TTA and OHU nurse often completed the patient assessment after a patient's return from offsite medical services and the OHU admission assessments, there were similar assessment and documentation deficiencies found in both the TTA and OHU nursing areas. See *Inter- and Intra-System Transfers* and *Specialized Medical Housing* indicators for specific findings.

Onsite Clinician Inspection

The OIG physician and nurse clinicians each attended the morning huddles on alternate days in both the Main and Lassen Clinics. The clinic LVN gathered the necessary reports and facilitated the morning huddle for the Main Clinic primary care teams. Sufficient time was allowed for each participant to cover topics such as the weekend TTA visits, transfers out and in, patients remaining in outside hospitals, significant diagnostic reports, physician and RN line schedules, add-ons, referrals, and mental health issues. However, there were no meaningful reports provided from nursing on the sick call RN line status, TTA, OHU, or other clinical nursing issues. An attendance record was circulated for all attendees to sign. Although the assigned sick call RN was present for the primary care team morning huddle held in the Lassen Clinic, the other outlying sick call RNs did not attend the morning huddle for the Main Clinic. Those nurses reported directly to their designated remote sick call locations. As discussed above, the medication line LVNs also did not attend the morning huddles. With the exception of the aforementioned absences, the morning huddles in the Main and Lassen Clinics had good attendance, including scheduled PCPs, the sick call RN (Lassen Clinic only), Supervising RN, clinic LVNs, and Office Technician schedulers.

The OIG RN clinician visited various clinical areas and spoke freely with nursing staff during walking rounds. Supervising nurses, RNs, and LVNs were knowledgeable about their duties, responsibilities, the patient populations within their assigned clinical areas, specific communication

channels for making requests, and reporting issues. On average, sick call RNs saw 7 to 12 patients per day, and there was no nursing sick call backlog in any area. Although sick call RNs outside of the Lassen Clinic did not attend the huddle, nurses indicated they generally had no problems communicating with PCPs throughout the day. Nursing staff was generally unclear about any nursing performance monitoring strategies in progress and specific performance improvement efforts currently underway at CCC. However, nursing staff at all levels verbalized having no major barriers initiating communication with PCPs, nursing supervisors, and custody staff in meeting patient care needs and providing nursing care.

The nursing education program at CCC was well-run and provided staff with valuable learning experiences. The program provided nurses with a comprehensive educational program, including the required annual mandated training, policy update reviews, skills improvement, as well as learning sessions on some unique and interesting topics. Examples of nursing education sessions provided within the past two years or scheduled to occur in the near future included the new inmate-patient transfer process, rare and unusual psychiatric syndromes, Ebola overview, prison drug store, and health benefits of chocolate. Other trainings such as medication management competency and various infectious disease processes were required for all nursing levels, including nursing managers. Almost all RN and some LVN staff had completed advanced cardiac life support certification. The orientation and training program in place for newly hired nursing staff, implemented by the Nurse Instructor, strongly supported and appropriately monitored both nursing staff who have transferred from other CDCR institutions and those new to prison health care.

The OIG RN clinician was unable to attend the regularly scheduled nursing management, staff, or other meetings because these meetings did not occur during the dates of the OIG's onsite inspection visit.

Recommendations

The OIG commends CCC for the strategies currently in place for evaluating individual nursing performance and overall nursing care and services. Although the case review process revealed adequate outpatient nursing care quality at CCC, quality improvement requires ongoing nursing education and monitoring of the following:

- Nurses should provide urgent or same-day face-to-face assessments, as appropriate, based on the patient's health history and current complaint(s).

- Nurses should provide face-to-face assessments for all CDCR Form 7362 service requests containing complaints of medical symptoms.

- Nurses should contact or refer patients to see the PCP for the third request for the same medical complaint following face-to-face triage by the RN.

- Nurses should conduct and document subjective and objective assessments for all complaints.

- Nurses should develop and document nursing diagnoses and conclusions in accordance with NANDA Taxonomy.

- All LVN medication nurses and all sick call RNs should attend the morning huddles associated with their assigned areas. Each huddle should follow a predefined huddle script and hold team members accountable for potential lapses in care.

- CCC management should solicit nursing staff at all levels and in all nursing service areas to identify and implement nursing-related quality improvement projects and monitoring strategies with the goal of improving program operations, such as nursing documentation.

QUALITY OF PROVIDER PERFORMANCE

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, nursing sick call, chronic care, TTA, CTC, and specialty services. The assessment of provider care is performed entirely by OIG physicians. There is no compliance testing component associated with this quality indicator.

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed over 375 medical provider encounters and identified 93 deficiencies related to provider performance at CCC. Of those 93 deficiencies, 18 were significant. As a whole, CCC provider performance was rated *inadequate.*

Assessment and Decision-Making

Problems with provider assessment and medical decision-making were found frequently throughout the cases reviewed. These deficiencies usually carried the greatest risk of patient harm, and were found throughout the cases reviewed (cases 1, 2, 4, 27, 29, 37, 38, 39, 40, 42, 44, 48, 55, 57, 59, 60, 86, and 88).

- In case 1, the patient had an extensive smoking history and began to complain to the nurse about coughing up blood. A recent CT scan showed a lung nodule, which could represent lung cancer in this individual. Two different providers failed to assess the patient's condition

promptly, which caused a delay in care. When a provider finally ordered the pulmonary consultation as routine instead of urgent, it further delayed care.

- In case 37, the patient had several months of rectal bleeding. When the provider was advised by medical administration to order a sigmoidoscopy test, the provider failed to act and allowed the patient to continue bleeding without meaningful diagnostic tests for several months. The patient was ultimately hospitalized and diagnosed with ulcerative colitis.

- In case 38, the patient complained of worsening of his chronic asthma symptoms. He had a history of asthma attacks that were so severe, he had required intubation and mechanical ventilation in the past. Over the course of several months, the provider failed to properly assess or treat the asthma condition when multiple primary care options were available. Instead, the provider only ordered a pulmonary specialty consultation, which did not occur until after the patient was hospitalized for symptoms likely due to the patient's uncontrolled asthma.

- In case 59, the patient's primary problem was a chronic non-healing wound on his right ankle. One provider failed to examine or address the issue even though it was the main reason for the provider encounter.

Review of Records

The institution providers sometimes demonstrated superficial and cursory review of diagnostic reports, specialty reports, and hospital reports. In addition to outside reports, CCC providers often failed to review or provided only a cursory review of the eUHR during each patient encounter. Many provider encounters appeared to be rushed or hurried, which led to many of problems in assessment and decision-making. Inadequate review of records was identified in cases 1, 5, 38, 39, 40, 42, 44, 48, 49, and 55.

- In case 1, a cursory review of the medical record resulted in some labs not being reviewed. Those labs demonstrated a profound hypothyroidism, but failure to review them during a provider encounter caused a delay in care. The patient was subsequently hospitalized for severe bradycardia and syncope, which was likely due to the hypothyroid condition.

- In case 39, a provider failed to review labs showing abnormally elevated liver function tests during consecutive provider encounters. Fortunately, the liver function tests normalized spontaneously.

- In case 40, the patient saw a provider for follow-up after having a cardiac procedure (ablation) performed for a condition called Wolff-Parkinson-White syndrome. The provider failed to review the chart with appropriate thoroughness and misdiagnosed the patient with

atrial fibrillation, even though the correct diagnosis was readily available in the eUHR at the time of the encounter.

- In case 44, during a chronic care encounter, the provider failed to review the record and did not note or address the patient's recent history of prostate cancer, recent treatment with prostate radiation seeds (brachytherapy), or the recent finding of a lung nodule on a CT scan.

Emergency Care

The OIG clinicians reviewed over 37 TTA encounters and found that CCC providers generally made appropriate triage decisions when patients presented emergently to the TTA. Only two deficiencies were identified in this area, which should be utilized for quality improvement purposes.

- In case 42, the provider ordered ten units of insulin for a blood glucose level of 439. The provider released the patient back to his housing unit without rechecking the patient's blood glucose level after the insulin was administered.

- In case 35, during a TTA encounter, the provider instructed the patient to be sent out to a community hospital. However, the provider failed to document a progress note for the encounter.

Chronic Care

The institution houses few chronic care patients. Among those chronic care patients who are housed at CCC, the vast majority of their conditions were mild, stable, and required no significant medical intervention. For example, there were only 52 diabetic patients listed in the diabetic registry at the time of the inspection, only 5 of whom required insulin. There were no patients receiving anticoagulation treatment and no patients with HIV. There was only one patient diagnosed with end-stage liver disease. Nevertheless, the OIG reviewed cases where chronic care interventions were needed and found performance to be lacking due to a combination of system deficiencies and questionable provider performance.

- In case 42, the patient was a non-compliant diabetic. Providers had great difficulty managing the patient's condition due to his non-cooperation. Despite this, providers failed to make appropriate assessments and made several questionable decisions regarding diabetic treatment, monitoring, and follow-up intervals. Some examples included a failure to review labs, a dramatic decrease in medication dose without a corresponding increase in monitoring, and a 90-day follow-up interval for diabetes assessed as "not at goal." Providers generally believed that those decisions reflected their attempts at negotiation with a non-compliant patient. However, neither the patient's non-compliance nor the providers' rationale for those decisions was adequately documented or explained.

