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Office of the Inspector General

California Correctional Center
Medical Inspection Results
Cycle 5

October 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CALIFORNIA CORRECTIONAL CENTER
Medical Inspection Results
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FOREWORD

Pursuant to California Penal Code Section 6126 et seq., 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. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards.

The OIG's inspections are mandated by the Penal Code and not aimed at specifically resolving the court's questions on constitutional care. To the degree that they provide another factor for the court to consider, the OIG is pleased to provide added value to the taxpayers of California.

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. At the time of the Cycle 5 inspection of California Correctional Center, the Receiver had not delegated this institution back to CDCR.

This fifth cycle of inspections will continue evaluating the areas addressed in Cycle 4, which included clinical case review, compliance testing, and a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures. In agreement with stakeholders, the OIG made changes to both the case review and compliance components. The OIG found that in every inspection in Cycle 4, larger samples were taken than were needed to assess the adequacy of medical care provided. As a result, the OIG reduced the number of case reviews and sample sizes for compliance testing. Also, in Cycle 4, compliance testing included two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*). For Cycle 5, these have been combined into one secondary indicator, *Administrative Operations*.

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EXECUTIVE SUMMARY

OVERALL RATING:

Adequate

The OIG performed its Cycle 5 medical inspection at California Correctional Center (CCC) from March to May 2017. The inspection included in-depth reviews of 36 patient files conducted by clinicians, as well as reviews of documents from 378 patient files, covering 86 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 13 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *CCC Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

CCC Executive Summary Table

Inspection Indicators	Case Review Rating	Compliance Rating	Cycle 5 Overall Rating	Cycle 4 Overall Rating**
1—Access to Care	*Adequate*	*Adequate*	***Adequate***	*Inadequate*
2—Diagnostic Services	*Inadequate*	*Adequate*	***Inadequate***	*Inadequate*
3—Emergency Services	*Adequate*	Not Applicable	***Adequate***	*Inadequate*
4—Health Information Management	*Adequate*	*Adequate*	***Adequate***	*Inadequate*
5—Health Care Environment	Not Applicable	*Inadequate*	***Inadequate***	*Inadequate*
6—Inter- and Intra-System Transfers	*Proficient*	*Inadequate*	***Adequate***	*Inadequate*
7—Pharmacy and Medication Management	*Adequate*	*Inadequate*	***Inadequate***	*Adequate*
8—Prenatal and Post-Delivery Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable
9—Preventive Services	Not Applicable	*Inadequate*	***Inadequate***	*Adequate*
10—Quality of Nursing Performance	*Adequate*	Not Applicable	***Adequate***	*Adequate*
11—Quality of Provider Performance	*Adequate*	Not Applicable	***Adequate***	*Inadequate*
12—Reception Center Arrivals	Not Applicable	Not Applicable	Not Applicable	Not Applicable
13—Specialized Medical Housing	*Adequate*	*Inadequate*	***Adequate***	*Inadequate*
14—Specialty Services	*Adequate*	*Adequate*	***Adequate***	*Inadequate*
15—Administrative Operations (Secondary)	Not Applicable	*Adequate*	***Adequate***	*Adequate**

* In Cycle 4, there were two secondary (administrative) indicators. This score reflects the average of those two scores.

** The original publication of this report inadvertently misreported the institution's Cycle 4 medical inspection ratings. Although the Cycle 4 ratings had no effect on the Cycle 5 results of this report, the OIG updated the Cycle 4 ratings for this report on December 11, 2017, to correct these errors.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 439 patient care events.[1] Of the 13 indicators applicable to CCC, clinician case reviewers evaluated 10; one was *proficient*, 8 were *adequate*, and one was *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- CCC demonstrated significant improvement with provider-ordered follow-up appointments since Cycle 4.
- The institution improved provider continuity since Cycle 4, with the same provider seeing the patient at each encounter, thereby committing to a primary care model.
- CCC continued providing timely and appropriate specialty services to patients.
- Clinicians at CCC used the telemedicine service innovatively, enhancing the delivery of medical care to their patients both at the institution and at remote fire camp locations.
- Nurse leadership values the nurses and supports the goal to provide the best care possible, and the institution has an effective nursing education program.
- Patients requesting health care services were timely seen by nurses.
- CCC changed the housing unit clinic areas so that nurses and providers are no longer physically separated from each other. This move resulted in improved communication among all members of the primary care team.

Program Weaknesses — Clinical

- CCC lacked stable health care leadership. The current chief physician and surgeon (CP&S) was acting during this case review, the chief medical executive (CME) was on long-term leave, and the new chief executive officer (CEO) had just started working at the institution during the onsite inspection period.
- Although CCC had only one provider vacancy, the institution continued to lack provider availability. One provider, who was nearing retirement, was regularly using accumulated

[1] Each OIG clinician team includes a board-certified physician and a registered nurse consultant with experience in correctional and community medical settings.

time off; the institution's sole onsite physician was on long-term sick leave; and one physician assistant was usually offsite, seeing patients at remote fire camp locations.

- The institution's clinical staff failed to perform diagnostic services in a timely manner and also failed to perform diagnostic tests as ordered by providers.

Compliance Testing Results

Of the 13 health care indicators applicable to CCC, 10 were evaluated by compliance inspectors.[2] Of these, five were *adequate* and five were *inadequate*. There were 86 individual compliance questions within those ten indicators, generating 1,015 data points that tested CCC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 86 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

The following are some of CCC's strengths based on its compliance scores on individual questions in all the health care indicators:

- Nursing staff reviewed patient health care requests the same day they were received, and nurses conducted face-to-face encounters with those patients within required time frames. In addition, all housing units observed by inspectors had an adequate supply of health care request forms.
- The institution's clinics had adequate hand hygiene supplies available, and staff adhered to universal hand hygiene precautions.
- Nursing staff administered new medication orders to patients within required time frames, and nurses followed appropriate protocols during medication preparation at medication line locations.
- CCC provided high-priority and routine specialty service appointments to patients within required time frames.
- The institution did well in administrative operation activities, specifically in regard to processing initial and secondary medical appeals, and reviews of emergency responses by the Emergency Medical Response Review Committee (EMRRC).

[2] The OIG's compliance inspectors are registered nurses with expertise in CDCR policies regarding medical staff and processes.

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

Program Weaknesses — Compliance

The following are some of the weaknesses identified by CCC's compliance scores on individual questions in all the health care indicators:

- Examination rooms at several clinic locations did not have an adequate environment conducive to providing medical services, with several rooms that were small and impeded access to patients; in addition, supplies were not always clearly marked in the clinics. Emergency medical response bags (EMRBs) at several clinic locations were not inventoried per CCHCS policy, and some EMRB logs did not have evidence that the bag was verified as sealed and intact.
- Nursing staff did not always answer all required questions on the Initial Health Screening form (CDCR Form 7277) for patients transferring into CCC.
- CCC did not always properly store non-narcotic medication at clinic and medication line locations that required both refrigeration and non-refrigeration.
- Clinical staff at the institution performed poorly in monitoring patients who were taking tuberculosis (TB) medications.
- Patients who transferred into CCC with a previously approved specialty service appointment from the sending institution did not always receive the pending appointment upon arrival at the institution, or received the appointment late.

Recommendations

- The OIG recommends that CCC re-examine and modify its diagnostic processes to ensure reliable test completion and diagnostic report retrieval.
- The OIG clinicians recommend that CCC develop a local policy addressing provider and nursing responsibilities for patients in the OHU for less-than-24-hour observation.
- The OIG recommends that, at the time of a patient's discharge, the OHU nurse verbally communicate patient information to the assigned primary care clinic nurse and document in the OHU discharge nursing note that the nurse-to-nurse transfer of information occurred.

Population-Based Metrics

In general, CCC performed at an acceptable level as measured by population-based metrics compared to the other state and national health care plans reviewed. In comprehensive diabetes care, the institution outperformed other state and national health care plans across the majority of measures. However, CCC performed less well compared to the same state and national health care plans for influenza immunizations and colorectal cancer screenings. The high rate of patient refusals for both services negatively affected CCC's scores. The institution may improve its score by educating patients on the benefits of these preventive services.

INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., 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. The OIG conducts a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

California Correctional Center (CCC) was the eighth medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is purely administrative and is not reflective of the actual clinical care provided.

ABOUT THE INSTITUTION

Located in Susanville, in Lassen County, CCC primarily houses minimum-custody patients for placement into one of the institution's 18 Northern California conservation camps. These camps are strategically located throughout the north state to provide hand crews for fire suppression, as well as an organized labor force for public conservation projects and other emergency response needs of the state.

The secondary mission of CCC is to provide meaningful work, training, and educational programs for patients who do not meet the criteria for assignment to a conservation camp. CCC operates multiple clinics in which medical staff members handle non-urgent requests for medical services. Patients who need urgent or emergent care are treated in the triage and treatment area (TTA). Those patients who require outpatient health services and assistance with the activities of daily living are housed in the outpatient housing unit (OHU). The institution also has a receiving and release (R&R) clinical area for screening incoming and outgoing patients.

CCC has been designated a "basic" health care institution by CDCR; basic facilities are typically located in rural areas, far away from tertiary care centers and specialty care providers whose services would likely be used frequently by patients with higher medical risk. Because of CCC's remote location and its basic health care status, CDCR generally places healthier patients in this institution.

The institution received national accreditation from the Commission on Accreditation for Corrections on August 8, 2016. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, CCC's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 18 percent in March 2017, with the highest percentage among rank-and-file nurses, at 21 percent, which equated to 10.6 vacant positions. The institution also had four medical staff out on long-term medical leave.

CCC Health Care Staffing Resources as of March 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	7%	6	8%	9.5	13%	51.6	72%	72.1	100%
Filled Positions	4	80%	5	83%	9	95%	41	79%	59	82%
Vacancies	1	20%	1	17%	0.5	5%	10.6	21%	13.1	18%
Recent Hires (within 12 months)	0	0%	1	20%	3	33%	10	24%	14	24%
Staff Utilized from Registry	0	0%	1	20%	0	0%	2	5%	3	5%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	1	2%	1	2%
Staff on Long-term Medical Leave	1	25%	1	20%	1	11%	1	2%	4	7%

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

As of March 13, 2017, the Master Registry for CCC showed that the institution had a total population of 4,313. Within that total population, 2 patients were designated as high medical risk, Priority 1 (High 1), and 18 patients were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory test results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than are those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

CCC Master Registry Data as of March 13, 2017

Medical Risk Level	# of Patients	Percentage
High 1	2	0.05%
High 2	18	0.42%
Medium	408	9.46%
Low	3,885	90.08%
Total	**4,313**	**100.0%**

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 15 indicators (14 primary (clinical) indicators and one secondary (administrative) indicator) of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicator addresses the administrative functions that support a health care delivery system. These 15 indicators are identified in the *CCC Executive Summary Table* on page *iv* of this report.

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 registered nurses. 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 done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. 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, this report only addresses the conditions related to medical care criteria. The OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer (CEO) 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 CEO 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 score 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 added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. 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 patient records. Accordingly, the group of patients the OIG targeted for chart review carried the highest clinical risk and utilized the majority of medical services. As there were only two patients at CCC classified by CCHCS as high-risk 1, the majority of patients selected for retrospective chart review were high-utilizing patients with chronic care illnesses who were classified as medium risk. 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; 11 percent of the total patient population is considered high-risk and accounts 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, the OIG clinical experts made the following 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. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.

