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Office of the Inspector General

Central California Women's Facility
Medical Inspection Results
Cycle 4

March 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CENTRAL CALIFORNIA WOMEN'S FACILITY
Medical Inspection Results
Cycle 4

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EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. 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 court may find that an institution the OIG found to be providing adequate care still did not meet constitutional standards, depending on the analysis of the underlying data provided by the OIG. Likewise, an institution that has been rated *inadequate* by the OIG could still be found to pass constitutional muster with the implementation of remedial measures if the underlying data were to reveal easily mitigated deficiencies.

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.

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

The OIG performed its Cycle 4 medical inspection at CCWF from June to August 2016. The inspection included in-depth reviews of 73 patient files conducted by clinicians, as well as reviews of documents from 453 patient files, covering 108 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 CCWF using 16 health care quality indicators applicable to the institution, made up of 14 primary clinical indicators and 2 secondary administrative indicators. 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 deputy inspectors general and registered nurses trained in monitoring medical policy compliance. Of the 14 primary indicators, nine were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at CCWF was ***inadequate***.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	CCWF Applicability
1–Access to Care	All institutions	Both case review and compliance
2–Diagnostic Services	All institutions	Both case review and compliance
3–Emergency Services	All institutions	Case review only
4–Health Information Management (Medical Records)	All institutions	Both case review and compliance
5–Health Care Environment	All institutions	Compliance only
6–Inter- and Intra-System Transfers	All institutions	Both case review and compliance
7–Pharmacy and Medication Management	All institutions	Both case review and compliance
8–Prenatal and Post-Delivery Services	Female institutions only	Both case review and compliance
9–Preventive Services	All institutions	Compliance only
10–Quality of Nursing Performance	All institutions	Case review only
11–Quality of Provider Performance	All institutions	Case review only
12–Reception Center Arrivals	Institutions with reception centers	Both case review and compliance
13–Specialized Medical Housing (OHU, CTC, SNF, Hospice)	All institutions with an OHU, CTC, SNF, or Hospice	Both case review and compliance
14–Specialty Services	All institutions	Both case review and compliance
Two Secondary Indicators (Administrative)	**All Institutions–Applicability**	**CCWF Applicability**
15–Internal Monitoring, Quality Improvement, and Administrative Operations	All institutions	Compliance only
16–Job Performance, Training, Licensing, and Certifications	All institutions	Compliance only

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for CCWF was *inadequate*. Of the 14 primary (clinical) quality indicators, the OIG found none *proficient*, four *adequate*, and ten *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for CCWF, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at CCWF.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,459 patient care events.[1] Of the 14 primary indicators applicable to CCWF, 12 were evaluated by clinician case review; 7 were rated *adequate*, and 5 were rated *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

- CCWF provided adequate emergency services. The treatment and triage area (TTA) nursing staff provided well-coordinated emergency services to their patients. Nursing assessments and treatments were generally appropriate.

- In the skilled nursing facility (SNF), nursing staff provided good care to the patients, which prevented common occurrences such as skin breakdown and hospital-acquired infections.

Program Weaknesses — Clinical

- Providers at CCWF performed poorly and contributed to the *inadequate* rating for the institution. The numerous significant deficiencies covered multiple aspects of patient care, including emergency care, chronic care, hospital returns, and specialty services.

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

- CCWF performed poorly with regard to access to care, as numerous important provider appointments did not occur and hindered patient care.

- Specialty services at CCWF were inadequate. Missed and delayed provider follow-up appointments led to untimely review of specialists' recommendations and hindered patient care.

- CCWF nursing services performed poorly in their patient-scheduling tasks following the implementation of the new electronic health record system (EHRS). The system was new to nursing and contributed to delays in the *Access to Care* indicator. In addition, nursing services performed poorly in documenting their outpatient assessments.