- In case 86, the provider made a decision to start long-acting insulin on a patient with poorly controlled diabetes. However, the provider started with a dose that was significantly higher than recommended and did not stop other diabetic medications that are usually stopped when beginning insulin treatment (i.e., sulfonylurea). The result was a significantly symptomatic low blood glucose level only one day after the first dose was administered, which led to a hasty discontinuation of the insulin therapy. Overall, this increased the risk of delayed or suboptimal diabetic care for the patient, who may have benefitted from appropriate insulin treatment.

- In case 4, the patient's asthma was not properly monitored or assessed. When the patient explained to the provider that he was just starting to recover from an asthma attack, the provider ordered an inappropriately long follow-up interval. Providers often failed to assess asthma classification and whether the condition was at goal or not. Asthma questionnaires were routinely completed by the patient but not correlated with the patient's clinical condition by the provider.

While none of the examples listed above demonstrate any severe or permanent harm, they are representative of the challenges faced by providers when a patient's chronic conditions invariably become poorly controlled. Based on case review, the OIG is not convinced that CCC providers will consistently intervene in an appropriate manner when faced with chronic conditions that become poorly controlled. Fortunately, CCC's overall population is of low medical risk, and these types of episodes should be an infrequent occurrence.

Specialty Services

Reviews of the specialty services referrals revealed that CCC providers generally referred patients to specialists appropriately. However, a pattern was identified where many referrals were found to be premature or unnecessary. When providers saw patients for follow-up after specialty services, they did review available reports and take appropriate actions. Unfortunately, in many cases, the report was not available and the only specialty notes available for review were a few handwritten sentences on the original referral form.

While an overdependence on specialty services does not, by itself, pose a risk of harm to patients, it can indicate a problem with providers who refer patients unnecessarily. These providers may be uncomfortable, unwilling, or even incapable of treating basic primary care conditions. These issues are further discussed in the *Specialty Services* indicator.

Documentation Quality

Inaccurate documentation usually reflects an insufficient assessment. This can range from an inadequate review of the record to an inadequate history, physical exam, or documentation of the differential diagnosis. Inaccurate documentation increases medical risk as it has the potential to

mislead subsequent medical providers upon a transfer of care. The OIG review of CCC cases revealed a pattern of hurried and insufficient documentation of provider encounters. Inadequate documentation deficiencies were identified in cases 1, 2, 4, 27, 42, and 57.

Provider Continuity

While on the surface, CCC appears to have a primary care team model of health care delivery, in practice, care is very disjointed. Each patient was assigned to one provider; however, during case review, OIG clinicians found severe problems with provider continuity. In most cases, a patient would see at least three to four outpatient providers over a span of six months. Continuity was even worse if the patient was housed in the OHU for any length of time. Since OHU utilization was so commonplace and frequent, the typical case reviewed by the OIG would show five or six different providers taking care of the patient. Of note, there are currently only seven practicing primary care providers at CCC. Poor provider continuity was found in cases 29, 36, 39, 40, 47, 49, 55, 56, 57, and 88.

Extremely poor provider continuity was responsible for a significant number of the provider deficiencies identified during case review. Providers who were unfamiliar with the patient had only one chance at thoroughly reviewing the chart. This led to subsequent PCPs missing important patient information normally discovered at the second, third, or fourth provider encounter. Many oversight errors were explained by poor provider continuity; these errors manifested themselves during case review as inadequate review of records, inadequate assessment and decision-making, and inadequate documentation.

For example, in case 1, two different providers failed to correlate symptoms of coughing up blood and a recent CT scan showing a pulmonary nodule. The patient had been going back and forth between two different providers who were assigned to the same primary care team. Both providers initially believed the CT scan was normal, and both providers failed to review the nursing notes that described the patient's coughing up of blood. Neither of the providers demonstrated strong familiarity with the patient's case or recent test results. This oversight potentially could have been avoided with a strong primary care home model. The nurse should have discussed the case with the one responsible provider the same day that the patient was evaluated in sick call, and it should have been a single provider's responsibility to know about the recent test results. Instead, nurses performed sick call evaluations in isolation, away from providers and where there was little daily collaboration other than a centralized huddle. Even with only two different providers involved in the case, the risk for a lapse in care remained.

California Correctional Center's medical administration is not committed to a true primary care home model. While CCC currently had provider staffing shortages that made implementation of the model difficult, there were other findings demonstrating that a primary care home concept was not a priority. Most schedulers were unaware that a patient was supposed to be scheduled with a particular provider, and in practice were not making any significant effort to maintain provider

continuity. They generally scheduled the patient with whichever provider happened to be available. Nurses performed sick call evaluations in locations that were physically separate from the main clinic. This presented a significant barrier to clinic team communication and collaboration. While a lack of physical space explained the current arrangement, CCC administrators had no plans to relate nursing sick call back into the main clinics, even after their Health Care Facilities Improvement Plan (HCFIP) has been completed.

Health Information Management

Providers generally documented patient encounters on the same day. Emergency encounters were also documented properly by providers, both in the TTA and when on call after hours.

Onsite Inspection

The OIG onsite interviews showed that CCC providers were generally competent. Most of the errors identified during case review were due to simple oversights. In addition, attempts at thorough and complete health care delivery were hampered by provider understaffing and poor continuity of care. Most providers saw 14 to 16 patients per day and admitted to feeling hurried and rushed in order to meet productivity expectations. Many providers felt overworked, especially with one open physician vacancy and two other physicians out on long-term sick leave. Despite the challenges they faced, most providers felt that provider morale was fair. Some providers felt that the chief medical executive could exercise tighter discipline on the provider staff at CCC, but was hampered by the extra demands that neighboring High Desert State Prison placed on the executive staff, who also oversee that medical program.

Provider managers felt that many or all of the problems identified were attributable to provider staff vacancies. The remote locale of CCC severely restricts the availability of well-qualified and high-performing provider staff. CCC provider managers had recently identified one provider who was believed to be performing below standards; that provider was on long-term sick leave at the time of the inspection. Another provider had recently experienced life-threatening medical problems and was also on long-term sick leave. Yet another provider had been counseled and offered mentoring for inadequate documentation. The large volume of patients, combined with low staffing levels, caused providers to feel rushed, which led to oversight errors. Many providers had large amounts of accumulated leave on their books, which could further exacerbate already low provider staffing levels going forward. Meanwhile, staffing levels are made even more unpredictable by some poor work habits demonstrated by some providers. For example, some providers decide to make rounds in the OHU whenever convenient solely for the purpose of accumulating overtime. At other times, the same providers may decide not to come into the facility to evaluate a needy patient because it is not convenient. Some providers have decided on their own to extend vacations without obtaining supervisory approval. According to CCC managers, insufficient and unpredictable provider staffing makes it difficult to maintain continuity of care.

Clinician Summary: Quality of Provider Performance

The OIG's case review identified many deficiencies pertaining to provider oversight. These included a widespread pattern of inadequate assessment and decision-making, inadequate review of records, questionable chronic care performance, overdependence on specialty services, inadequate documentation, and very poor provider continuity. CCC providers did well with respect to providing emergency services and documenting their clinical encounters on the same day. The OIG found during individual provider interviews that provider staff were individually competent providers. Therefore, underperformance was most likely due to system factors, such as patient unfamiliarity, insufficient provider staffing, poor continuity of care, a lack of dedication to a primary care home model, and an insufficient utilization management program. However, some of the deficiencies went beyond the system level and were more likely related to the professional culture of the institution, such as reporting to work only when convenient, even in instances where patients were in need of medical attention.

While individual provider performance was marginally adequate, as a whole the provider deficiencies were too numerous and bore significant responsibility for the inadequate cases examined during case review. In addition, there were few examples of providers going above and beyond in an attempt to overcome the existing system deficiencies, which significantly hampered provider performance. The overall rating for this indicator is *inadequate*.

Recommendations

- CCC should commit itself to the implementation of a true primary care home model, where each patient is assigned a single primary provider and nurse, and all efforts are made to ensure maximum provider continuity.

- To ensure that each provider is capable and competent of diagnosing and intervening when needed, CCC should develop a protocol that requires the primary provider and supervisor to audit the records of patients who suffer from out-of-control chronic care conditions.

- Providers should be monitored for signs of overwork, as many OIG-reviewed cases showed evidence of rushed or hurried providers. CCC providers should be held accountable if they fail to perform an adequate record review for each clinical encounter.

- To relieve strain on current providers, CCC should expeditiously fill vacant position(s) with qualified and high-performing physician providers. In addition, temporary measures should be taken to ensure the workload of providers on long-term leave is adequately managed.

SPECIALIZED MEDICAL HOUSING

This indicator addresses whether the institution follows appropriate policies and procedures when admitting inmate-patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. CCC's only specialized medical housing unit is the outpatient housing unit (OHU).