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 generated during death reviews, sentinel events (unexpected occurrences 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

As indicated in *Appendix B, Table B-1: CCC Sample Sets*, the OIG clinicians evaluated medical charts for 36 unique patients. *Appendix B, Table B-4: CCC Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 10 of those patients, for 46 reviews in total. Physicians performed detailed reviews of 20 charts, and nurses performed detailed reviews of

10 charts, totaling 30 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 16 patients. These generated 439 clinical events for review (*Appendix B, Table B-3: CCC Event – Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 5 chronic care patient records, i.e., 4 diabetes patients and one anticoagulation patient (*Appendix B, Table B-1: CCC Sample Sets*), the 36 unique patients sampled included patients with 54 chronic care diagnoses (*Appendix B, Table B-2: CCC Chronic Care Diagnoses*). As CCC is a basic institution with few high-risk patients, no additional patients with diabetes or anticoagulation management were identified. The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff was 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 OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were re-analyzed using 50 percent of the cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number. For Cycle 5 inspections, basic institutions, with few high-risk patients, case review will use 67 percent of the case review samples used in the Cycle 4 inspection (20 detailed physician reviewed cases). For intermediate or basic institutions housing many high-risk patients, the case review samples will use 83 percent (25 detailed physician reviewed cases). Finally, for the most medically complex institution, California Health Care Facility (CHCF), the OIG will continue to use a sample size 100 percent as large as that used in Cycle 4.

With regard to reviewing charts from different providers, 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. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians 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 *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate

confidential *CCC Supplemental Medical Inspection Results: Individual 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 — Clinical Data, Table B-1; Table B-2; Table B-3;* and *Table B-4.*

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

From March to May 2017, registered nurse inspectors obtained answers to 86 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. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 378 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of March 27, 2017, registered nurse field inspectors conducted a detailed onsite inspection of CCC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,015 scored data points to assess care.

In addition to the scored questions, the OIG obtained information from the institution that it did not score. This included, for example, information about CCC's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

For Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*) and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

After compiling the answers to the 86 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator 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* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

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 registered nurse inspectors 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 of 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 of the primary quality indicators, which directly relate to the health care provided to 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 Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for CCC, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CCC data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organizations.

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *CCC Executive Summary Table* on page *iv* of this report, 13 of the OIG's indicators were applicable to CCC. Of those 13 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 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution. Based on the analysis of the results in the primary indicators, the OIG made a considered and measured opinion that the quality of health care at CCC was ***adequate***.

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 primary (clinical) indicators applicable to CCC. Of these 10 indicators, OIG clinicians rated one *proficient*, eight *adequate*, and one *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 15 were *adequate*, and 5 were *inadequate*. In the 439 events reviewed, there were 146 deficiencies, of which 34 were considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse events are medical errors that are more likely than not to cause grave patient harm. Medical care is a complex and 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 nature of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events.

There was one adverse event identified in the case reviews at CCC:

- In case 6, a provider ordered an urgent ultrasound (a type of scan) of the patient's leg to evaluate for a deep venous thrombosis (a blood clot), but failed to start the patient on a blood thinner while waiting for the ultrasound report. As a result, the patient was not treated with a blood thinner for one week. This delay placed the patient at unsafe risk for developing a pulmonary embolism (a blood clot in the lung). In addition, during another encounter with a different provider, the patient stated he had not received his blood-thinning medication for three days. The provider failed to investigate the patient's claim. This failure also placed the patient at unsafe risk of developing a pulmonary embolism. Fortunately, the patient did not have a pulmonary embolism.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to CCC. Of these ten indicators, OIG inspectors rated five *adequate* and five *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.*

1 — *ACCESS TO CARE*

This indicator evaluates the institution's ability to provide patients with timely clinical appointments. Areas specific to patients' access to care are reviewed, such as initial assessments of newly arriving patients, acute and chronic care follow-ups, face-to-face nurse appointments when a 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 patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.5%)
Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 271 provider, nursing, specialty, and outside hospital encounters, and identified 21 deficiencies relating to access to care. Of the 21 deficiencies, 10 were significant and placed the patient at risk of harm. The OIG rated this indicator *adequate.*

Provider-to-Provider Follow-up Appointments

CCC demonstrated improvement with provider-ordered follow-up appointments for the cases that were reviewed since Cycle 4. These types of 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 appointments. The OIG clinicians reviewed 113 outpatient provider encounters and noted four significant deficiencies. Although uncommon, errors such as these placed the patient at significant risk of harm. The deficiencies occurred in cases 2, 16, and the following:

- In case 1, the patient returned to CCC from a community hospital after being treated for a lung abscess and severe pneumonia. The provider initially saw the patient and ordered a follow-up in one month, which was delayed for nearly one month. This meant the patient was not seen again for two months.

- In case 10, the provider ordered a follow-up visit to occur in one to two weeks for a patient with diabetes. This follow-up never occurred. As a result, the patient was not seen for diabetic care for an extended period, and his diabetes became uncontrollable.

RN Sick Call Access

Nursing performance for sick call access was excellent. Sick call requests at CCC were received and reviewed by a registered nurse (RN) on first watch. The request forms were then scanned into the electronic health record system (EHRS). Routine (non-urgent) face-to-face nursing assessments took place on second watch on the same day. Assessments for non-urgent sick call requests received and reviewed on a weekend or holiday occurred on the next business day. If a patient reported

urgent medical symptoms, he was sent to the TTA. At the onsite inspection, the OIG clinicians discovered the nurses evaluated more than 30 patients for sick call nursing assessments per day. However, there were no delays in reviewing patient sick call requests or performing nursing assessments.

RN-to-Provider Referrals

CCC performance in ensuring timely provider visits after a nurse referral was poor. Nurses referred patients to a provider when nursing assessment indicated the patient needed a higher level of care for diagnosis and treatment. However, the OIG clinicians identified a pattern of delays in these provider visits likely due to provider backlogs. The OIG clinicians reviewed 61 outpatient nursing encounters. Five cases were found to have only minor deficiencies. The following three cases had significant deficiencies:

- In case 19, the patient complained of sharp, constant pain in his abdomen. The sick call RN made an urgent referral to the provider, but the provider encounter was delayed for 14 days.
- In case 30, the patient, who had asthma, complained of sharp chest pain that increased with deep inspiration. The sick call RN made a referral for a provider follow-up appointment within one week. However, there was a delay of 13 days before the patient was evaluated by a provider.
- In case 36, the patient had a hernia repair surgery. The patient had postoperative abdominal pain. The nurse requested a routine referral for a provider evaluation. However, this visit occurred 12 days beyond the requested time frame.

Provider Follow-Up After Specialty Service

CCC consistently provided patients with a provider follow-up after specialty services. The OIG clinicians reviewed 37 diagnostic and consultative specialty services and found no deficiencies in this area.

Intra-System Transfers

As in Cycle 4, nurses assessed newly transferred patients and always referred them to a provider. The OIG clinicians reviewed six patients who transferred in and found no deficiencies with access to care in this area.

Follow-up After Hospitalization

CCC had no difficulty ensuring that providers saw their patients after they returned from an outside hospital or an emergency department. CCC had 20 hospitalization and outside emergency events. There were no deficiencies with access to care in this area.

Urgent/Emergent Care

CCC generally ensured that the primary care provider or the clinic nurse evaluated patients in the TTA. The OIG clinicians reviewed 16 urgent or emergent encounters, 8 of which required a primary care provider or a nurse follow-up. The OIG clinicians found no deficiencies in provider or nurse follow-ups from the TTA.

Specialized Medical Housing

CCC performed adequately with provider access both during and after admission to the OHU, based on the limited number of events available to review. The providers would often utilize the OHU as a temporary observational unit for patients, who would generally be discharged within 24 hours. Therefore, a formal admission to the OHU would not be required. A provider usually made clinical rounds in the OHU at appropriate time intervals, despite the limited number of formal OHU admissions. The OIG clinicians reviewed two OHU admissions with nine provider encounters. No instances were found in which a provider failed to follow up with OHU patients.

RN Case Management

The primary care nurse in each clinic was also the designated care manager for the assigned patient panel. Each primary care team had a licensed vocational nurse (LVN) care coordinator who presented new patients to the medical staff in the morning huddle or at the population management meeting. The nurse care manager and the LVN care coordinator evaluated new patients within 30 days after the patient's arrival to CCC. Patient meetings with the nurse care managers and LVN care coordinators were comprehensive and timely.

Specialty Access

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

Clinician Onsite Inspection

Problems with *Access to Care* were primarily due to a lack of provider availability as seen in Cycle 4. Although CCC had only one provider vacancy, both the one physician on staff and the CME were also on long-term sick leave. In addition, a physician assistant was regularly using accumulated time off as this staff member was nearing retirement. Consequently, this provider was absent from the institution on average once a week every month. Furthermore, CCC was one of the few institutions in which a large number of the patients were located at offsite fire camps. These offsite locations posed a unique challenge to this institution in terms of providing access to care, especially with the distant location of some of these fire camps. During the onsite inspection, the previous CEO explained that onsite provider availability was further reduced because all providers had taken turns weekly to travel to these fire camps and provide care. However, the previous CEO had recently allowed two mid-level providers to cover these fire camps due to the current limited provider availability. Therefore, at any given time, the institution was short at least four providers on a given day if the vacant provider position was also taken into account.

The OIG clinicians discovered that Yard A had a backlog of 150 patients, and Yard B had a backlog of 125 patients. Yard C had no patient backlog at the time of the onsite inspection. The large number of provider backlog appointments at CCC actually consisted of young, healthy patients who were not physically present at CCC, but were located at the offsite fire camps. These appointments were generally for administrative purposes and did not reflect true medical needs. According to the previous CEO, the actual provider backlog for Yards A and B would have been approximately 30 percent to 40 percent lower if the tally for offsite fire camp patients was not included in these yards.

CCC also relied heavily on telemedicine providers to strengthen access to care for the institution's patients. At the time of the onsite inspection, the previous CEO informed the OIG clinicians that the institution would be starting a pilot telemedicine program in June for patients located at the fire camps. This telemedicine program would allow the designated provider to potentially reduce travel time to certain distant fire campsites by at least two days. The provider could use these two days for onsite patient care at CCC. The OIG commends CCC for its innovative use of the telemedicine clinic to enhance delivery of medical care to its patients, both onsite and offsite.

Finally, CCC leadership expressed concerns with future physician recruitment and retention as a 15 percent recruitment-and-retention bonus was put into effect for other institutions in 2017, but not for CCC. As a result, CCC leadership is concerned that physicians would have a greater incentive to transfer to these higher-paying institutions.

Case Review Conclusion

In general, CCC demonstrated adequate ability to provide patients with access to care despite severe limitations in provider availability. Although significant provider backlogs were initially found in two of the yards at CCC, the majority of the population was minimal-risk medical patients at offsite fire camps. Therefore, CCC's backlog of high-risk patients was actually much lower. The institution has also implemented a pilot program to address patient care at offsite fire camp locations. Furthermore, CCC has improved its provider-ordered follow-up appointments, OHU follow-ups, and RN-to-provider referrals since Cycle 4. With these improvements in *Access to Care*, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution performed in the *adequate* range in the *Access to Care* indicator, with a compliance score of 75.5 percent. The following tests received scores in the *proficient* range:

- Patients had access to health care services request forms at all five housing units the OIG inspected (MIT 1.101).
- The OIG inspectors sampled 32 health care services request forms, and for 30 of these (94 percent), determined that nursing staff reviewed the forms on the same day received. For

the remaining two sampled forms, nursing staff did not document either the date or the time when this form was received or reviewed (MIT 1.003).

- Nursing staff timely completed a face-to-face triage encounter for 27 of 30 sampled patients who submitted a health care services request form (90 percent). Of the remaining three samples, nursing staff did not document the required subjective, objective, assessment, plan, and education (SOAPE) notes for two patients, and did not conduct a face-to-face visit for one patient (MIT 1.004).

The following test received an *adequate* score:

- Among 20 applicable sampled health care services request forms for which nursing staff referred the patient to a provider visit, 15 patients (75 percent) received their appointments timely. Two patients received their appointments three and four days late. Three other patients received their appointments from 15 to 22 days late (MIT 1.005).