Compliance Testing Results

All 16 health care indicators were applicable to CCWF; 13 were evaluated by compliance inspectors.[2] There were 108 individual compliance questions within those 13 indicators, generating 1,385 data points, testing CCWF's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 108 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 13 applicable indicators ranged from 40.7 percent to 98.0 percent, with the primary (clinical) indicator *Reception Center Arrivals* receiving the lowest score, and the primary indicator *Specialized Medical Housing* receiving the highest. Of the 11 primary indicators applicable to compliance testing, the OIG rated one *proficient,* one *adequate,* and nine *inadequate.* Both of the two secondary indicators, which involve administrative health care functions, were rated *inadequate.*

Program Strengths — Compliance

As the *CCWF Executive Summary Table* on page *viii* indicates, the institution's compliance ratings were *proficient,* above 85 percent, in only the *Specialized Medical Housing* indicator. The following are some of CCWF's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Patients had a standardized process to obtain and submit health care service request forms; nursing staff timely reviewed patients' health care requests and conducted face-to-face visits within the required time frame.

- Patients timely received their radiology and pathology services. Providers also timely reviewed laboratory reports.

[2] The OIG's compliance inspectors are trained deputy inspectors general and 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 where CCHCS policies and procedures did not specifically address an issue.

- Clinical staff followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste; staff properly managed and stored bulk medical supplies; and clinic common areas had an adequate environment for providing medical services.

- When patients transferred into CCWF from other institutions, nurses timely completed their initial health screening assessments. When patients transferred out of CCWF to other institutions, health care staff properly prepared medication transfer packages, including required medications and corresponding medical administration records and medication reconciliations.

- Nursing staff followed proper hand hygiene and administrative controls and protocols when preparing medications.

- CCWF's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored and monitored refrigerated, frozen, and non-refrigerated medications; and properly accounted for narcotic medications.

- CCWF timely provided or offered patients seasonal influenza vaccinations and routine mammograms per CCHCS policy.

- When patients arrived from county jails, nursing staff timely completed the assessment and disposition section on the initial health screening form.

- Sampled patients in CCWF's SNF timely received initial nursing assessments on the day of admission. In addition, providers timely completed their required initial assessments, history and physical examinations, and routine patient monitoring.

- Most patients timely received their approved high-priority and routine specialty services, and providers timely reviewed all high-priority consultant reports.

The following are some of the strengths identified within the two secondary administrative indicators:

- The institution's Emergency Medical Response Review Committee performed timely incident package reviews that included required documentation.

- All providers, nurses, and custody staff were current with their emergency response certifications.

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

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following nine primary indicators: *Access to care*, *Diagnostic Services*, *Health Information Management*, *Inter-Intra-System Transfers*, *Pharmacy and Medication Management*, *Prenatal and Post-Delivery Services*, *Preventive Services*, *Reception Center Arrivals*, and *Specialty Services*. The institution also received *inadequate* scores in both secondary indicators, *Internal Monitoring, Quality Improvement, and Administrative Operations*, and *Job Performance, Training, Licensing, and Certifications*.

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

- Patients with chronic care conditions did not receive timely routine follow-up appointments.
- Patients who arrived from other institutions and were then referred by a nurse to see a provider did not always receive timely provider appointments. In addition, most patients did not receive medical appointments within the required time frame when nursing staff determined a referral to a provider was necessary.
- Providers did not timely review and communicate patients' radiology and pathology results.
- Providers did not routinely review hospital discharge reports within the required time frame.
- Several clinics lacked core equipment and essential supplies in the common areas and exam rooms.
- Nursing staff did not always properly or timely complete initial health screening forms for patients who arrived from other CDCR institutions. The newly transferred patients also did not always receive their previously approved medications.
- Clinical nursing staff did not timely and correctly administer all required chronic care medications or follow proper protocols when patients refused or did not show up to receive their medication.
- Health care staff did not timely order, make available, or administer medications to patients returning from a community hospital.
- Many patients who arrived from a non-CDCR facility did not have all of their medications either made available or administered timely.
- Nursing staff did not timely administer medications to patients transferred from one housing unit to another.

- Patients who were in transition to another institution and temporary laid over at CCWF did not always receive their medications without interruption.

- CCWF physicians did not timely order pregnant patients' extra daily nutritional supplements, such as extra food and milk. In addition, CCWF did not ensure that required postpartum visits timely occurred. Patients being treated for active tuberculosis (TB) infections were not always administered TB medications as prescribed.