***Case Review Rating**:*
Inadequate
***Compliance Score**:*
92.0%

Overall Rating:
Inadequate

For this indicator, the OIG made notably different findings between the case review and compliance review test results. While each area's results are discussed in detail below, the case review's *inadequate* rating and the compliance review's *proficient* rating are readily explained by the different testing approaches. For example, OHU documents may have been present in the medical record as required by policy, and the finding was positively reflected in the compliance rating. However, the clinical quality of those same documents may have been poor and negatively reflected in the case review rating. This indicator's overall rating is ultimately determined (as all overall ratings are determined) by the OIG's team of experts' overall consideration of both case review and compliance review results and the totality and significance of the issues identified. For this indicator, because it was determined that the case review results significantly outweighed the compliance review results, the final overall rating is *inadequate.*

Case Review Results

The California Correctional Center has a 14-bed medical OHU onsite. Eighty provider encounters and 98 nursing encounters were reviewed in 24 cases. These included admissions to the medical OHU for medical conditions and holds in the OHU such as overnight placements prior to transferring out for procedures scheduled at community health care centers.

OHU Utilization

The institution's utilization of the OHU appears to be based on habit and custom rather than medical necessity.

- Virtually every patient who had an offsite specialty appointment was housed in the OHU the day prior to the appointment. Many of these short OHU "hold" admissions were not accompanied by a corresponding provider progress note. In case 41, the patient was housed in the OHU the night prior to a CT scan in order to advise the patient to not take any antihistamines or caffeine four hours prior to the procedure. In case 44, the patient was held in the OHU only to enforce an order to have him take nothing by mouth after midnight. In case 45, the patient was kept in the OHU in order to provide laxatives and also have nothing taken by mouth after midnight.

- Some patients were housed in the OHU for no other reason than they carried a medical classification of "high-risk." In case 21, the patient may have been inappropriately transferred to CCC, but there was no apparent medical reason to use the OHU bed for this patient. During the onsite inspection, there was another patient not requiring nursing assistance but housed in the OHU solely because of his high-risk classification.

- Virtually all patients returning from an outside hospitalization and many patients returning from an offsite specialty service were returned to the OHU, whether it was medically necessary or not. In some cases, this may have been a reasonable and safe method to ensure patient safety and recovery. However, the routine use of the OHU in this manner increases the number of patient handoffs and transfers of care before the patient can see his primary provider, which increases the risk of miscommunication and lapses in care.

Provider Performance

General provider performance in the OHU was acceptable. Of the 80 OHU provider encounters reviewed, only 14 deficiencies were identified; of those, only two were considered significant.

- In case 88, the provider started the patient on insulin glargine for the first time. Within 24 hours of the first dose of glargine, the provider rapidly increased the dose from 20 units per day up to 40 units per day. This extremely aggressive titration of insulin glargine placed the patient at high risk for hypoglycemia and was far higher than any titration regimen recommended by either the American Diabetes Association or CCHCS. Fortunately, the patient did not suffer any adverse reaction.

- In case 55, the patient was admitted to the OHU, but the admission history and physical were cursory and incomplete, and did not address the full spectrum of the patient's health problems as would be expected for this type of encounter.

Provider continuity in the OHU was poor, just as it was in the clinic setting.

- In case 37, one OHU provider diagnosed the patient with an infected toe. A few days later, a different OHU provider discharged the patient without ever addressing the infected toe. This type of oversight was attributed to poor provider continuity.

Provider documentation in the OHU was sometimes incomplete or missing.

- In case 1, an admission note was not completed within 24 hours of admission.

- In cases 1, 2, 29, and 59, a full history and physical examination was not performed and documented in the eUHR within 72 hours of admission.

Since all the clinic providers seemed to rotate into the OHU, the same types of deficiencies found in the clinics were occasionally found in the OHU. For example, incomplete or inadequate documentation (cases 1, 37, 46, 48, 55, and 58) or inadequate review of the record or labs (case 39) was generally mirrored in the OHU. However, since most OHU admissions were for the purpose of completing a specific task, providers generally were able to accomplish that one specified task. Thus, provider performance is considered only marginally acceptable in the OHU.

Nursing Performance

The majority of serious practice issues involved inadequate assessment and improper documentation by nursing staff. Of the 41 deficiencies identified for nursing services, 21 were considered unlikely to contribute to patient harm. However, 20 were likely to contribute to patient harm if not addressed.

Case review findings clearly showed the close connection between adequate nursing care provided and the nursing documentation of the assessment and interventions. For example, the consistent use of "cloned" documentation over consecutive days and illegible handwriting made meaningful evaluation of nursing care extremely difficult and, in many cases, impossible. Documentation was considered cloned when entries were worded exactly the same or similar to the previous entries, making it impossible to distinguish notes from one date of service to another. Numerous incidents of cloned nursing notes by OHU nurses showed exact or almost exact copies from previous encounters, which could potentially result in inaccurate medical records and poor patient care.

Handwriting legibility is essential for clear documentation of patient medical records. Nursing documentation in numerous cases was reviewed by several OIG nurse and physician clinicians and was illegible, with most words impossible to decipher. Illegible nursing notes may result in disruption in the continuity of patient care and potentially put the patient at risk.

The OIG clinicians identified multiple issues in nursing, demonstrated by findings in the following case review examples.

<u>Inadequate Nursing Assessment</u>

- In case 2, the RN gave the patient laxative medications (Milk of Magnesia and Colace) as ordered by the primary care provider (PCP) for constipation at 8:00 a.m., and the instructed the patient to increase oral fluids and walk more often. At 2:00 p.m., the departing second watch RN noted the patient had "still had no bowel movement;" 30 minutes later, the newly arrived third watch RN noted "patient had bowel movement today."

- In case 16, the patient was admitted to the OHU immediately upon arrival to CCC from another CDCR institution. The RN did not assess the actual weight for the obese patient with cellulitis and edematous lower leg, did not describe the lower leg stasis ulcer, and did not recheck the patient's elevated blood pressure. The RNs completing the OHU admission

assessment generally did not check patients' actual weights but documented only "stated" weights (cases 17, 18, 19, 55).

- In case 19, the patient developed an elevated temperature (101.4 degrees). The RN administered acetaminophen with codeine with a plan of care to monitor and recheck the patient's temperature and pain level in one hour. The RN did not recheck the patient or contact the PCP regarding the elevated temperature. The next temperature check was eight hours later.

- In case 29, the patient was admitted to the OHU in January 2014 for leg pain and difficulty walking following a canine bite incurred while attempting to escape. The RN documented essentially the same set of vital signs at 9:25 a.m. for the OHU admission that had been documented by the TTA RN at 8:11 a.m. and by the RN medical responder at 7:45 a.m. Similar documentation of the same vital signs at different times also occurred in case 55 on August 28, 2014. These findings indicate may indicate the nurses did not actually take the vital signs.

- In case 58, the RN did not assess the condition of the incision site upon return to the TTA and at the time of admission to the OHU. The RN documented that pain medication was given but did not document the time the medication was administered on the OHU admission nursing note or on a MAR.

Cloned Nursing Assessment Documentation

- In case 56, the nursing assessment was contradictory. The RN repeatedly documented that patient "stated pain was 3/10" and "denies pain" in the same objective assessment in cloned-style nursing notes on October 24, October 25, and October 26, 2014.

- Cloned nursing notes and, therefore, questionable nursing assessments occurring over a period of two to six consecutive days were found in cases 2, 18, 20, 29, 37, 39, 56, and 58.

Illegible Nursing Documentation

- Illegible TTA and OHU nursing notes and, as a result, inadequate nursing assessments were found in cases 1, 2, 5, 18, 21, 35, 36, 38, 39, 50, 55, 56, and 58.

Documentation on Wrong Patient

- In case 4, the patient was discharged from the OHU during second watch at 12:30 p.m. on August 28, 2014. The following third watch RN and first watch RN incorrectly documented assessments and interventions for another patient on this patient's medical record. During

the onsite visit, the supervising RN explained the documentation error occurred because the patients had the "same last name."

- In case 17, the patient returned to the institution after evaluation at a community hospital for a fractured jaw. The TTA RN evaluating this patient upon his return incorrectly recorded the assessment as twisted knee. This TTA note appeared to document another patient's medical encounter.

Clinician Summary: Specialized Medical Housing

The institution's use of the OHU as a routine housing unit for patients far exceeded the unit's intended purpose of providing outpatient health services and assistance with the activities of daily living. This unnecessary increased provider utilization exacerbated the provider shortage problem, and increased the risk for lapses in care due to the greater number of patient handoffs. Providers generally exhibited similar patterns of deficiencies in the OHU as they did in the clinic. However, because the reason for OHU admission was generally problem-focused, providers generally performed acceptably in this setting. OHU nurses demonstrated severe problems with nursing assessment and documentation. Many nursing assessments did not seem to match the patient's clinical condition. Many documents were cloned copies of prior documents and demonstrated that a proper assessment had not been performed. Nurses' illegible handwriting was a widespread finding in numerous OHU cases reviewed. Because of the severity of the nursing deficiencies, the excessive utilization of the OHU, and the only marginally acceptable provider performance, the overall quality of OHU care was rated as *inadequate*.

Compliance Testing Results

The institution received a *proficient* score of 92.0 percent for the *Specialized Medical Housing* indicator, which focused on the institution's outpatient housing unit (OHU). CCC scored well in the following areas:

- For all ten inmate-patients sampled (100 percent), nursing staff completed an initial assessment on the day the patient was admitted to the OHU (MIT 13.001).