The following tests received scores in the *inadequate* range and showed room for improvement:

- Seven of ten sampled patients who were discharged from a community hospital (70 percent) received timely provider follow-up appointments upon their return to CCC. Two patients received their follow-up appointments one and two days late. One patient received his follow-up 12 days late (MIT 1.007).

- Among 21 sampled patients who received a high-priority or routine specialty service visit, 14 of them (67 percent) received timely follow-up appointments with the primary care provider. Six patients received follow-up appointments from 3 to 18 days late. One patient received a follow-up appointment that was 51 days late (MIT 1.008).

- Inspectors sampled 25 patients who had one or more chronic care conditions; of these, 16 patients timely received their provider-ordered follow-up appointments (64 percent). Nine other patients received their appointments late: three whose follow-up appointments were from two to five days late; three whose follow-up appointments were from 8 to 13 days late; and three whose follow-up appointments were from 21 to 38 days late (MIT 1.001).

- Among 24 applicable sampled patients who transferred into CCC from other institutions and who were referred to a provider based on nursing staff's initial health care screening, 15 patients (63 percent) were seen timely. Seven patients received their provider appointments from one to 15 days late. One patient received his provider appointment 40 days late. Finally, for one patient, no evidence was found that he ever received a provider appointment (MIT 1.002).

- Among the seven applicable sampled health care services request forms for which the primary care provider ordered a follow-up appointment, four patients (57 percent) received timely appointments. Two patients received their follow-up appointments one and four days late, and one patient did not receive a follow-up appointment (MIT 1.006).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(76.9%)
Overall Rating:
Inadequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether the primary care provider timely reviewed the results, and whether the results were communicated to the 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 provider timely reviewed and communicated the pathology results to the patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic tests ordered and the clinical response to the results.

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in an *adequate* score. Case review identified many events concerning provider-ordered diagnostic tests that were not completed, which the compliance testing methodology was unable to identify. Diagnostic tests that are not completed are a serious deficiency that can potentially lead to significant delays or even lapses in medical care. CCC errors involving tests that were not completed as ordered were frequent and recurring. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*.

Case Review Results

The OIG clinicians reviewed 83 diagnostic-related events and found 39 deficiencies. Of those 39 deficiencies, 11 were related to health information management and 14 were related to ordered tests not being completed. Within health information management, test reports that were never retrieved or reviewed were considered as severe a problem as tests that were not completed as ordered.

Since Cycle 4, CCC has continued to fail in performing diagnostic services in a timely manner and has also failed to perform diagnostic tests as ordered by the provider. Diagnostic tests that are not completed are a serious deficiency that can potentially lead to significant delays or even lapses in medical care. CCC errors involving tests that were not completed as ordered were frequent and more likely to occur when tests were ordered with longer processing time frames.

Laboratory tests ordered by the provider but that the laboratory never processed were found in cases 6, 8, 9, 10, 15, and the following:

- In case 19, the provider ordered specific tests that the laboratory never completed. As a result, these test results were not available to the provider at the time of the patient's follow-up visit, and the provider had to reorder these tests. This failure not only delayed the patient's medical care, but also generated an unnecessary extra provider follow-up visit.

- In case 20, the patient requested treatment for his hepatitis C (a type of viral liver disease). The provider ordered a hepatitis C genotype (a test that determines the type of hepatitis C virus) as part of the workup required to qualify for treatment. This test was never completed by the laboratory, which potentially delayed the patient's treatment.

Delays in the completing of diagnostic tests were found in cases 12, 13, 21, and the following:

- In case 15, the provider ordered a laboratory test to be completed within two weeks, but the test was delayed for more than one month.
- In case 16, an electrocardiogram (diagnostic scan of the heart) was ordered, but was not performed.

With regard to health information management for this indicator, the following deficiencies occurred:

- In cases 11 and 20, the OIG clinicians found laboratory results were not electronically entered into the EHRS.
- In cases 1 and 2, radiological reports from offsite facilities were not retrieved or scanned into the EHRS and were not found in the radiological information system-picture archiving and communication system (RIS-PACS). Missing reports increase the risk of patient harm or a lapse in care, as the primary provider or subsequent medical staff may be unaware this pertinent information is available to them.
- In cases 2, 8, 12, 14, 17, 19, and 21, diagnostic and laboratory reports lacking either a provider signature or initials were found during the OIG's clinician review.
- In cases 1 and 8, delays in reviewing diagnostic reports were identified. Otherwise, CCC providers consistently reviewed diagnostic and laboratory results in a timely manner.
- In cases 14 and 19, CCC providers signed off on laboratory reports with either no date or the wrong date.
- In case 11, the OIG clinicians found one mislabeled diagnostic report.

Clinician Onsite Inspection

During the onsite inspection at CCC, the OIG clinicians inquired about the delays and laboratory tests that were ordered, but never completed. The laboratory supervisor conceded that some of the orders had been either dropped or delayed during the transition from the eUHR to the new EHRS.

The OIG clinicians found that CCC also often had missing offsite radiology reports that were not found in the eUHR, the EHRS, or the RIS-PACS. The OIG clinicians continue to assert that lapses in patient care may occur if providers remain unaware of the availability of radiology reports. Furthermore, the missing reports continued to pose a tremendous barrier in maintaining continuity

of care, as subsequent medical staff were unable to access these critically important diagnostic reports.

Case Review Conclusion

CCC continued to perform poorly in most aspects of diagnostic services that related to laboratory services. The institution had a recurring rate of laboratory tests ordered, but not completed, as well as delays in the processing of laboratory requests. The failure to complete laboratory tests as well as the missing laboratory and offsite radiology reports presented a significant, ongoing risk for lapses in patient care. Therefore, the OIG clinicians rated this indicator *inadequate.*

Compliance Testing Results

The institution received an *adequate* compliance score of 76.9 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

- Radiology services were timely performed for all ten sampled patients (MIT 2.001). With regard to providers' review of the radiology results, however, CCC scored poorly. For all ten radiology reports reviewed, OIG inspectors found no evidence that providers initialed and dated the reports as required by CCHCS policy (MIT 2.002). Among eight of the ten sampled patients (80 percent), providers timely communicated the results. For the remaining two patients, the providers communicated the results four and seven days late (MIT 2.003).

Laboratory Services

- Eight of the nine sampled patients (89 percent) received their provider-ordered laboratory services timely. The one other patient received his laboratory service 30 days late (MIT 2.004). Providers reviewed all ten resulting laboratory reports within the required time frame (MIT 2.005). Providers timely communicated results to all ten patients (MIT 2.006).

Pathology Services

- CCC received final pathology reports timely for nine of the ten sampled patients (90 percent). For the remaining patient, inspectors found no evidence in the electronic medical record that the institution ever received the report (MIT 2.007). In addition, providers properly evidenced their review of the pathology results for all nine applicable reports (MIT 2.008). Providers timely communicated the final pathology results to only three of the nine applicable sampled patients (33 percent). For five other patients, providers communicated the reports from 6 to 25 days late. For one other patient, there was no evidence that the provider communicated the report (MIT 2.009).

3 — *EMERGENCY SERVICES*

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

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 a 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 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 and conducts no separate compliance testing element.

Case Review Results

The OIG clinicians reviewed 16 urgent/emergent events and found 11 deficiencies with various aspects of emergency care. The OIG clinicians considered 2 of the 11 deficiencies significant, which are identified in cases 6 and 13. The *Quality of Provider Performance* indicator offers more discussion for these cases. The OIG clinicians rated the *Emergency Services* indicator *adequate*.

Cardiopulmonary Resuscitation Response

During the review period, only one patient required a cardiopulmonary resuscitation (CPR) response:

- In case 3, the patient had a heart attack while jogging at camp. Camp custody staff initiated CPR and transferred the patient to a hospital for higher-level medical care. The CPR response was good.

Provider Performance

Provider performance in this indicator was good; it is discussed in the *Quality of Provider Performance* indicator.

Nursing Performance

The institution's TTA nurses provided prompt emergency care. There were no delays in the emergency medical response times. Nursing assessments and interventions were appropriate to the patients' needs. Nursing staff contacted medical providers timely to receive orders and to communicate clinical findings of patients.

Nursing Documentation

The OIG clinicians identified various incidents of incomplete or poor nursing documentation, which continued to be an ongoing issue, as identified in the Cycle 4 inspection. Illegible writing issues have been resolved, as EHRS has replaced handwritten notes. However, the following cases are minor deficiencies and examples of incomplete nursing documentation:

- In case 4, the first medical responder did not document the emergency response timeline, the patient's vital signs, or objective (physical examination) data such as breathing status, skin assessment, and pupil size and reactivity.
- In case 15, the TTA nurse did not document the patient's response to a breathing treatment before sending the patient to the OHU for observation.

Emergency Medical Response Review Committee

The EMRRC reviewed the emergency medical response cases, identified deficiencies, and provided staff training as necessary.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians found the patient care environment in the TTA to be sufficient with two patient beds. Nursing staff had sufficient space to perform patient care duties. The TTA was staffed with two RNs for each shift. One nurse was assigned as the first medical responder, while the other nurse remained in the TTA. The TTA and the OHU nurses' station were located adjacent to one another. The TTA nurses were responsible for OHU nursing assessments and interventions during the first and third watches.

Case Review Conclusion

The CCC TTA providers and nurses performed well in providing *Emergency Services* and had minor deficiencies related only to nursing documentation. The indicator rating was *adequate.*

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(77.3%)
Overall Rating:
Adequate

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 health record; whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the patient's electronic health record; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

CCC converted to the new electronic health record system (EHRS) November 2016; therefore, most testing occurred in the EHRS, with a minor portion of the review occurring in the electronic unit health record (eUHR).

Case Review Results

The OIG clinicians reviewed 439 events and found 19 deficiencies related to health information management. Of those 19 deficiencies, five were significant (cases 1, 2, and 6, and two times in case 21). The OIG clinicians rated this indicator *adequate*.

Inter-Departmental Transmission

CCC performed well with the inter-departmental transmission of information, except for deficiencies related to transmitting diagnostic reports. Furthermore, a few transmission errors were identified in the cases below. Deficiencies involving diagnostic report transmission are discussed in the *Diagnostic Services* and *Specialty Services* indicators.

- In case 12, the patient was being treated for valley fever (a fungal infection of the lung) and complained of left-sided rib pain. A nurse evaluated the patient and found he had decreased breath sounds on the left side of his chest, but this information was not transmitted to a provider.

With the exception of diagnostic reports, there were no other missing documents. CCC performed well in ensuring provider notes, nursing notes, on- and offsite specialty notes, and medication administration records (MARs) were available for the medical staff.

Dictated Progress Notes

Most providers used handwritten progress notes with a few dictated notes prior to the transition from the eUHR to the new EHRS. Once CCC had transitioned to the EHRS, however, handwritten

and dictated progress notes were no longer causes for concern, as providers were required to type their notes directly into this new system.

Hospital Records

CCC displayed great improvement concerning the retrieval of emergency department (ED) physician reports and hospital discharge summaries since Cycle 4. The OIG clinicians reviewed 5 ED events and 15 community hospital events. All ED reports and discharge summaries were retrieved and scanned in a timely manner. All hospital records were retrieved and scanned into the eUHR and the EHRS.

All hospital records were appropriately reviewed, dated, and signed by a provider, except in two cases, which were minor deficiencies.

Specialty Services

CCC displayed some improvement in health information management for specialty services. However, the OIG clinicians found continuing issues with retrieving, having providers review and sign, and scanning the specialty reports into the eUHR or the EHRS. These findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

The OIG clinicians also found significant improvement in health information management for diagnostic services. Only a few diagnostic reports were not retrieved and scanned into the EHRS. These deficiencies are discussed in the health information section of the *Diagnostic Services* indicator.

Urgent/Emergent Records

CCC on-call providers performed well with documenting their telephone encounters. Missing on-call provider documentation was identified in two cases.