- For nine of the ten inmate-patients sampled (90 percent), the PCP evaluated the patient within 24 hours of the patient's admission to the OHU. However, one patient was not seen by the PCP until three days after he was admitted to the OHU. For all seven applicable patients who remained in the OHU for two weeks or more (100 percent), the PCP completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required intervals (MIT 13.002, 13.004).

- When the OIG observed the working order of sampled call buttons in OHU patient rooms, inspectors found the call buttons were working properly. According to staff the OIG

interviewed, custody officers and clinicians respond and access inmate-patients' rooms in less than 30 seconds when an emergent event occurs. As a result, the institution received a score of 100 percent in this area (MIT 13.101).

While the institution did well in several areas, it needs to improve in the following area:

- When the OIG tested whether the PCP completes a written history and physical (H&P) examination of each patient in the OHU, inspectors found that only seven of the ten patients sampled (70 percent) received an H&P exam within 72 hours of admission. For three patients, inspectors could not find evidence that an H&P exam was completed (MIT 13.003).

Recommendations

- Careful consideration should be given to the utilization of OHU resources. Unnecessary OHU utilization exacerbates existing provider shortages. Routine use of the OHU also increases the number of patient handoffs, which in turn increases the potential for lapses in care. All OHU admissions, even short-term holds, should be accompanied by the required provider documentation that demonstrates the need for the OHU admission.

- The institution should evaluate the process currently in place in the OHU for monitoring nursing performance in the areas of completion of assessments and accurate, legible documentation. Methods should be established to ensure that nursing assessments and interventions are documented for each patient encounter that specifically reflect current patient status, and that documentation is legible and accurate.

- The PCP assigned to the OHU should ensure that each patient generally receives an H&P examination within 72 hours of admission to the OHU, unless an H&P examination had already been completed within the five-day period prior to the patient's admission.

SPECIALTY SERVICES

***Case Review Rating**:* *Inadequate*
***Compliance Score**:* *79.8%*

Overall Rating: *Inadequate*

This indicator focuses on specialist care from the time a request for services or physician's order for specialist care is completed to the receipt of related recommendations from specialists. This indicator also evaluates the providers' timely review of specialist records and documentation reflecting the patients' care plans, including course of care when specialist recommendations were not ordered, and whether the results of specialists' reports are communicated to the patients. For specialty services denied by the institution, the OIG determines whether the denials are timely and appropriate and whether the inmate-patient is updated on the plan of care.

Case Review Results

The OIG clinicians reviewed 145 events related to *Specialty Services*, including at least 125 specialty consultations or procedures. Eighty-one deficiencies were found in this category, 18 of which were considered significant.

Primary Care Provider—Specialty Performance

The OIG's inspection found that CCC providers have developed an unusually high dependence on specialty services. This dependence extended into some of the most common medical areas that typically fall within the scope of practice for primary care providers (PCPs). The following are just a few of the examples found during case review.

- In case 41, the patient had just admitted to the provider that he had been trying to hide his pre-existing diagnoses of diabetes and hyperlipidemia. The patient had no cardiac symptoms and a normal EKG, but the patient was nevertheless referred to a cardiology specialist for management of cardiac risk, which is typically within the PCP's scope of practice. This patient was subsequently exposed inappropriately to radiation when the cardiologist recommended an unnecessary coronary artery calcium CT scan.

- In case 44, the patient with a history of prostate cancer had already been treated extensively by a cardiologist for asymptomatic, intermittent tachycardia. He received a myocardial perfusion scan, a CT angiogram of the chest, an echocardiogram, and a lower extremity duplex scan, which were all normal. The cardiologist had already cleared the patient of any significant cardiac abnormality, but the patient was referred back to the cardiologist for yet another cardiac clearance.

- In case 48, the patient developed small kidney stones. He developed painful symptoms, which resolved completely after a few hours. The typical treatment for asymptomatic small kidney stones is to watch and wait for a period of time, as most of those stones will pass spontaneously without any surgical intervention. However, the provider referred the patient to a specialist, even though the symptoms had resolved three days prior. In addition, the provider inaccurately documented the size of one of the stones, which resulted in an inappropriate approval of the referral through utilization review.

- In case 88, the patient developed persistent left arm pain after vigorous exercise. The provider reviewed an EKG, which was unremarkable. While it was quite likely that the patient had a musculoskeletal problem, the provider ordered a cardiology consult anyway without first performing preliminary cardiac risk stratification (cardiac stress test).

At first glance, these examples of overutilization do not seem to indicate any significant problems with the delivery of adequate medical care. However, the pattern of specialty overuse suggests

significant problems with primary care provider performance. One troubling conclusion is that some providers may be uncomfortable, unwilling, or even incapable of treating some of the most basic conditions in primary care practice, such as high cholesterol, kidney stones, preliminary cardiac risk stratification, or routine cardiac clearance prior to surgery. In addition, there is an apparent lack of PCP accountability for the primary care needs of their patients. Instead of taking primary responsibility for some of these basic needs, some providers attempt to transfer the responsibility to the specialist, as evidenced by subsequent progress notes where the issues are only addressed by the PCP in a cursory manner.

Specialty Access

Case reviews found that specialty services were generally provided within excellent time frames for both routine and urgent services. Out of 125 specialty consults and procedures, case reviews found only 5 episodes where the specialty service did not occur within the time frame specified. In those cases, the delays were generally due to specialist unavailability and did not result in harm to the patient. These delays were identified in cases 18, 38, 49, 57, and 58. Considering CCC's remote locale, this performance was remarkable.

Health Information Management

If specialty reports were available, providers generally reviewed them timely. After provider review, the reports were scanned within an acceptable time frame. However, case review found that there were significant problems with the processing of specialty reports. Of the 125 specialty consultations or procedures reviewed, there were 53 deficiencies found with regard to health information management, 10 of which were considered significant.

- Specialty reports were sometimes not retrieved or not found in the medical record. When specialty reports were not retrieved or reviewed, patients were placed at high risk for delays or even lapses in care. In case 57, the medical record suggested that the patient had undergone a cardiac procedure (cardioversion) for an irregular heartbeat. However, during the onsite inspection, OIG clinicians learned that the procedure was never actually performed. The medical record indicates that no provider was aware that the procedure did not occur, as the cardiologist's report had not been retrieved or reviewed. This case highlights the importance of ensuring that every specialty report is retrieved, reviewed, and placed in the medical record. This type of deficiency was identified in cases 29, 36, 44, 45, 46, 47, 48, 55, 56, 57, 58, 60, and 88.

- Specialty reports were sometimes retrieved but were late or delayed. This type of deficiency was identified in cases 1, 37, 40, 41, 44, 55, 56, 57, 58, and 88.

- Specialty reports were sometimes not available to the provider at the time of the appointment intended to review the specialty recommendations or procedure. This type of deficiency was identified in cases 37, 57, and 58.

- Specialty reports were sometimes not reviewed by a provider, or were not reviewed timely. This type of deficiency was identified in cases 1, 29, 40, 55, 56, 58, and 88.

- Specialty reports were often initialed as reviewed, but the date of the review was not indicated on the specialty report. This type of deficiency was identified in cases 38, 40, 44, 55, 60, and 88.

Utilization Management

The OIG clinicians found evidence of a poorly performing utilization management system, with examples of insufficient depth of review as well as inappropriate approvals for specialty services.

- In case 4, the patient had a growth in the eye (pterygium) that is normally treated conservatively and is not removed unless it begins to grow across the cornea and interfere with vision. The patient was inappropriately approved for the surgery despite no evidence that there was encroachment of the cornea or interference with vision.

- In case 45, a urology specialist made an extremely questionable recommendation to perform a prostate biopsy because the patient's PSA level was 2.4. Most community physicians, both specialists and primary care doctors, would consider a PSA level of 2.4 normal, and would not require further testing. Nevertheless, the urologist proceeded to perform an invasive ultrasound and biopsy procedure, which was never reviewed or approved through CCC's utilization management process.

- In case 48, the patient with kidney stones was approved to have a lithotripsy procedure prematurely. The patient had not been given a proper trial of medications and watchful waiting to see if the stones would pass spontaneously before the procedure had been approved.

- In case 41, the patient was inappropriately approved for a referral to a cardiologist under the guise of a patient with severe, uncontrolled high cholesterol. In fact, the patient had only been started on cholesterol medications less than two weeks prior, and a repeat cholesterol level had not yet been checked.

- In case 57, the patient was inappropriately approved for a referral for the surgical removal of skin tags, which are typically a benign condition that rarely require surgical intervention.

- In case 88, the patient was inappropriately approved to see a cardiologist for risk factor management. Utilization management approved the referral under the guise of carotid artery disease, which the patient did not have.

- In case 60, the patient was inappropriately approved for surgical resection of a lipoma, which is typically a painless and benign condition.

Nursing Performance

Patients returning from an outside specialty service usually encounter a registered nurse (RN) upon return to the facility. RNs occasionally failed to properly review the specialist's recommendations and communicate them to the primary care provider.

- In case 36, the RN did not contact the provider to discuss the specialist's recommendation to increase the frequency of one of the patient's medications.

- In case 55, the RN did not document the specialist's recommendations and did not contact the provider regarding those recommendations. On a separate occasion, the patient was administered medications that had been missed while he had been out of the facility seeing the specialist. However, the RN did not document the administered medications.