At times, CCC nurses did not properly document their urgent and emergent encounters. Minor deficiencies included missing nurse documentation, which was identified in three cases.

Scanning Performance

The OIG clinicians identified mistakes in the document scanning process as mislabeled, misfiled (filed in the wrong chart), or incorrectly dated. Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. CCC performed adequately in this area, with the following cases depicting examples of the deficiencies noted:

- In cases 9 and 11, case reviewers found mislabeled documents in the eUHR and the EHRS.
- In cases 19 and 23, case reviewers found documents filed with incorrect dates.

Scanning times for most documents were generally good. Only a few cases were identified pertaining to delays in the time needed to scan laboratory results and diagnostic reports into the eUHR. In turn, these delays appeared to be related to provider delays in signing laboratory and diagnostic reports. These findings, as well as missing laboratory and offsite radiology reports, are further discussed in the *Diagnostic Services* and *Specialty Services* indicators.

Legibility

At times, provider documentation was scant with certain providers failing to document their thought processes and reasoning in their progress notes. At times, such failings resulted in poor care management.

Illegibility in progress notes, signatures, or initials was not an issue in Cycle 5 due to providers' change to typing and electronically signing their notes directly into the EHRS. In two cases, signatures were not dated, but these were minor deficiencies.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the daily morning huddles. In addition, the OIG clinicians interviewed various health care staff regarding how information was processed outside of the clinic hours. The process CCC used to transmit information was found to be appropriate. While a standard CCHCS huddle report agenda was used, the OIG clinicians observed that important after-hours clinical information was also distributed and discussed by the care teams during these morning huddles.

In addition, the OIG clinicians discovered a few of the CCC providers maintained open lines of communication with their local hospitals and many of the local specialists, which likely mitigated any problems in obtaining hospital records and specialist reports.

Case Review Conclusion

CCC showed significant improvement in the *Health Information Management* indicator since Cycle 4. The institution displayed good performance in retrieving both hospital and outside ED reports and progress notes by providers, nurses, and specialists. Furthermore, the process the institution used to transmit clinical information between departments and among various medical staff was effective. Therefore, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* score of 77.3 percent in the *Health Information Management* indicator, performing in the *proficient* range in the following two tests:

- For the three sampled MARs, the institution timely scanned all of them into the patients' electronic medical records (MIT 4.005).

- The institution timely scanned 15 of the 16 sampled non-dictated progress notes (94 percent). One non-dictated progress note was not scanned timely (MIT 4.001).

The following tests received *adequate* scores:

- The institution timely scanned 16 of 20 sampled specialty notes (80 percent). Four other specialty notes were scanned from one to five days late (MIT 4.003)

- CCC timely scanned community hospital discharge documents into patients' electronic medical records for eight of the ten sampled reports (80 percent); two reports were scanned one and four days late (MIT 4.004).

The following two tests showed room for improvement with scores in the *inadequate* range:

- CCC scored 50 percent in its labeling and filing of documents scanned into patients' electronic medical records. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. Of the 12 mislabeled or misfiled documents found, 6 documents were mislabeled; 5 documents were missing or could not be found; and one document was inadvertently scanned into a different patient's file (MIT 4.006).

- Among ten sampled patients admitted to a community hospital and then returned to the institution, CCC's providers timely reviewed six patients' corresponding hospital discharge reports within three calendar days of patient discharge (60 percent). For the other four sampled patients, providers did not timely review the discharge reports; these four reports were reviewed from two to nine days late (MIT 4.007).

5 — *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 patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. Rating of this component is based entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(74.2%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance testing. There is no case review portion.

Compliance Testing Results

The institution received an *inadequate* compliance score of 74.2 percent in the *Health Care Environment* indicator, showing room for improvement in the following test areas:

- Only two of eight clinic examination rooms observed (25 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Six clinics had one or more deficiencies observed: clinical staff had insufficient space to perform patient examinations (*Figure 1*); clinicians had impeded access to examination tables; examination room supplies were not clearly labeled for easy identification; and clinics had no portable screens available for visual privacy (MIT 5.110).

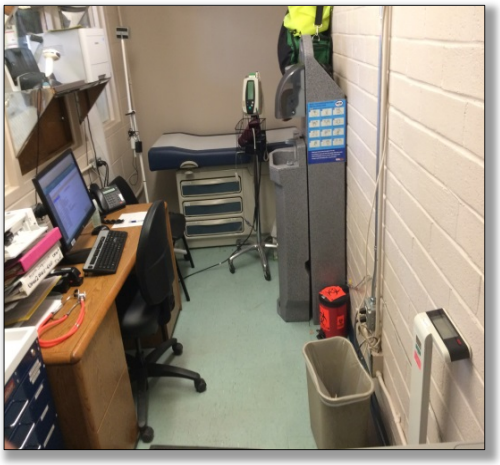

Figure 1: Exam room with insufficient space

- Inspectors examined Emergency Medical Response Bags (EMRBs) and the crash cart in the TTA to determine whether they were inspected daily and inventoried monthly, and contained all essential items. EMRBs were compliant in only two of the six clinical locations in which they were stored (33 percent). One or more of the following deficiencies were noted at four locations. In two locations, the OIG inspectors found no documentation indicating that an inventory of the EMRB had been completed in the previous 30 days; two locations' EMRB logs were each missing a single entry to show staff had verified that the respective bags' compartments were sealed and intact. The TTA crash cart was also missing minimum par levels of the medical supplies randomly inventoried at the time of inspection (MIT 5.111).

- Five of the eight clinics inspected followed adequate medical supply storage and management protocols (63 percent). Medical supplies at two clinics were not orderly or clearly identifiable (*Figure 2*), and in one clinic, germicidal disposable cloths and disinfectants were stored together with medical supplies (MIT 5.107).

Figure 2: Exam supplies that are not orderly or clearly identifiable

- When inspecting for proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, only six of nine clinics (67 percent) followed acceptable protocols. In three clinics, one or more of the following deficiencies were observed: one examination room lacked a sharps container, while another had a sharps container that was not secured (*Figure 3*), and a biohazard receptacle was stored in a patient restroom, which was not a secure location (MIT 5.105).

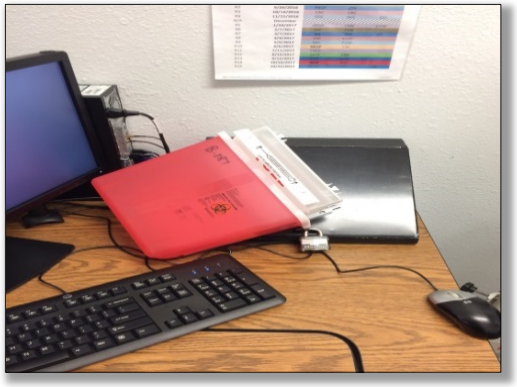

Figure 3: Sharps container that is not secured

The institution scored in the *adequate* range in the following two tests:

- Clinic common areas and examination rooms were sometimes missing core equipment or other essential supplies necessary to conduct a comprehensive examination. As a result, six of the eight clinics were compliant (75 percent). Equipment and supply deficiencies included two clinics without a glucometer and strips, and an oto-ophthalmoscope without a full charge. One clinic's examination rooms were also missing tongue depressors, a biohazard waste receptacle, and labeled biohazard bags (MIT 5.108).

- Of the nine clinics examined, seven (78 percent) were appropriately disinfected, cleaned, and sanitized. In two clinics, cleaning logs completed by patient porters were missing staff validation (MIT 5.101).

The institution received *proficient* scores in the following five tests:

- Clinical health care staff at all applicable clinics ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (MIT 5.102).

- The OIG inspectors examined CCC's nine clinics to verify that adequate hygiene supplies were available and sinks were operable; all clinics were compliant (MIT 5.103).

- The non-clinic bulk medical supply storage areas met the supply management process and support needs of the medical health care program, earning CCC a score of 100 percent in this test (MIT 5.106).

- Clinic common areas at seven of the eight clinics (88 percent) had environments conducive to providing medical services. One clinic, however, lacked wheelchair mobility access (MIT 5.109).

- Clinicians whom inspectors observed in eight of nine clinics (89 percent) adhered to universal hand hygiene precautions, except for one clinic, in which a provider did not observe these protocols before putting on gloves (MIT 5.104).

Non-Scored Results

- The OIG gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. The OIG does not score this question. When the OIG inspectors interviewed health care managers, no significant concerns were identified. At the time of the OIG's medical inspection, CCC had several significant infrastructure projects underway, which included increasing clinic space at four yards and remodeling the TTA. These projects were started in the summer of 2016, and the institution estimated a completion date for them by the summer of 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Proficient
Compliance Score:
Inadequate
(72.6%)
Overall Rating:
Adequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for this indicator include those received from, as well as those transferring out to, other CDCR institutions. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For 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 OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving a *proficient* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The determining factors were case review found that staff completed patient transfers and hospital returns proficiently, with no significant deficiencies noted. However, compliance testing found problems with initial health care assessments completed by nursing staff for patients who transferred into the institution, as well as timely medication administration for those newly arrived patients. Based on these concerns found in compliance testing, the OIG determined a rating of *adequate* was appropriate.

Case Review Results

The OIG clinicians reviewed 29 inter- and intra-system transfer events, including information from both sending and receiving institutions. These included 20 hospitalization and outside emergency room events, each of which resulted in a transfer back to the institution. There were 11 minor deficiencies. The OIG clinicians rated this indicator *proficient.*

Transfers In

The transfer process was good for patients transferring into CCC. The OIG clinicians reviewed five patients who were transferred to CCC. One of them was transferred to and from court, and four were transferred from other CDCR institutions. The R&R nurses reviewed the health care transfer information, appropriately assessed the patients, ordered medications, and followed up with

referrals. Patients received their prescribed medications timely. Referrals to medical providers were appropriate to the patient's condition.

Nonetheless, one pattern of minor deficiencies was identified whereby nurses did not always measure complete vital signs (including blood pressure, temperature, pulse, and respirations) for patients transferring into CCC. Nurses did not assess one or more of these basic vital signs in five cases.

Transfers Out

The OIG clinicians reviewed three patients who transferred out of CCC to other CDCR institutions. The CCC nurses performed face-to-face evaluations prior to the patients' transfers. In all cases, CCC nurses sent health care transfer information, medications, and health care equipment with the patient to the receiving institution. CCC nurses performed well in the transfer-out process. No deficiency patterns were identified.

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. CCC performed proficiently with regard to patients returning from the hospital. The OIG clinicians reviewed 20 events in which patients returned to CCC from an offsite hospital or emergency department. There were three minor deficiencies:

- In case 3, an antibiotic medication was prescribed to be given once every 24 hours. The nurse administered a dose of medication after the patient returned from the hospital discharge, but the medication had already been administered in the hospital earlier in the day.

- In cases 2 and 19, the medical provider did not sign or initial the hospital discharge form acknowledging that discharge notes had been reviewed.

Clinician Onsite Inspection

The R&R area had adequate space in which to conduct the initial health screenings. The institution experienced a high volume of transfers because of patients assigned to fire camps, which resulted in a high-volume R&R area. During the onsite interview, the R&R nurse demonstrated sufficient knowledge of the transfer process. One nurse was assigned to each watch, with an additional nurse assigned to the third watch when patients typically arrived at CCC. The nurse received the transfer information on a weekly basis, and prepared the health care transfer information packets with either electronic or paper transfer forms according to the receiving institution's current medical record system. Patients returning from an outside hospital or emergency department were assessed in the TTA. At CCC, most patients returning from a hospitalization were sent to the OHU for 23-hour observation. Details about this practice are included in the *Specialized Medical Housing* indicator.