- In case 56, the RN did not document the type of consultation, procedure, or care instructions the patient received. Additionally, the RN did not sign the progress note.

OIG Clinician Onsite Inspection

During the onsite inspection, OIG clinicians reviewed many of the deficiencies noted above with the specialty department and utilization management staff. The specialty department was aware of some of the problems with respect to specialty report handling, and had already implemented some changes in an attempt to improve the retrieval of reports. A full tracking system had not yet been implemented. The utilization management department was not aware of the problems identified with regard to insufficient review or inappropriate approval of specialty referrals. Providers and provider managers acknowledged a mild overdependence on specialty services but did not believe that this compromised patient care.

Clinician Summary: Specialty Services

There were many problems found within Specialty Services. Providers appeared to be overly dependent on specialty services, which suggests that some CCC providers may be uncomfortable, unwilling, or even incapable of treating some of the most basic conditions in primary care practice. In addition, CCC providers demonstrated a lack of accountability by attempting to shift some basic patient care responsibilities to the specialist. The OIG found many problems with the handling of specialty reports, where reports were not retrieved at all, retrieved late, or not properly reviewed by a provider. The utilization management review process was superficial and incomplete; the OIG found many examples of insufficiently reviewed and inappropriately approved specialty referrals. Nursing staff did not consistently perform full assessments for patients returning from a specialty

service. They also did not consistently document the recommendations or notify the provider regarding the findings. On a positive note, CCC patients were provided with excellent specialty services access. As a whole, the combination of poor provider performance, poor processing of specialty reports, and poor utilization management resulted in an *inadequate* rating for this indicator.

Compliance Testing Results

The institution received an *adequate* score of 79.8 percent in the *Specialty Services* indicator. Although CCC received *adequate* to *proficient* scores in five of the seven tests conducted, it needs to improve in two areas. The following areas were in the *proficient* range:

- The OIG found that all 15 inmate-patients sampled (100 percent) received their routine specialty services appointment or service within 90 calendar days of the provider's order. In addition, all 15 of the related specialty services reports (100 percent) were reviewed timely by a provider within three business days (MIT 14.003, 14.004).

- For 13 of the 15 inmate-patients sampled (87 percent), their high-priority specialty service appointment or service occurred within 14 calendar days of the provider's order. One patient's appointment was four days late and another patient's appointment was two days late (MIT 14.001).

The institution performed within the *adequate* range in the following areas:

- When inmate-patients are approved or scheduled for specialty services appointments from one institution and then transfer to another institution, policy requires that the receiving institution ensure that a patient's appointment is timely rescheduled or scheduled and held. For 16 of the 19 patients sampled (84 percent), the patient received his specialty service appointment within the required action date. Three other patients received their dermatology or optometry appointments from 6 to 24 days late (MIT 14.005).

- Inspectors found that providers reviewed the high-priority specialists' reports within three business days for 12 of the 15 patients sampled (80 percent). Two patients' reports were reviewed three days late; another patient's report was reviewed one day late (MIT 14.002).

The institution performed poorly in the following two tests regarding specialty services denials:

- When the institution denied a PCP's request for a patient's specialty service, the provider did not always communicate the denial status to the patient within 30 calendar days and provide the patient with alternate treatment strategies. Denials were timely communicated to only three of the eight patients the OIG sampled (38 percent). For three patients, providers communicated the denial of service 2, 21, and 49 days late, respectively; for two other

patients, inspectors did not find any evidence that the provider ever discussed the denial with the patient (MIT 14.007).

- Inspectors tested the timeliness of CCC's denials of providers' specialty services requests for ten patients and found that seven of the denials (70 percent) occurred within the required time frame. For three patients' routine specialty services, the institution's second-level reviewer issued the denial from two to five days late (14.006).

Recommendations

- The chief medical executive should collaborate with utilization management staff to develop a quality improvement plan to ensure that all specialty referrals are reviewed with sufficient depth so that all utilization management entries into the InterQual system are accurate.

- Extensive training should be held so that physician reviewers can consistently make appropriate approvals and denials of specialty requests. Primary care providers should have ongoing, regular, and frequent training to reinforce the expectations that providers take ownership and responsibility for the entire patient, including all of the patient's medical needs. Specialty referrals are solely intended to assist the PCP with medical management, and are not to be used to transfer patient care responsibility to a specialty provider.

- The institution should develop and test quality improvement and quality control processes to ensure that every specialty report is retrieved, reviewed, and placed in the medical record.

- Nursing supervisors should regularly audit cases where a patient returns from a specialty service to ensure that registered nurses are performing full assessments, fully reviewing the specialty recommendations, and ensuring that the provider is fully informed of those recommendations.

- When a PCP's order for a routine specialty service is denied at the first or second level of review, the institution should ensure that the denial is made within seven calendar days of the request. In addition, providers should communicate the status of denied specialty services requests to the inmate-patient within 30 calendar days of the highest level of denial.

- The institution must ensure that patients who transfer into CCC with a previously approved specialty services request from the sending institution receive their appointment (or service) within the required time frame.

- CCC providers should review consultants' specialty reports for high-priority services within three days of the date the specialty service was provided.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

The last two quality indicators involve health care administrative systems and processes. Testing in these areas applies only to the compliance component of the process. Therefore, there is no case review assessment associated with either of the two indicators. As part of the compliance component for the first indicator below, the OIG did not score several questions. Instead, the OIG presented the findings for informational purposes only. For example, the OIG described certain local processes in place at CCC.

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to CCC in March 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection.

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
75.7%

Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes inmate-patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and inmate deaths, and whether the institution is making progress toward its Performance Improvement Work Plan initiatives. In addition, the OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held.

Compliance Testing Results

Overall, CCC scored within the *adequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving an overall score of 75.7 percent. Of the nine scoreable tests for this indicator, the following five tests individually scored in the *proficient* range with scores of 100 percent:

- Inspectors reviewed the institution's medical appeal data and found that CCC promptly processed inmate medical appeals timely for all 12 of the most recent months (100 percent) (MIT 15.001).

- Inspectors reviewed six recent months of QMC meeting minutes and confirmed that the institution's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003).

- Inspectors determined that the institution's QMC takes adequate steps to ensure the accuracy of its Dashboard data reporting, scoring 100 percent for this test (MIT 15.004).

- The OIG inspected documentation for 12 emergency medical response incidents reviewed by the Emergency Medical Response Review Committee (EMRRC) during the prior six-month period and found that all 12 incident packets had been appropriately reviewed and included all required documentation. As a result, CCC received a score of 100 percent for this test (MIT 15.007).

- When the OIG sampled ten second-level medical appeals, inspectors found that for all ten appeals (100 percent), the institution's response addressed all of the patients' appealed issues (MIT 15.102)

The institution scored in the *adequate* range for the following test:

- Medical staff properly processed and timely submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for three of four deaths that occurred at CCC in the prior 12-month period. One of the four death reports was not initialed by either the CME or CEO to evidence their review. As a result, the institution scored 75 percent for this test (MIT 15.103).

CCC scored in the *inadequate* range for the three tests below:

- The OIG reviewed the only adverse/sentinel event (ASE) that occurred at CCC during the prior six-month period, which required a root cause analysis. Inspectors found the event was reported to CCHCS's ASE Committee 12 days late; policy requires staff report all ASEs within 24 hours of occurrence. As a result, the institution received a score of 0 percent for this test (MIT 15.002).

- When the OIG reviewed CCC's 2014 Performance Improvement Work Plan, inspectors found that the institution documented improvement in achieving targeted performance objectives for only two of its five quality improvement initiatives, or 40 percent (MIT 15.005).

- Inspectors reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter and found that only two of the three

drills (67 percent) included participation by both health care and custody staff. Custody staff did not participate in one of the drills (MIT 15.101).

Other Information Obtained From Non-Scored Areas

- The OIG reviewed the timeliness of the CCHCS death review summaries related to the four aforementioned deaths that occurred at CCC during the prior 12-month period. The CCHCS Death Review Committee is required to complete its review within 30 business days of the death and submit the summary to the institution within 35 business days of the death. Inspectors found that none of the death review summaries were completed timely; CCHCS submitted the four reports to the institution 46, 66, 115, and 131 days late, respectively (MIT 15.996).

- Inspectors met with the institution's chief executive officer (CEO) and health care appeals coordinator to inquire about CCC's protocols for tracking appeals. The coordinator indicated management is provided a weekly workload report and a monthly activity report. The reports break down the number of appeals and each appeal's category and status. According to the CEO, the management team reviews and discusses appeals during monthly QMC meetings to identify any adverse trends or systemic issues. When problem areas are identified, staff will contact the inmate who filed the appeal and attempt to resolve the issue at the lowest level. Management has not identified any critical appeal issues; most of CCC's appeals involve inmate-patients who want to qualify for adult firefighting conservation camps (MIT 15.997).

- Data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicated the institution has an effective process in place for developing LOPs. The health program specialist (HPS) monitors existing LOPs to ensure they are current and reviews new and revised CCHCS policies and procedures to determine whether they impact existing LOPs or require a new LOP. The applicable area supervisor and the HPS work together to revise existing LOPs or develop new ones, as needed. After CCC's Quality Management Review Committee approves a new or revised LOP, it is added to the monthly training curriculum. Currently, the institution has implemented 42 of the 49 applicable stakeholder-recommended LOPs (86 percent) (MIT 15.998).

- The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page 2 of this report (MIT 15.999).

CCHCS Dashboard Comparative Data

The Dashboard and the OIG scores both show that CCC is processing medical appeals at a *proficient* level, with both measures scoring at 100 percent.

Internal Monitoring, Quality Improvement, and Administrative Operations— CCC Dashboard and OIG Compliance Results

CCC DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Timely Appeals March 2015	Medical Appeals—Timely Processing (15.001) 12 Months Ending January 2015
100%	**100%**

Note: The CCHCS Dashboard data includes appeal data for American Disability Act, mental health, dental, and staff complaint areas; the OIG excluded these appeal areas.

Recommendations

- The institution should report adverse/sentinel events (ASEs) to CCHCS's ASE committee within 24 hours of the event.

- Institution management should document the status of performance objectives for all quality improvement initiatives identified in the Performance Improvement Work Plan.

- In preparation for medical emergencies, custody staff should participate in all medical emergency response drills.

- Medical staff should ensure that each Initial Inmate Death Report (CDCR Form 7229A) is reviewed and initialed by the CME or CEO before submitting it to CCHCS' Death Review Unit.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

In this indicator, the OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current medical emergency response certifications.

Case Review Rating:
Not Applicable
Compliance Score:
78.3%

Overall Rating:
Adequate

Compliance Testing Results

The institution received an overall score of 78.3 percent in the *Job Performance Training, Licensing, and Certifications* indicator.

For five of the indicator's eight tests, the institution scored 100 percent. Those tests included the following:

- The OIG found that CCC providers possessed current professional licenses. Nursing staff and the pharmacist-in-charge also possessed current professional licenses and met all certification requirements (MIT 16.001, 16.105).

- When the OIG reviewed training records for ten nursing staff who administer medications, inspectors found that all ten had current clinical competency validations. Inspectors also confirmed that all nursing staff hired within the last 12 months received new employee orientation training (MIT 16.102, 16.107).

- The institution's pharmacy and providers who prescribe controlled substances have current Drug Enforcement Agency registrations (MIT 16.106).

The institution scored in the *inadequate* range in the following three notable areas:

- When the OIG reviewed annual performance evaluation packets for the institution's eight providers, inspectors found many exceptions that caused CCC to receive a score of 0 percent for this test. Although required unit health record clinical appraisals (UCAs) were conducted for seven of the providers, there was no evidence in the evaluation packet that the reviewing supervisor had discussed the results of those UCAs with the provider; the remaining provider's evaluation packet did not include any UCAs. In addition, for five of the providers, their most recent performance appraisal had not been completed within the last 13 months. For four of the providers, the required 360-Degree Evaluation was not performed.

Inspectors also noted that the evaluation for one provider was not signed by either the supervisor or the provider (MIT 16.103).

- Supervising registered nurses (SRNs) do not always conduct adequate reviews of their nursing staff. When the OIG reviewed files for five nurses, inspectors found that the SRN completed the required nursing reviews for only three of the five sampled nurses (60 percent). For two nurses, the SRNs' reviews of nurse-patient encounters did not include aspects of the encounter that were well done and aspects that needed improvement (MIT 16.101).

- The OIG tested provider, nursing, and custody staff records to determine if the institution ensures that those staff members have current emergency response certifications. While the institution's provider and nursing staff were all compliant, custody staff were not. Specifically, the institution does not require custody staff at the rank of captain and above to maintain CPR certifications. It should be noted that while the California Penal Code exempts those custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. The institution received a score of 67 percent for this test (MIT 16.104).

Recommendations

- Supervisors who conduct annual performance evaluations of clinical providers should conduct these evaluations every 12 months, perform a 360-Degree Evaluation and UCAs as part of the evaluations, and discuss all results with the evaluated provider.

- Institution management should require that all custody staff, including custody managers, receive and maintain a current emergency response certification.

- The institution's SRNs should include aspects of the encounter that are performed well and aspects that need improvement when documenting periodic nursing reviews of nurse-patient encounters.

POPULATION-BASED METRICS

The compliance testing and the case reviews give an accurate assessment of how the institution's health care systems are functioning with regard to the patients with the highest risk and utilization. This information is vital to assess the capacity of the institution to provide sustainable, adequate care. However, one significant limitation of the case review methodology is that it does not give a clear assessment of how the institution performs for the entire population. For better insight into this performance, the OIG has turned to population-based metrics. For comparative purposes, the OIG has selected several Healthcare Effectiveness Data and Information Set (HEDIS) measures for disease management to gauge the institution's effectiveness in outpatient health care, especially chronic disease management.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) with input from over 300 organizations representing every sector of the nation's health care industry. It is used by over 90 percent of the nation's health plans as well as many leading employers and regulators. It was designed to ensure that the public (including employers, the Centers for Medicare and Medicaid Services (CMS), and researchers) has the information it needs to compare accurately the performance of health care plans. HEDIS data is often used to produce health plan report cards, analyze quality improvement activities, and benchmark performance.

Methodology

For population-based metrics, the OIG used a subset of HEDIS measures applicable to the CDCR inmate-patient population. Selection of the measures was based on the availability, reliability, and feasibility of the data required for performing the measurement. The OIG collected data utilizing various information sources, including the eUHR, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For California Correctional Center, nine HEDIS measures were selected and are listed below in *Table 1–CCC Results Compared to State and National HEDIS Scores*. Multiple health plans publish their HEDIS performance measures at the State and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes. In addition, the OIG selected California's Medi-Cal Managed Care Program as the population most similar to that of the CDCR inmate population. As indicated below in *Table 2–CCC Results Compared to Medi-Cal Minimum and Maximum Performance*, the California Department of Health Care Services (DHCS)

annually establishes a minimum performance level (MPL) and a high performance level (HPL) for each of its required performance measures. Where applicable, the OIG compared CCC's results to the Medi-Cal MPL and HPL levels.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. CCC performed well with its management of diabetes.

When compared statewide, CCC outperformed or matched the Medi-Cal HPL scores (Table 2) in four of the five diabetic measures selected (HbA1c monitoring, HbA1c poor control, HbA1c good control, and blood pressure control). For diabetic patient eye examinations, CCC scored 3 percentage points lower than Medi-Cal's HPL. When compared to Kaiser Permanente (Table 1), CCC outperformed Kaiser in the first three diabetic measures (as cited above). However, CCC's scores for blood pressure control and eye exams were 10 and 15 percentage points lower, respectively, than Kaiser's highest average score.

When compared nationally (Table 1), CCC outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the five diabetic measures listed, with one exception. For eye exams, CCC's score was 2 percentage points below Medicare's score. When compared to the U.S. Department of Veterans Affairs (VA), CCC outperformed the VA by 13 percentage points for its diabetic patients considered to be under poor control and was only slightly lower than the VA for its diabetic monitoring. However, for blood pressure control and eye exams, the CCC trailed the VA by 5 and 23 percentage points, respectively.

Immunizations

Comparative data for immunizations (Table 1) was only fully available for the VA (national) and partially available for Kaiser Permanente (statewide) and commercial (national). CCC scored 10 percentage points lower than Kaiser's highest average, only 1 percentage point lower than commercial, and 16 percentage points lower than the VA for influenza shots for adults up to age 64. In addition, CCC received a score of 0 percent for both immunizations of patients 65 and older and pneumococcal vaccinations. The institution had only two applicable patients to sample for both tests. With regard to the influenza vaccinations, both patients were offered the vaccination but refused it. With regard to pneumococcal vaccinations, one of the two patients was offered the vaccination and refused it, and the other patient had no record of being offered or receiving the vaccination at all.

Cancer Screening

For colorectal cancer screening (Table 1), CCC scored significantly lower than each of the other entities that reported data (Kaiser, commercial, Medicare, and the VA). However, the OIG found that all 33 inmates sampled were offered the screening timely, but over half of them had subsequently refused the test.

Summary

The California Correctional Center's population-based metrics performance was strong for most diabetic measures but weak for immunizations and cancer screening when compared to State and national results. CCC outperformed all State and national average scores for both its diabetics considered to be under poor control and diabetics considered to be under good control, and, except for the VA, the institution outperformed others for its diabetic monitoring. With regard to blood pressure control and eye exams for diabetic patients, CCC's scores were mid-range when compared to the other entities.

For immunization measures and colorectal cancer screening, the institution performed poorly, receiving lower scores than Kaiser, commercial, and the VA, which were the only entities that reported data in these areas. However, CCC's scores were negatively impacted by patients who were offered immunizations and cancer screenings but refused them.

Overall, CCC's HEDIS performance was marginally adequate. With regard to CCC's performance in the immunization and colorectal screening measures, the institution should make interventions to lower the rate of patient refusal for influenza shots, pneumococcal vaccinations, and colorectal cancer screening.