Case Review Conclusion

The OIG clinicians found few minor deficiencies with regard to *Inter- and Intra-System Transfers*. The indicator rating was thus *proficient.*

Compliance Testing Results

The institution received an *inadequate* score of 72.6 percent in the *Inter- and Intra-System Transfers* indicator, performing poorly in the following two tests:

- The OIG tested 25 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. CCC received a score of 12 percent for this test because nursing staff timely completed the assessments for only three of the sampled patients. For 21 of the remaining 22 sampled patients, nursing staff either did not document a complete set of vital signs or neglected to answer one or more of the screening form questions. For one final patient, no evidence was found of an initial health screening (MIT 6.001).

- Among the five applicable sampled patients who transferred to CCC with an existing medication order, three patients received their medications without interruption (60 percent). For the remaining two patients, one patient incurred a direct observation therapy (DOT) medication interruption of one dosing period, and the other patient did not receive his keep-on-person (KOP) medication (MIT 6.003).

The institution scored within the *proficient* range in the following three tests:

- The OIG clinicians inspected the transfer packages of six patients who were transferring out of the facility to determine whether the packages included required medications and support documentation, and all packages were compliant (MIT 6.101).

- Nursing staff timely completed the assessment and disposition sections of the screening form for 23 of the 24 applicable patients (96 percent). For one patient, the nursing staff did not complete the assessment and disposition section of the screening form (MIT 6.002).

- The OIG inspectors tested 20 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 form. CCC nursing staff identified the scheduled appointments for 19 of the sampled patients (95 percent). For one patient, nursing staff did not document a pending specialty service on the transfer form (MIT 6.004).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.2%)
Overall Rating:
Inadequate

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 prescriber, staff, and patient.

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating, and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. While case review focused on medication administration, the compliance testing was a more robust assessment of medication administration and pharmacy protocols combined with onsite observations of medication and pharmacy operations. As a result, the compliance score was deemed appropriate for the overall indicator rating.

Case Review Results

The OIG clinicians evaluated seven events related to medications. There were three minor deficiencies. The OIG clinicians rated this indicator *adequate.*

Medication Continuity

CCC performed well with medication continuity. There was one minor deficiency. Patients who transferred to CCC received their medications timely. The nurses communicated the list of medications for patients transferring out to the receiving institutions. Patients who submitted sick call requests for medication refills were generally seen the same day by the sick call nurse if the medication order had expired.

Medication Administration

For the majority of cases reviewed, CCC nurses administered medications timely and accurately. The OIG clinicians identified one minor deficiency that occurred in the TTA:

- In case 3, the TTA nurse administered a second dose of levofloxacin (an antibiotic) to the patient upon his return from the hospital. The patient had already received his once-daily dose at the hospital, earlier in the day.

Pharmacy Errors

The OIG clinicians did not detect any deficiency pattern in this area.

Clinician Onsite Inspection

The OIG clinicians interviewed pharmacy, medical, and nursing staff during the onsite inspection. The pharmacist-in-charge (PIC) reported there were no medication backlogs. He reported the implementation of electronic medical records facilitated communication among various levels of staff. This resulted in timely medication ordering and delivery to the patients.

Case Review Conclusion

CCC's performance for *Pharmacy and Medication Management* regarding case reviews improved over the previous inspection with fewer deficiencies identified. Thus, the clinical review rating for this indicator is *adequate*.

Compliance Testing Results

The institution received a compliance score of 72.2 percent in 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

In this sub-indicator, the institution received an *adequate* score of 78.2 percent. The following received a *proficient* score:

- CCC timely administered or delivered new medication orders to all 25 sampled patients (MIT 7.002).

One test received an *adequate* score:

- After transferring from one housing unit to another, 16 of 21 sampled patients (76 percent) received their ordered medications without interruption. For five other patients, either they did not receive their medications at the next required dosing interval, or nursing staff did not properly document the patient refusal (MIT 7.005).

The institution showed room for improvement in the following two areas:

- Among 12 sampled patients, 8 of them (67 percent) timely received their ordered chronic care medications. For the other four patients, no evidence was found that they either received or properly refused their chronic care medications (MIT 7.001).

- CCC timely provided new and previously prescribed medications to seven of ten sampled patients upon their return to the institution from a community hospital (70 percent). For the other three patients, CCC did not administer, make available, or deliver ordered medications within required time frames (MIT 7.003).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* score of 64.3 percent. The following tests scored in the *inadequate* range:

- The institution properly stored non-narcotic medications not requiring refrigeration in only three of the seven applicable clinic and medication line storage locations (43 percent). In four locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; external and internal medications were not properly separated from one another when stored; medication rooms and cabinets were unlocked; multi-use medication was not labeled with the date it was opened; medication was stored beyond its expiration date; and the crash cart log was missing staff signatures validating a daily seal check was performed for the cart, ensuring it was sealed, was intact, and the seal was not compromised (MIT 7.102).

- Non-narcotic refrigerated medications were properly stored at three of seven clinics and medication line storage locations (43 percent). At four locations, one or more of the following deficiencies were observed: either refrigerator temperatures were not consistently maintained within the acceptable range or the temperature logbook was not consistently completed; the medication area lacked a designated area for return-to-pharmacy medications; and multi-use medication was not labeled with the date it was opened (MIT 7.103).

- The institution employed suitable security controls over narcotic medications in four of the seven applicable clinic and medication line locations where narcotics were stored (57 percent). At two clinics, the narcotics logbook lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff. At one clinic, the OIG inspectors observed nursing staff removing narcotics from the narcotic medication locker in a manner that did not allow for a spontaneous count (MIT 7.101).

- Only four of the seven inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (57 percent). At three different locations, the following deficiencies were identified: OIG inspectors observed that CCC nurses did not follow manufacturer's guidelines related to the proper administration of insulin to diabetic patients. These guidelines require nurses to sanitize multi-use insulin vials before withdrawing and administering these medications to patients. Patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather. Medication nurses did not always ensure that patients swallowed their

DOT medications. Medication nurses also did not appropriately administer crush-and-float (crushed and suspended in water) medications as ordered by the provider (MIT 7.106).

The following two tests received scores in the *proficient* range:

- At all seven of the inspected medication line locations, nursing staff employed appropriate administrative controls and followed appropriate protocols during medication preparation (MIT 7.105).
- At six of the seven sampled medication preparation and administration locations (86 percent), nursing staff followed proper hand hygiene contamination control protocols during medication preparation and administrative processes. At one location, nursing staff did not sanitize their hands before re-gloving and after physically touching a patient (MIT 7.104).

Pharmacy Protocols

In this sub-indicator, the institution received an *adequate* score of 76.8 percent, composed of scores received at the institution's main pharmacy. The following three tests scored in the *proficient* range:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols (MIT 7.107).
- The main pharmacy properly stored refrigerated or frozen medications (MIT 7.109).
- The institution's PIC properly accounted for narcotic medications stored in CCC's pharmacy and reviewed monthly inventories of controlled substances in the institution's clinical and medication line storage locations (MIT 7.110).

One test received an *adequate* score*:*

- The institution's PIC followed required protocols for 21 of the 25 medication error reports and monthly statistical reports reviewed (84 percent). For four medication error reports, the PIC completed corresponding medication error follow-up reports from 6 to 10 days late (MIT 7.111).

One test received an *inadequate* score and showed room for improvement:

- In its main pharmacy, CCC did not properly store non-refrigerated medication. Inspectors found previously opened medication stored in an unlabeled container (MIT 7.108).

Non-Scored Tests

- In addition to testing reported medication errors, the OIG inspectors follow up on any significant medication errors found during the 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 inspectors did not identify any level four or higher medication errors during the testing period (MIT 7.998).

- The OIG interviewed patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers. All eight of the sampled patients had access to their rescue medications (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services to pregnant patients. This includes the ordering and monitoring of indicated screening tests, follow-up visits, referrals to higher levels of care, e.g., high-risk obstetrics clinic, when necessary, and postnatal follow-up.

As CCC is a male-only institution, this indicator is not applicable.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable
Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(71.7%)
Overall Rating:
Inadequate

The OIG rates this indicator entirely through the compliance testing component; the case review process does not include a separate qualitative analysis for this indicator.

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 71.7 percent. The following two tests received scores in the *inadequate* range, showing room for improvement:

- The institution scored 21 percent for the required monitoring of patients on TB medications. For 19 of the 24 applicable sampled patients, the institution failed to complete the monitoring at all required intervals, failed to conduct the monitoring in a timely manner, or failed to scan the monitoring forms into the patient's medical record in a timely manner (MIT 9.002).

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Of the sampled patients, 15 were classified as Code 22 (requiring a TB skin test in addition to a signs and symptoms check), and 15 more sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check). Of the 30 sampled patients, the nursing staff timely and appropriately conducted those screenings for only 10 of them (33 percent). Specifically, nurses properly screened 2 of the 15 Code 22 patients and 8 of the 15 Code 34 patients. The OIG inspectors identified the following deficiencies (MIT 9.003):

    - For ten of the Code 22 patients, an LVN or psychiatric technician read the test results rather than an RN, a public health nurse, or a primary care provider as required by CCHCS policy in place at the time of the OIG's review.

    - For one Code 22 patient, nursing staff did not sign and date the signs and symptoms and history section of the Tuberculin Testing/Evaluation Report (CDCR Form 7331).

    - For another Code 22 patient, the patient did not receive a screening or TB test within the last year.

- For one final Code 22 patient, nursing staff did not refer the patient's refusal of his TB test to the provider.
- For seven Code 34 patients, nursing staff did not complete the history section of the CDCR Form 7331.

In the following test, the institution received an *adequate* score:

- CCC scored 76 percent for administering ordered TB medications to patients with 19 of 25 patients receiving their medications timely. Five of the other six patients neither received nor properly refused their TB medications. One final patient missed his TB medications and did not timely receive the required provider counseling for the missed dosages (MIT 9.001).

Three tests received scores in the *proficient* range:

- All 25 sampled patients timely received or were timely offered influenza vaccinations during the most recent influenza season (MIT 9.004).
- The institution timely offered colorectal cancer screenings to all 25 sampled patients who were subject to the annual screening requirements (MIT 9.005).
- The OIG clinicians tested whether patients who suffered from an applicable chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. All 12 sampled patients were timely offered the vaccinations (MIT 9.008).

10 — *QUALITY OF NURSING PERFORMANCE*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed onsite, such as outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of 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, and accurate, thorough, and legible documentation. Although nursing services provided in the OHU, CTC, or other inpatient units are reported in the *Specialized Medical Housing* indicator and nursing services provided in the TTA or related to emergency medical responses are reported in the *Emergency Services* indicator, all areas of nursing services are summarized in this *Quality of Nursing Performance* indicator.

Case Review Results

The OIG clinicians reviewed 120 nursing encounters, of which 61 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests and LVN care coordinator visits. In all, there were 27 deficiencies related to nursing care performance, only two of which were considered significant.

- In case 12, the patient was receiving treatment for valley fever (a fungal infection) and had undergone lung surgery five months earlier. The nurse did not contact the provider for this patient who was reporting severe pain in the left rib cage area, and had a bulging deformity, increased pain to touch, and diminished lung sounds in the left lower lobe. Although the nurse referred the patient to the provider, the patient was not evaluated by a provider until four days later when he was given pain medication.

- In case 13, the patient requested treatment for hepatitis C infection. The provider ordered the resubmission of the patient's hepatitis C treatment packet, but no evidence was found in the medical record that the care coordinator nurse completed the packet.

The OIG nursing clinicians noted marked improvement in nursing care since the Cycle 4 inspection, and included the areas of emergency care, transfers, out-to-medical returns, medication management, and specialized medical housing.

Nursing Assessment

Most CCC nurses performed good nursing assessments. Nursing deficiencies included not measuring vital signs or assessing a patient's complaint of pain. These deficiencies are discussed within specific indicators.

Nursing Intervention

The CCC nurses generally initiated appropriate and timely interventions. Deficiencies in this phase of the nursing process included failure to refer the patient to the provider and failure of the primary care RN to follow up with patients seen in sick call.