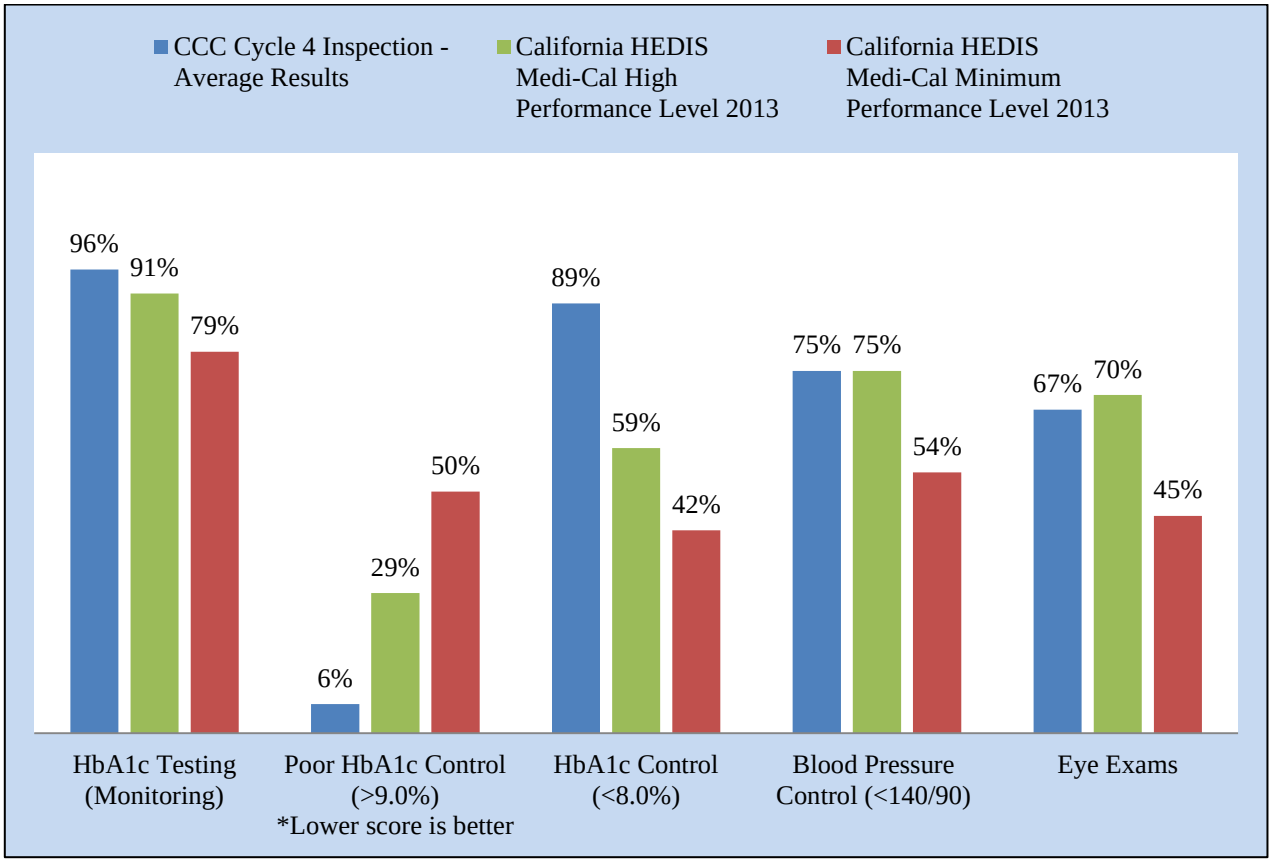
Table 1—CCC Results Compared to State and National HEDIS Scores

Clinical Measures	Institution	California			National			
	CCC Cycle 4 Results [1]	HEDIS Medi-Cal 2013 [2]	Kaiser (No.CA) HEDIS Scores 2014 [3]	Kaiser (So.CA) HEDIS Scores 2014 [3]	HEDIS Medicaid 2013 [4]	HEDIS Com-mercial 2013 [4]	HEDIS Medicare 2013 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**96%**	83%	95%	94%	84%	90%	92%	99%
Poor HbA1c Control (>9.0%) [6,7]	**6%**	40%	18%	21%	46%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**89%**	49%	70%	67%	46%	59%	66%	-
Blood Pressure Control (<140/90) [6]	**75%**	63%	82%	85%	60%	65%	66%	80%
Eye Exams	**67%**	51%	69%	82%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (50–64) [8]	**49%**	-	59%	55%	-	50%	-	65%
Influenza Shots - Adults (65+) [9]	**0%**	-	-	-	-	-	-	76%
Immunizations: Pneumococcal [9]	**0%**	-	-	-	-	-	-	93%
Cancer Screening								
Colorectal Cancer Screening	**46%**	-	78%	80%	-	63%	64%	82%

1. Unless otherwise stated, data was collected in March 2015 by reviewing medical records from a sample of CCC's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.
2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2013 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.
3. Data was obtained from Kaiser Permanente November 2014 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial, and Medicare was obtained from the 2014 State of Health Care Quality Report, available on the NCQA website: www.ncqa.org. The results for commercial were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the VHA Facility Quality and Safety Report–Fiscal Year 2012 Data.
6. For this indicator, the entire applicable CCC population was tested.
7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.
8. The Kaiser Permanente and commercial HEDIS data is for the age range 18–64.
9. CCC only had two applicable inmate-patients for this test. For scoring purposes, both samples failed the test resulting in a zero score.

Table 2—CCC Results Compared to Medi-Cal Minimum and Maximum Performance

Clinical Measures	**CCC** Cycle 4 Inspection Results	California HEDIS Medi-Cal High Performance Level 2013	California HEDIS Medi-Cal Minimum Performance Level 2013
Comprehensive Diabetes Care			
HbA1c Testing (Monitoring)	**96%**	91%	79%
Poor HbA1c Control (>9.0%) **Lower score is better*	**6%**	29%	50%
HbA1c Control (<8.0%)	**89%**	59%	42%
Blood Pressure Control (<140/90)	**75%**	75%	54%
Eye Exams	**67%**	70%	45%



APPENDIX A—COMPLIANCE TEST RESULTS

California Correctional Center **Range of Summary Scores: 52.65% - 92.00%**	
Indicator	**Overall Score (Yes %)**
Access to Care	81.65%
Diagnostic Services	78.57%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	59.65%
Health Care Environment	52.65%
Inter- and Intra-System Transfers	64.67%
Pharmacy and Medication Management	88.83%
Prenatal and Post-delivery Services	Not Applicable
Preventive Services	80.56%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	92.00%
Specialty Services	79.77%
Internal Monitoring, Quality Improvement, and Administrative Operations	75.74%
Job Performance, Training, Licensing, and Certifications	78.33%

Reference Number	Access to Care	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	19	11	30	63.33%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	21	6	27	77.78%	3
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	31	1	32	96.88%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	31	1	32	96.88%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	13	5	18	72.22%	14
1.006	**Sick call follow-up appointments:** If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	8	0	8	100.00%	24
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment with a primary care provider within the required time frame?	4	5	9	44.44%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	25	5	30	83.33%	0
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	5	0	5	100.00%	0
Overall percentage:					**81.65%**	

Reference Number	Diagnostic Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	4	6	10	40.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	8	2	10	80.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	6	1	7	85.71%	3
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	5	2	7	71.43%	3
Overall percentage:					**78.57%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	**Not Applicable**

Reference Number	Health Information Management (Medical Records)	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and Health Care Service Request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	Not Applicable				
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	15	5	20	75.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	7	2	9	77.78%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	15	5	20	75.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	9	23	32	28.13%	0
4.008	**For inmate-patient's discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	6	3	9	66.67%	0
Overall percentage:					**59.65%**	

Reference Number	Health Care Environment	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned, and sanitary?	0	9	9	0.00%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	4	4	8	50.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	6	3	9	66.67%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	5	3	8	62.50%	1
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	6	3	9	66.67%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	8
5.107	**Clinical areas:** Does each clinic follow adequate medical supply storage and management protocols?	8	1	9	88.89%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	5	4	9	55.56%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	6	3	9	66.67%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	2	7	9	22.22%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily, inventoried monthly, and do they contain essential items?	7	0	7	100.00%	1
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**52.65%**	

Reference Number	Inter- and Intra-System Transfers	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	28	2	30	93.33%	0
6.002	**For endorsed inmate-patients received from another CDCR institution:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	27	3	30	90.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	2	2	4	50.00%	26
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	4	6	10	40.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	2	2	4	50.00%	6
Overall percentage:					**64.67%**	

Reference Number	Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	24	2	26	92.31%	4
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	26	4	30	86.67%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	7	2	9	77.78%	0
7.004	**For inmate-patients received from a county jail or COCF:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	21	2	23	91.30%	1
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	2	2	4	50.00%	6
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	10	2	12	83.33%	0
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	6	2	8	75.00%	3
7.104	**Medication preparation and administration areas:** Does nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	4	1	5	80.00%	7
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	0	6	100.00%	6
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	4	0	4	100.00%	8

Reference Number	Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	24	1	25	96.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:					**88.83%**	

Prenatal and Post-delivery Services	Scored Answers
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	Preventive Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	24	6	30	80.00%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	14	16	30	46.67%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	24	6	30	80.00%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	29	1	30	96.67%	0
9.005	**All inmate-patients from the age 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	30	0	30	100.00%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	16	4	20	80.00%	0
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**80.56%**	