Nursing Documentation

Most of the cases reviewed had been reviewed in the EHRS. In general, nursing documentation was adequate. However, minor documentation deficiencies were found in all clinical areas. The following are examples of these deficiencies:

- In case 1, the sick call nurse did not document the reason on the sick call request form that the patient's request was not reviewed for 23 days (the patient was hospitalized), and how the nurse addressed the request.

- In cases 2 and 17, nurses did not describe the appearance of wounds after completing wound care dressing changes. Documentation of a wound's appearance allows all staff to monitor the healing process and treatment effectiveness.

- In case 20, the patient requested hepatitis C treatment, but the RN care coordinator did not complete the hepatitis C treatment request form.

Nursing Sick Call

The OIG clinicians reviewed 41 nursing sick call encounters. Nursing performance for sick call was adequate. Nurses reviewed most sick call requests timely and saw patients the same day or the next business day for face-to-face assessments. Nurses generally recognized potentially urgent conditions, performed adequate assessments, and made appropriate interventions and dispositions. However, a deficiency pattern was identified for incomplete nursing assessment, such as in the following examples:

- In case 14, the patient submitted a sick call request asking to see the provider because the pain medication was not effective for his sciatica (nerve pain in the patient's lower back and leg).The nurse did not assess the patient's mobility to ensure the pain did not affect his ability to maintain safety when walking.

- In case 15, the sick call nurse assessed the patient for cold symptoms including a bad cough. The patient had asthma and used an inhaler and self-administered nebulizer treatments (breathing treatments of medication in a mist form). The assessment was incomplete as the

nurse did not ask the patient how often he used the inhalers and the nebulizer treatments, and whether they were effective. The nurse did not schedule a follow-up visit with the primary care nurse to monitor the patient's condition and did not refer the patient to the provider.

RN Care – Fire Camps

CCC provided medical and nursing care to patients at 18 fire camps, and maintained a log of each camp patient who required urgent or emergent medical care, or who completed a sick call request. Custody officers at the camps either contacted the TTA or the camp nurse regarding patients' medical complaints. The nurse triaged the complaint, often by speaking directly to the patient. Patients with non-urgent problems returned to CCC via a weekly bus to be seen by a provider, or were referred to a community facility closer to the camp. Prescription medications were filled either at CCC and sent to the camp, or at a nearby community pharmacy. Custody officers notified the TTA or camp nurse concerning any patients who received emergent care at a community facility or patient deaths. Hospitalized patients were followed by the utilization management (UM) nurse. Emergency medical responses were reviewed by the EMRRC at CCC, although information provided for this inspection was minimal. The camp nurse and office technician also tracked provider visits to each camp and prepared an information packet for each patient to be evaluated. A primary care provider visit was required every 180 days, or sooner if medically necessary. Two nurses assisted the provider at each week-long camp clinic. Finally, a provider and a nurse were sent to any camp with active firefighting activity.

Care Management

CCHCS defined the care manager role as a primary care RN who develops, implements, and evaluates patient care services and care plans for an assigned patient panel. At CCC, the primary care nurse in each clinic was the designated care manager for that patient panel. A care coordinator was an LVN who was assigned a group of patients with chronic medical problems within the patient panel. At the institution, the LVN care coordinators identified new patient arrivals, reviewed their patient summaries, checked future appointments, and reviewed laboratory and diagnostic test results and pending orders. The LVN reviewed the information with the RN care manager. The RN and LVN presented the cases in the morning huddle or in the next CCC population management meeting. The RN care manager met with each new patient initially, and as needed thereafter. The LVN care coordinator met with the assigned patients within 30 days, and periodically thereafter to discuss progress toward treatment plan goals, and also monitored completion of provider orders and specialty referrals, and provided patient education. Patient visits with LVN care coordinators at CCC were comprehensive and timely.

Clinician Onsite Inspection

The OIG clinicians visited most clinical areas and interviewed staff about their position responsibilities, the methodology of their performance evaluations, and their suggestions for improvement. The nurses all denied having any communication barriers with providers, nursing

supervisors, pharmacy, and custody staff. The majority of nurses interviewed reported good morale and job satisfaction.

The OIG clinicians attended morning huddles in the primary care clinics on both days of the inspection. Huddles were well-attended by nursing staff, including supervising RNs, RN care managers, LVN care coordinators, and medication LVNs. Huddles were facilitated by the clinic's office technician by following the daily huddle report script. While all topics on the huddle form were addressed, information presented concerning patients new to the clinic's panel was minimal. Primary care nurses did not follow up with the current conditions of sick call patients whose referrals to a provider had exceeded the requested time frame.

Case Review Conclusion

The *Quality of Nursing Performance* indicator was rated *adequate*.

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11 — *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 programs, TTA, specialized medical housing, 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:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 124 medical provider encounters and identified 58 deficiencies related to provider performance at CCC. Of the 58 deficiencies identified, 8 were considered significant; once each in cases 1, 11, 13, 16, and 17; and three times in case 6. The OIG clinicians rated CCC provider performance *adequate.*

Assessment and Decision-Making

CCC providers generally made sound assessments and accurate diagnoses. Poor assessment and misdiagnosis, although infrequent, did occur. Errors with provider assessment were identified in cases 8, 9, 11, 14, and the following cases:

- In case 6, a provider ordered an urgent ultrasound (a type of scan) of the patient's leg to evaluate for a deep venous thrombosis (a blood clot), but failed to start the patient on Lovenox (a blood thinner) while waiting for the ultrasound report. As a result, the patient was not treated with Lovenox for one week. While this placed the patient at risk of serious harm, fortunately, no harm came to him.

- In case 17, the provider documented that the patient had a wrist abscess, which was being treated with an antibiotic. However, the provider failed to realize the patient's abscess also required a surgical drainage procedure. As a result, the patient's abscess progressively worsened, and he was hospitalized. This hospitalization may have been prevented if the patient's initial treatment had been appropriate.

CCC was classified as a basic medical institution with the majority of its patients being at minimal medical risk and requiring only basic medical services. After an in-depth review, CCC demonstrated that basic medical services were provided to its patients.

Provider-Ordered Follow-up Intervals

CCC providers generally ordered appropriate follow-ups. Only two cases were found in which provider follow-ups were not appropriate. They did not significantly affect patient care, however, and the deficiencies were minor.

Provider Continuity

CCC improved its provider continuity since Cycle 4 by consistently assigning patients to the same provider at each follow-up appointment. Therefore, the institution demonstrated its commitment to the primary care model that was not observed in Cycle 4.

Review of Records

CCC providers generally performed adequate chart review, which greatly aided in their diagnostic assessments and their ability to provide comprehensive medical care for their patients. However, there was insufficient depth of review of medical records by providers in the following three cases:

- In case 8, the provider failed to thoroughly review the patient's chart and, therefore, did not recognize the patient's extreme weight loss of 23 pounds over a four-month period. Unexplained weight loss is a classic sign of uncontrolled diabetes. As a result, the provider was unaware the patient's diabetes had progressively worsened and that oral diabetic medications were no longer controlling his diabetes.

- In cases 9 and 21, the providers failed to thoroughly review the electronic chart. As a result, they unnecessarily ordered laboratory tests the respective patients had already completed.

Emergency Care

CCC emergency care provider performance was good. While assessments and decision-making at times were inaccurate and questionable, the providers in the TTA were able to make appropriate decisions and sent patients to higher levels of care when indicated. This is further discussed in the *Emergency Services* indicator. Of the 16 TTA encounters reviewed, two significant errors were attributable to providers.

- In case 6, the patient had a history of pulmonary embolism (a blood clot in the lung). The patient had injured his leg and was brought to the TTA with the limb painful and swollen. His condition was managed as a leg infection. The providers seeing the patient, for the next two weeks, failed to consider and recognize that a deep venous thrombosis (DVT) was the cause of the patient's symptoms. This failure placed the patient at a significant risk of harm as treatment of his DVT was delayed.

- In case 13, the patient was placed on blood-thinning medications to prevent a recently placed cardiac stent (a small tube inserted into a blood vessel to keep it open) from narrowing. The patient developed a nosebleed while on these medications, and he was taken

to the TTA, where his nosebleed was halted after a prolonged application of pressure and ice. However, the provider stopped the patient's blood-thinning medication for one day. This was an inappropriate decision by the provider as it increased the patient's risk of restenosis (a stented blood vessel becoming blocked again).

Chronic Care

Chronic care performance was good. CCC providers demonstrated fair skill and knowledge in caring for patients, even though a few providers struggled with patients who had complicated medical issues. The majority of patients at the institution had conditions considered to be of low medical complexity, which did not require management of difficult problems such as HIV infection or anticoagulation. Patients were properly monitored and assessed, with providers intervening when appropriate. Diabetic management at CCC was adequate based on the limited number of events available to review. CCC providers generally demonstrated adequate diabetic management skills. The following minor deficiencies were identified:

- In case 8, the provider failed to perform and document an appropriate foot examination for a diabetic patient.

- In case 17, the patient had several provider encounters during which the provider failed to address the patient's tachycardia (a fast heart rate). In addition, the patient's heart rate should have been re-checked before he was sent back to general housing.

Specialty Services

CCC providers appropriately referred patients for specialty services. The *Specialty Services* indicator provides further details.

Documentation Quality

Provider documentation quality was frequently poor. Many instances of insufficient documentation were identified during this case review, the most common of which were failure to address one or more medical problems; acute medical issues; inaccurate documentation; and poor documentation supporting a medical decision, or a lack of documentation altogether, particularly in off-hours TTA visits. However, OIG clinicians determined the majority of poor documentation was attributable to one provider. Poor documentation was identified in cases 1, 9, 11, 13, 17, 18, and 20, with significant deficiencies noted in the following two cases:

- In case 6, the provider evaluated the patient's complaint that he had not received his blood-thinning medication for three days. Furthermore, this provider documented poor and contradictory information in the subjective and the review-of-system portions in another progress note. For example, the provider documented "less drainage and pain" in the subjective portion of this progress note, but then documented "increase [*sic*] pain, drainage" in the review of systems. The provider noted "fevers [*sic*] chills," but failed to document any additional details that would have indicated the patient actually had these symptoms.

- In case 21, several encounters occurred in which the same provider discussed in case 6 failed to include a plan portion in the progress note. Therefore, the OIG clinicians could not determine whether any actual medical care had been delivered to the patient during these encounters.

The majority of progress notes were typed into both the eUHR as well as the new EHRS. Therefore, legibility was not an issue, with most of the progress notes written by the providers. The OIG clinicians found minimal evidence of "cloned" progress notes, in which outdated medical information was inappropriately carried forward to a current progress note.

Health Information Management

CCC providers generally documented patient encounters on the same day. The *Health Information Management* indicator provides further details.

Clinician Onsite Inspection

The OIG clinicians observed the daily morning huddles that occurred at CCC. The *Health Information Management* indicator provides further details.

In general, CCC providers performed adequately, both as individual providers and as a group, with the institution committed to following a primary care model.

Onsite interviews revealed the providers found the nursing staff easy to work with, despite an absence of nursing continuity at each of the yards. Certain providers felt the lack of regularly scheduled nurses at each of the yards made it difficult to maintain continuity because patients saw a different nurse with each visit.

While the majority of providers described their morale as good, any frustration was generally due to the lack of physician availability that plagued CCC. As a result, a few of the providers expressed feeling overworked. This issue was discussed in the clinician onsite inspection section of the *Access to Care* indicator.

At the time of the onsite visit, the new CEO had just started working at the institution, and the CME was away on long-term leave. Therefore, CCHCS instituted a new pilot program at CCC in December 2016, whereby the acting CP&S was located at the southern California office, but performed daily duties via telemedicine. However, the CP&S was at CCC for the first time during the OIG onsite inspection in May 2017.

While the OIG acknowledges the new pilot program for the acting CP&S was providing temporary leadership for CCC, whether this pilot program will be a long-term solution for the current lack of physician leadership at CCC has yet to be determined. As a result, job performance was not closely monitored as reflected in the annual provider performance appraisals. The majority of the annual provider performance appraisals had not been completed for this year, 2017, and some provider appraisals had not been updated for several years. Although the OIG recognizes that CCC

leadership has changed with the addition of the new CEO and the acting CP&S, the OIG contends this was evidence that leadership has not been stable at this institution.

Case Review Conclusion

As a whole, CCC providers performed adequately with a patient population that generally required only basic medical care. Providers usually made sound and accurate diagnoses with appropriate treatment plans for these less medically complex and generally healthy patients. While documentation was at times poor, one provider was responsible for the majority of poor documentation found during case review. Medical records were appropriately reviewed by providers. Emergency care and diabetes management were also good. CCC providers appropriately referred patients for specialty services with the overall quality of documentation being fair. The majority of patient follow-ups were typically ordered within the appropriate time interval. However, provider appraisal evaluations were not kept current. This was likely due to the unstable leadership at CCC. Despite these concerns, the continuity of care at CCC has improved since Cycle 4, and basic medical services were provided. Therefore, the OIG clinicians rated this indicator *adequate.*

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable
Overall Rating:
Not Applicable

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

Because CCC does not have a reception center, this indicator did not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting 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 an OHU.

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(66.7%)
Overall Rating:
Adequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. While each area's results are discussed in detail below, the result variance is due to the testing approaches. Because the case review process contained a more detailed review, the OIG inspection team determined the final overall rating was *adequate*.

Case Review Results

The specialized medical unit at CCC was a 14-bed medical OHU. The OIG clinicians reviewed 27 events, consisting of 13 provider encounters or orders, and 14 nursing encounters with 9 patients. Eight of the nine patients reviewed were sent to the OHU for the purpose of observation. Nine deficiencies were identified, of which three were significant (cases 1, 6, and 11). The OIG clinicians rated this indicator *adequate.*

OHU Utilization

The institution continued the practice identified in Cycle 4 of placing patients in the OHU on brief holds (less than 24 hours) to support patient compliance with preparation and readiness for scheduled diagnostic tests, and for observation after hospital discharge. The patients on these brief holds generally were brought to the OHU the evening before the scheduled tests and were returned to their regular housing units in the morning following the procedure. The patients returning from hospitalization were sent to the OHU, placed on hold for observation, and released the next day. The providers ordered vital signs, special or regular diets, activity levels, medications, and follow-up provider appointments for these patients. OHU nurses provided the same level of nursing care to all patients, whether they were on hold or had been formally admitted. In the cases reviewed, most patients were evaluated by a provider before they were discharged from the OHU. When a patient returned to regular housing, the primary care coordinator nurse reviewed the medical record and presented patient information to the primary care team at the next huddle.

Provider Performance

OHU providers performed adequately. Providers generally documented comprehensive history-and-physical examinations as well as adequate summaries that reflected medical records had been reviewed. Providers also demonstrated adequate assessment and decision-making activities during patient care, except for the three following cases that had significant deficiencies:

- In case 1, the provider failed to complete an admission history-and-physical examination.
- In case 6, the provider failed to follow up on the patient's complaint that he had not received his blood-thinning medication for three days. The provider failed to investigate whether the patient had received this medication to protect him from blood clots or pulmonary embolism (blood clots traveling to the lungs). While this placed the patient at the risk of significant harm, fortunately, no harm came to him.
- In case 11, the patient was admitted to the OHU from an outside hospital for further monitoring of his diabetes. The provider documented that the patient had weakness in his legs when walking, but failed to provide the patient with either a cane or a walker. This was a significant lapse in the patient's medical care as it increased his risk of falling.

Nursing Performance

The quality of nursing care in the OHU improved since Cycle 4. Although poor nursing assessments and documentation deficiencies were identified in Cycle 4, these issues have been addressed with implementation of the new EHRS. In addition, the second watch nurses were proficient in providing patient education at the time of discharge, including providing written material about medical diagnoses and medications. Conversely, OHU nurses did not communicate verbally with primary care nurses before releasing patients from the OHU. The CCC nurses provided adequate care to patients in the OHU.

Clinician Onsite Inspection

During the OIG clinicians' onsite inspection, three patients were in the OHU for observation. Staffing consisted of RNs during the second watch and LVNs during the first and third watches. When no RN was assigned to the OHU, the TTA nurses provided any necessary nursing assessments and conducted nursing rounds. In interviews conducted by the OIG clinicians, nurses reported they provided the same care to all patients, regardless of whether patients were on observation status or had been admitted to the unit.

Case Review Conclusion

The institution's providers and nurses performed adequately with respect to OHU care. The OIG clinicians noted that sending patients to the OHU for 23-hour observation increased the providers' workload. The lack of verbal communication between the OHU nurse and the clinic nurse at the time of discharge could increase the potential for lapses in care.

Compliance Testing Results

CCC received an *inadequate* compliance score of 66.7 percent, with the following test area showing room for improvement:

- Although the institution's OHU utilized a call-button system, OHU staff did not properly document on the daily log whether the call-button tests reported the system was in proper working condition. As a result, CCC scored zero for this test. However, knowledgeable staff stated that urgent or emergent access to cells was timely, with response rates of less than a minute, and management did not identify any concerns related to this reported response time (MIT 13.101).

The institution scored in the *proficient* range in the following two tests:

- For all ten sampled patients, nursing staff timely completed an initial health assessment on the day the patient was admitted to the OHU (MIT 13.001).
- CCC providers timely completed SOAPE notes at required intervals for all ten applicable sampled OHU patients (MIT 13.003).

14 — *SPECIALTY SERVICES*

This indicator focuses on specialist care from the time a request for services or physician's order for specialist care is completed to the time of 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 patient is updated on the plan of care.

Case Review Rating:
Adequate
Compliance Score:
Adequate
(79.6%)
Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 56 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. In this category, 12 deficiencies were found with 6 being significant. The OIG clinicians rated this indicator *adequate.*

Access to Specialty Services

Case reviews found that specialty services at CCC were still generally provided within adequate time frames for both routine and urgent services. Nearly all the initial referrals to specialty services at the institution were completed within an acceptable time frame, except in case 1 and in the following case:

- In case 20, the patient developed pain and swelling in his genitals. The provider submitted an urgent referral for a visit with the urologist (a genitourinary surgeon). However, this visit was delayed for more than one month. This was a significant deficiency and lapse in the patient's medical care, given this was an urgent referral.

Nursing Performance

Nursing performance for patients returning from offsite specialty appointments was good. CCC nurses generally assessed the patient, reviewed the specialty recommendations, and obtained pertinent orders to provide appropriate care. The following case highlights one significant deficiency:

- In case 20, the OIG clinicians noted the RN care coordinator failed to complete the hepatitis C treatment request form as ordered by the provider. As a result, a four-month delay transpired before the hepatitis C committee reviewed the patient's case for hepatitis C treatment.

The telemedicine nurse performed well in telemedicine specialty services, performing adequate nursing assessments and transmitting this information to the telemedicine provider.

Provider Performance

In Cycle 4, the OIG clinicians identified what appeared to be an inappropriate overutilization of specialty services, with providers shifting patient care responsibilities to the specialist. However, CCC providers displayed significant improvement in Cycle 5, as specialty services were being appropriately utilized. Providers also performed proficiently in submitting appropriate referrals for specialty services. Furthermore, all referrals were submitted with the proper priority designation.

Health Information Management

Although OIG clinicians found continued problems with processing a few of the specialty reports, CCC showed marked improvement in this category. A few of these specialty reports were not retrieved and scanned into either the eUHR or the EHRS, resulting in providers not having relevant information available to them. Even if the ordering provider had been notified and had reviewed the report, that information would not have been readily available to any subsequent medical staff. Therefore, the absence of specialty reports created a significant barrier for any provider or nurse to overcome in providing quality and continuity of care to patients. This deficiency was identified in cases 1 and 6, and in the following case:

- In case 21, the patient had chest pain. The provider ordered a cardiac nuclear scan (an imaging test to evaluate the blood flow of the heart) and an echocardiogram (a type of ultrasound scan) to further evaluate the patient's chest pain. However, medical records staff failed to retrieve and scan these reports into the eUHR. This was a significant lapse in care as this pertinent information was not available to subsequent providers.

Clinician Onsite Inspection

The telemedicine clinic was clean and adequate. The nurse kept an organized tracking and scheduling system for all telemedicine appointments. No appointment backlog for telemedicine was reported.

The majority of the providers also reported having much better access to on- and offsite specialty reports since Cycle 4. The OIG clinicians discovered that the offsite specialty nurse and the UM nurse had an excellent process to track specialty and hospital reports. The offsite specialty and UM nurses diligently obtained all specialty and hospital reports, and then notified the providers through the EHRS via the message center.

The OIG commends CCC's leadership in fully utilizing the telemedicine service. The institution's remote location made providing on- and offsite specialty services challenging. Therefore, the institution's leadership has relied heavily on telemedicine providers to overcome this barrier to specialty services access. Specialists who were not able travel to CCC because of its remote

location could still provide specialty care via telemedicine. The institution's leadership also utilized telemedicine service in an innovative manner for patients located in remote fire camps. This onsite observation is discussed in the *Access to Care* indicator.

Case Review Conclusion

CCC experienced significant improvement in managing its specialty services since Cycle 4. The institution continued to provide specialty services within adequate time frames for routine and urgent services. CCC providers also displayed great improvement in utilizing specialty services. Providers were no longer submitting inappropriate referrals, which shifted the responsibility of patient care to the specialists. Providers also reported having good access to both on- and offsite specialty reports since Cycle 4. CCC leadership demonstrated a proficient use of the telemedicine service to improve patient access to specialty services. Due to these improvements since Cycle 4, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 79.6 percent in the *Specialty Services* indicator. The following three tests received *proficient* scores:

- For all 15 sampled patients, high-priority specialty services appointments occurred within 14 calendar days of the provider's order (MIT 14.001).
- For all 15 sampled patients, routine specialty services appointments occurred within 90 calendar days of the provider's order (MIT 14.003).
- Providers timely received and reviewed the routine priority specialists' reports for all 13 applicable sampled patients (MIT 14.004).

One test received an *adequate* score:

- The OIG inspectors tested the timeliness of CCC's administrative denials of provider specialty services requests. For the sampled requests, 17 of the 20 (85 percent) were denied in a timely manner. Three requests for specialty service were denied from 20 to 28 days late (MIT 14.006).

Three tests received scores in the *inadequate* range:

- Among 20 sampled patients for whom CCC's health care management denied a specialty service, 14 patients (70 percent) received a timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternative treatment strategies. For four patients, the provider's follow-up visit occurred from 4 to 48 days late. For two patients, there was no evidence at all of provider follow-up to discuss the denial (MIT 14.007).

- Providers timely received and reviewed the specialists' reports for 9 of the 15 sampled patients (60 percent). For five patients, the institution did not scan the specialists' reports into the patients' electronic medical records, and for one final patient, the provider reviewed the specialist's report two days late (MIT 14.002).
- Among the 19 applicable sampled patients, only eight who transferred to CCC with an approved specialty service appointment (42 percent) received it within the required time frame. The remaining 11 sampled patients did not timely receive their previously approved services or did not receive the service at all. Four patients received their appointments from 25 to 43 days late; two patients received their appointments 59 and 75 days late; two other patients received their appointments 80 and 108 days late; and three other patients never received their specialty service appointments (MIT 14.005).