Quality of Nursing Performance	Scored Answers
The quality of nursing performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of nursing performance are presented in a separate inspection document entitled OIG MIU Retrospective Case Review Methodology.	**Not Applicable**

Quality of Provider Performance	Scored Answers
The quality of provider performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of provider performance are presented in a separate inspection document entitled OIG MIU Retrospective Case Review Methodology.	**Not Applicable**

Reception Center Arrivals	Scored Answers
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	Specialized Medical Housing (OHU, CTC, SNF, Hospice)	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	9	1	10	90.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	7	3	10	70.00%	0
13.004	**For all higher level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	7	0	7	100.00%	3
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall percentage:					**92.00%**	

Reference Number	Specialty Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high priority specialty service within 14 calendar days of the PCP order?	13	2	15	86.67%	0
14.002	Did the PCP review the high priority specialty service consultant report within three business days after the service was provided?	12	3	15	80.00%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within three business days after the service was provided?	15	0	15	100.00%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	16	3	19	84.21%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	7	3	10	70.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	3	5	8	37.50%	2
Overall percentage:					**79.77%**	

Reference Number	Internal Monitoring, Quality Improvement, and Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow Adverse/ Sentinel Event reporting requirements?	0	1	1	0.00%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	2	3	5	40.00%	0
15.006	**For institutions with licensed care facilities:** does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	2	1	3	66.67%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	1	4	75.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				

Reference Number	Internal Monitoring, Quality Improvement, and Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.999	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
Overall percentage:					**75.74%**	

Reference Number	Job Performance, Training, Licensing, and Certifications	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	9	0	9	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	3	2	5	60.00%	0
16.102	Are nursing staff that administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	0	8	8	0.00%	0
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**78.33%**	

APPENDIX B—CLINICAL DATA

Table B–1: CCC Sample Sets	
Sample Set	**Total**
CTC/OHU	5
Death Review/Sentinel Events	3
Diabetes	4
Emergency Services - Non-CPR	5
High Risk	6
Hospitalization	6
Intra-System Transfers-In	3
Intra-System Transfers-Out	3
RN Sick Call	35
Specialty Services	6
	76

Table B–2: CCC Chronic Care Diagnoses	
Diagnosis	**Total**
Arthritis/Degenerative Joint Disease	8
Asthma	14
COPD	5
Cancer	1
Cardiovascular Disease	8
Chronic Kidney Disease	2
Chronic Pain	9
Cirrhosis/End-Stage Liver Disease	1
Diabetes	8
Gastroesophageal Reflux Disease	17
HIV	1
Hepatitis C	18
Hyperlipidemia	14
Hypertension	12
Mental Health	3
Seizure Disorder	1
Thyroid Disease	1
	123

Table B–3: CCC Event—Program	
Program	**Total**
Diagnostic Services	148
Emergency Care	50
Hospitalization	32
Intra-System Transfers-In	11
Intra-System Transfers-Out	13
Outpatient Care	440
Specialized Medical Housing	217
Specialty Services	145
	1,056

Table B–4: CCC Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	23
RN Reviews Focused	41
Total Reviews	94
Total Unique Cases	76
Overlapping Reviews (MD & RN)	18

APPENDIX C—COMPLIANCE SAMPLING METHODOLOGY

California Correctional Center			
Quality Indicator	**Sample Category (number of patients)**	**Data Source**	**Filters**
Access to Care	Chronic Care (30—Basic Level) (40—Inter Level)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
	Nursing Sick Call (5 per clinic) (minimum of 30)	MedSATS	• Clinic (each clinic tested) • Appt. date (2–9 months) • **Randomize**
	Returns from Community Hospital (30)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
Diagnostic Services	Radiology (10)	Radiology Logs	• Appt. Date (90 days–9 months) • **Randomize** • Abnormal
	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**
Health Information Management (Medical Records)	Timely Scanning (20 each)	OIG Qs: 1.001, 1.002, 1.006, & 9.004	• Non-dictated documents • First 5 inmate-patients selected for each question
		OIG Q: 1.001	• Dictated documents • First 20 inmate-patients selected
		OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 inmate-patients selected for each question
		OIG Q: 4.008	• Community hospital discharge documents • First 20 inmate-patients selected for the question
		OIG Q: 7.001	• MARs • First 20 inmate-patients selected
	Legible Signatures and Review (40)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	• First 8 inmates sampled • One source document per inmate-patient
	Complete and Accurate Scanning	Documents for any tested inmate	• Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
	Returns from Community Hospital (30)	Inpatient Claims Data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Health Care Environment	Clinical Areas (number varies by institution)	OIG Inspector Onsite Review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers	Intra-System transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
	Specialty Service Send-outs (20)	MedSATS	• Date of Transfer (3–9 months) • **Randomize**
Pharmacy and Medication Management	Chronic Care Medication (30—Basic Level) (40—Inter Level)	OIG Q: 1.001	*See* ***Access to Care*** • (At least one condition per inmate-patient—any risk level) • **Randomize**
	New Medication Orders (30—Basic Level) (40—Inter Level)	Master Registry	• Rx Count • **Randomize** • Ensure no duplication of inmate-patients tested in chronic care medications
	Intra-Facility moves (30)	MAPIP Transfer Data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (high–low)–*inmate-patient must have NA/DOT meds to qualify for testing* • **Randomize**
	En Route (10) *N/A at this institution*	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • Length of stay (minimum of 2 days) • NA/DOT meds
	Returns from Community Hospital (30)	*Inpatient Claims Data*	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
	Medication Preparation and Administration Areas	OIG Inspector Onsite Review	• Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy	OIG Inspector Onsite Review	• Identify and inspect onsite pharmacies
	Medication Error Reporting	OIG Inspector Review	• Any medication error identified during OIG eUHR file review, e.g., case reviews and/or compliance testing
Prenatal and Post-delivery Services	Recent Deliveries (5) *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals (5) *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (30—Basic Level) (40—Inter Level) *Not all conditions require vaccinations*	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per inmate-patient—any risk level) • **Randomize** • Condition must require vaccination(s)
	INH (all applicable up to 30)	Maxor	• Dispense date (past 9 months) • Time period on INH (at least a full 3 months) • **Randomize**
	Colorectal Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out inmate-patients tested in chronic care vaccination sample
	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
	Mammogram (30) *N/A at this institution*	SOMS	• Arrival date (at least 2 years prior to inspection) • Date of birth (age 52–74) • **Randomize**
	Pap Smear (30) *N/A at this institution*	SOMS	• Arrival date (at least three years prior to inspection) • Date of birth (age 24–53) • **Randomize**
	Valley Fever (number will vary) *N/A at this institution*	Cocci Transfer Status Report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**
Reception Center Arrivals	RC (20) *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing	OHU, CTC, SNF, Hospice (10 per housing area)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Specialty Services Access	High-Priority (10)	MedSATS	• Appt. date (3–9 months) • **Randomize**
	Routine (10)	MedSATS	• Appt. date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
	Specialty Service Arrivals (20)	MedSATS	• Sending institution • Date of transfer (3–9 months) • Sent to (another CDCR facility) • **Randomize**
	Denials (20)* **Ten InterQual* *Ten MARs*	InterQual	• Review date (3–9 months) • **Randomize**
		IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement and Administrative Operations	Medical Appeals (all)	Monthly Medical Appeals Reports	• Medical appeals (12 months)
	Adverse/Sentinel Events (5)	Adverse/Sentinel Events Report	• Adverse/sentinel events (2–8 months)
	QMC Meetings (12)	Quality Management Committee Meeting Minutes	• Meeting minutes (12 months)
	Performance Improvement Plans (12)	Performance Improvement Work Plan	• Performance Improvement Work Plan with updates (12 months)
	Local Governing Body *N/A at this institution*	Local Governing Body Meeting Minutes	• Meeting minutes (12 months)
	EMRRC (6)	EMRRC Meeting Minutes	• Meeting minutes (6 months)
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	• Most recent full quarter • Each watch
	2nd Level Medical Appeals (10)	OIG Inspector Onsite Review	• Medical appeals denied (6 months)
	Death Reports (10)	OIG Inspector Onsite Review	• Death reports (12 months)
	Local Operating Procedures (all)	OIG Inspector Onsite Review	• Review all

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Job Performance and Training, Licensing and Certifications	RN Review Evaluations (5)	OIG Inspector Onsite Review	• Current Supervising RN reviews
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	• Review annual competency validations • **Randomize**
	Provider Annual Evaluation Packets (all)	OIG Inspector Onsite Review	• All required performance evaluation documents
	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o Custody (CPR/BLS)
	Nursing staff and Pharmacist-in-Charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	• All licenses and certifications
	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	• All current DEA registrations
	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	• New employees (within the last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

August 21, 2015

Robert A. Barton, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California Correctional Center (CCC) conducted from March 2015 to May 2015. California Correctional Health Care Services (CCHCS) acknowledges OIG's findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-9573.

Sincerely,

JANET LEWIS
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, Undersecretary, California Department of Corrections and Rehabilitation
Richard Kirkland, Chief Deputy Receiver
Jared Goldman, Counsel to the Receiver
Christine Berthold, Deputy Inspector General, Senior, OIG
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