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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(84.2%)
Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. 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. In addition, 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. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Compliance Testing Results

The institution received a score of *adequate* in the *Administrative Operations* indicator, receiving a compliance score of 84.2 percent. The following tests received scores in the *proficient* range:

- The institution promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).
- CCC's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities. In addition, the institution took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.003, 15.004).
- All ten sampled nurses were current with their clinical competency validations (MIT 15.105).
- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the PIC were current with their professional licenses and certification requirements (MIT 15.107, 15.109).
- All active duty providers, nurses, and custody staff were current with their emergency response certifications (MIT 15.108).
- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

- All nursing staff hired within the last year timely received new employee orientation training (MIT 15.111).

- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by CCC's EMRRC during the prior six-month period; 11 of 12 sampled packages (92 percent) complied with policy. One EMRRC package was not included in the EMRRC meeting minutes (MIT 15.005).

One test scored in the *adequate* range:

- When the OIG inspectors examined records to determine whether nursing supervisors were completing the required number of monthly case reviews for subordinate nurses, as well as discussing the results of those reviews, only four of five sampled nurse supervisors had properly completed their reviews (80 percent). One of the reviewing nurses did not properly follow protocols by documenting evidence the reviewing nurse had discussed the review results with the subordinate nurse (MIT 15.104).

Three tests received *inadequate* scores:

- CCC had two patient deaths that occurred during the OIG's sample test period; however, the institution did not timely notify CCHCS' Death Review Unit of the death or use the correct form to report the death. Specifically, CCC's medical staff incorrectly submitted the Initial Inmate Death Report (CDCR Form 7229A) for one patient; because the death was a suicide, the Initial Inmate Suicide Report (CDCR Form 7229B) should have been used instead. For one other patient, the Initial Inmate Death Report (CDCR Form 7229A) was submitted one business day late. As a result, the institution received a score of zero for this test (MIT 15.103).

- Only one of four CCC providers had a proper clinical performance appraisal completed by a supervisor (25 percent). Three other providers did not have either timely or properly completed appraisals, including the following (MIT 15.106):

    - A performance appraisal summary (CDCR Form 637) for one provider was overdue by 47 months.

    - Performance appraisal summaries (CDCR Form 637) for two providers were overdue by 3 and 8 months. In addition, both of these providers' most recently completed evaluations did not include current 360-degree evaluations.

- The institution did not meet the emergency response drill requirements for the most recent quarter for one of its three watches, resulting in a score of 67 percent. Specifically, the institution's first watch drill package did not contain a complete documentation of Cardiopulmonary Resuscitation Record (CDCR Form 7462) or Interdisciplinary Progress Notes (CDCR Form 7230) as required by CCHCS policy (MIT 15.101).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports. CCHCS' Death Review Committee (DRC) did not timely complete its death review summary for either of the two CCC deaths that occurred during the OIG's inspection period. The DRC is generally required to complete a death review summary within either 30 or 60 days of death, depending on whether the death was expected or unexpected, and then notify the institution's CEO of the review results within 7 days so that any corrective action may be promptly pursued. For one patient's death, the committee completed its summary 79 days late (139 days after death), and the institution's CEO was notified of said results 94 days late. For the remaining patient's death, which occurred on December 12, 2016, the final report was not yet available as of June 16, 2017 (MIT 15.998).
- The OIG discusses the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

RECOMMENDATIONS

- The OIG recommends that CCC re-examine and modify its diagnostic processes to ensure reliable test completion and diagnostic report retrieval.
- The OIG clinicians recommend that CCC develop a local policy addressing provider and nursing responsibilities for patients in the OHU for less-than-24-hour observation.
- The OIG recommends that, at the time of a patient's discharge, the OHU nurse verbally communicate patient information to the assigned primary care clinic nurse and document in the OHU discharge nursing note that the nurse-to-nurse transfer of information occurred.

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 is a set of standardized performance measures developed by the National Committee for Quality Assurance 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, and researchers) has the information it needs to accurately compare the performance of health care plans. Healthcare Effectiveness Data and Information Set data is often used to produce health plan report cards, analyze quality improvement activities, and create performance benchmarks.

Methodology

For population-based metrics, the OIG used a subset of HEDIS measures applicable to the CDCR 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 the California Correctional Center, nine HEDIS measures were selected and are listed in the following *CCC Results Compared to State and National HEDIS Scores* table. 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.

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 Medi-Cal in all five measures and outperformed Kaiser in four of the five measures, scoring slightly lower for diabetic eye exams compared to Kaiser South. In addition, when compared nationally, CCC outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures, and outperformed the VA in three of the four applicable diabetic measures, with the VA outperforming CCC in eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, CCC scored lower than all entities except Medicaid. The high patient refusal rate of 56 percent for influenza vaccinations offered to younger adults negatively affected the institution's score. When administering influenza and pneumococcal vaccinations to older adults, CCC scored lower than both Medicare and the VA for influenza vaccinations, but the institution performed better than both Medicare and the VA for pneumococcal vaccinations. However, the institution had only two applicable patients for older adult vaccinations.

Cancer Screening

With respect to colorectal cancer screening, CCC was outperformed by all other health care entities, statewide and nationally. However, the institution's score was negatively affected by a 68 percent refusal rate.

Summary

CCC's population-based metrics performance reflected a good chronic care program compared to the statewide and national health care plans reviewed. The institution may improve its scores for immunizations and colorectal cancer screening, and thus reduce the patient refusal rate, through education on the preventive benefits of these services.

CCC Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	CCC Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**8%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**84%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**88%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**70%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**42%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)[6]	**50%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal[6]	**100%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**30%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in March 2017 by reviewing medical records from a sample of CCC's population of applicable 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 *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.

3. Data was obtained from Kaiser Permanente November 2016 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2016 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov. For the Immunizations: Pneumococcal measure only, the 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.

APPENDIX A — COMPLIANCE TEST RESULTS

California Correctional Center Range of Summary Scores: 66.67%–84.22%	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	75.45%
2 – ***Diagnostic Services***	76.91%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	77.29%
5 – ***Health Care Environment***	74.24%
6 – ***Inter- and Intra-System Transfers***	72.58%
7 – ***Pharmacy and Medication Management***	72.17%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	71.69%
10 – ***Quality of Nursing Performance***	Not Applicable
11 – ***Quality of Provider Performance***	Not Applicable
12 – ***Reception Center Arrivals***	Not Applicable
13 – ***Specialized Medical Housing (OHU, CTC)***	66.67%
14 – ***Specialty Services***	79.59%
15 – ***Administrative Operations***	84.22%

Reference Number	1 – *Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the 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?	16	9	25	64.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	15	9	24	62.50%	1
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	30	2	32	93.75%	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?	27	3	30	90.00%	2
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	15	5	20	75.00%	12
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?	4	3	7	57.14%	25
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	7	3	10	70.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	14	7	21	66.67%	9
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	5	0	5	100%	0
Overall percentage:					**75.45%**	

Reference Number	2 – *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%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	8	2	10	80.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	8	1	9	88.89%	1
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	10	0	10	100%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	0	9	100%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	6	9	33.33%	1
Overall percentage:					**76.91%**	

3 – *Emergency Services*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	15	1	16	93.75%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	16	4	20	80.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	8	2	10	80.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	3	0	3	100%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	12	12	24	50.00%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	6	4	10	60.00%	0
Overall percentage:					**77.29%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	7	2	9	77.78%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	9	0	9	100%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	9	0	9	100%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	8	1	9	88.89%	0
5.105	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?	1	0	1	100%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	5	3	8	62.50%	1
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	6	2	8	75.00%	1
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	7	1	8	87.50%	1
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	2	6	8	25.00%	1
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	2	4	6	33.33%	3
Overall percentage:					**74.24%**	

Reference Number	6 – *Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	3	22	25	12.00%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the 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?	23	1	24	95.83%	1
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	3	2	5	60.00%	20
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	19	1	20	95.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	6	0	6	100%	0
Overall percentage:					**72.57%**	

Reference Number	*7 – Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	8	4	12	66.67%	13
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	25	0	25	100%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	7	3	10	70.00%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	16	5	21	76.19%	4
7.006	For patients en route who lay over at the institution: If the temporarily housed 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 over narcotic medications assigned to its clinical areas?	4	3	7	57.14%	4
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?	3	4	7	42.86%	4
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?	3	4	7	42.86%	4
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	6	1	7	85.71%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	7	0	7	100%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	4	3	7	57.14%	4
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%	0

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	Does the institution follow key medication error reporting protocols?	21	4	25	84.00%	0
Overall percentage:					**72.17%**	

8 – *Prenatal and Post-Delivery Services*

The institution has no female patients, so this indicator is not applicable.

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	19	6	25	76.00%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	5	19	24	20.83%	1
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	10	20	30	33.33%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	25	0	25	100%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	12	0	12	100%	13
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**71.69%**	

10 – *Quality of Nursing Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

11 – *Quality of Provider Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

12 – *Reception Center Arrivals*

The institution has no reception center, so this indicator is not applicable.

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	0	0	0	0%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	10	0	10	100%	0
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 patient's cells?	0	1	1	0%	0
Overall percentage:					**66.67%**	

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	15	0	15	100%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	9	6	15	60.00%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	13	0	13	100%	2
14.005	For endorsed patients received from another CDCR institution: If the 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?	8	11	19	42.11%	1
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	17	3	20	85.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	14	6	20	70.00%	0
Overall percentage:					**79.59%**	

Reference Number	15 – *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%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
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%	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%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	11	1	12	91.67%	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				
15.101	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 patient's appealed issues?	10	0	10	100%	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?	0	2	2	0.00%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	4	1	5	80.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
15.106	Are structured clinical performance appraisals completed timely?	1	3	4	25.00%	0
15.107	Do all providers maintain a current medical license?	14	0	14	100%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100%	0

15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
Overall percentage:					**84.22%**	

APPENDIX B — CLINICAL DATA

Table B-1: CCC Sample Sets

Sample Set	Total
Anticoagulation	1
Death Review/Sentinel Events	2
Diabetes	4
Emergency Services – CPR	1
Emergency Services – Non-CPR	3
High Risk	4
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	9
Specialty Services	2
	36

Table B-2: CCC Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Arthritis/Degenerative Joint Disease	2
Asthma	7
COPD	2
Cardiovascular Disease	1
Chronic Pain	5
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	4
Gastroesophageal Reflux Disease	1
Hepatitis C	7
Hyperlipidemia	6
Hypertension	12
Mental Health	1
Seizure Disorder	2
	54

Table B-3: CCC Event – Program

Program	Total
Diagnostic Services	84
Emergency Care	28
Hospitalization	27
Intra-System Transfers In	6
Intra-System Transfers Out	3
Not Specified	1
Outpatient Care	210
Specialized Medical Housing	25
Specialty Services	55
	439

Table B-4: CCC Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	10
RN Reviews Focused	16
Total Reviews	46
Total Unique Cases	36
Overlapping Reviews (MD & RN)	10

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Correctional Center			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003–006	Nursing Sick Call (8 per clinic) 32	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (10)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (5)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology-related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (16)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	*N/A at this institution*	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(10)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(3)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Returns From Community Hospital (10)	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 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (8)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MITs 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (6)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (10)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	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 (and risk level) • **Randomize**
MIT 7.006	En Route *N/A at this institution*	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (10)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MITs 8.001–007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (25)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	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**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	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**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	OHU (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons OHU (all)	OIG inspector onsite review	• Review by location
Specialty Services Access			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MITs 14.006–007	Denials (10)	InterQual	• Review date (3–9 months) • **Randomize**
	(10)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events *N/A at this institution*	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB *N/A at this institution*	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (2)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (4)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (14)	Current provider listing (at start of inspection)	• Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff o Providers (ACLS) o Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (2)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

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October 12, 2017

Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

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 2017 to May 2017. California Correctional Health Care Services (CCHCS) acknowledges the OIG 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, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Ryan Baer, Senior Deputy Inspector General, OIG
Stephen Tseng, M.D., Chief Physician and Surgeon, OIG
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