- When patients arrived at the reception center, providers did not always timely complete history and physical exams, and providers did not always timely communicate to the patients' their laboratory test results.

- When patients transferred to CCWF from other institutions with an approved specialty service appointment, they often did not receive their services or received them late.

- When CCWF's health care management denied patients' specialty service, providers did not timely communicate the denials to their patients.

The following are some of the weaknesses identified within the two secondary administrative indicators:

- During the most recent quarter, CCWF did not complete required emergency response training drills for all three watches. For two watches, custody staff did not participate in the drill; another watch, staff did not complete all required event documentation.

- Providers did not timely receive clinical performance evaluations; nursing supervisors did not always properly complete subordinate nurse reviews.

- The pharmacy did not have a process in place to independently track providers' Drug Enforcement Agency controlled substance registrations.

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

CCWF Executive Summary Table

Primary Indicators (Clinical)	Case Review Rating	Compliance Rating	Overall Indicator Rating
Access to Care	*Inadequate*	*Inadequate*	*Inadequate*
Diagnostic Services	*Adequate*	*Inadequate*	*Inadequate*
Emergency Services	*Adequate*	Not Applicable	*Adequate*
Health Information Management (Medical Records)	*Adequate*	*Inadequate*	*Inadequate*
Health Care Environment	Not Applicable	*Adequate*	*Adequate*
Inter- and Intra-System Transfers	*Adequate*	*Inadequate*	*Inadequate*
Pharmacy and Medication Management	*Adequate*	*Inadequate*	*Inadequate*
Prenatal and Post-Delivery Services	*Adequate*	*Inadequate*	*Adequate*
Preventive Services	Not Applicable	*Inadequate*	*Inadequate*
Quality of Nursing Performance	*Inadequate*	Not Applicable	*Inadequate*
Quality of Provider Performance	*Inadequate*	Not Applicable	*Inadequate*
Reception Center Arrivals	*Inadequate*	*Inadequate*	*Inadequate*
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	*Adequate*	*Proficient*	*Adequate*
Specialty Services	*Inadequate*	*Inadequate*	*Inadequate*
Secondary Indicators (Administrative)	**Case Review Rating**	**Compliance Rating**	**Overall Indicator Rating**
Internal Monitoring, Quality Improvement, and Administrative Operations	Not Applicable	*Inadequate*	*Inadequate*
Job Performance, Training, Licensing, and Certifications	Not Applicable	*Inadequate*	*Inadequate*

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

Population-Based Metrics

The OIG's population-based metrics analysis of diabetic care, immunizations, cancer screening, and prenatal care showed that CCWF's State and national comparative performance was only moderately adequate. More specifically, the institution scored comparatively well in 6 of the 12 measured areas: comprehensive diabetes care in four of five measured metrics, influenza vaccinations to older adults, and breast cancer screenings. However, the institution had mixed comparative results in six other areas: diabetic eye exams, influenza vaccinations to younger adults, pneumococcal immunizations to older adults, cervical cancer screenings, colorectal cancer screenings, and prenatal care. For these areas, the institution generally had higher scores than some comparable entities but lower scores than others.

With regard to the measures in which CCWF performed only moderately adequately, the institution's scores were adversely affected by patient refusals in five of those six measures. Based on generally accepted population-based metric comparative methodology, an entity's score is based only on patients who actually receive a service, as opposed to patients who were simply offered the service. At CCWF, had patient refusals not occurred for several scoring measures, the institution would have received perfect or near perfect scores and surpassed all other comparable entities' scores. The institution could improve its scores in these areas by educating patients on the benefits of these preventive services.

INTRODUCTION

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

Central California Women's Facility (CCWF) was the 33rd medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 14 primary clinical health care indicators and 2 secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

The Central California Women's Facility is the State's largest female institution and the only female reception center. California Correctional Health Care Services (CCHCS) designated CCWF as a "basic" health care institution, a designation for institutions that are located in rural areas away from tertiary care centers and specialty care providers whose services are likely to be used frequently by higher-risk patients. Even though CCWF is designated as a basic institution, approximately 10 percent of the patients are high risk patients. In addition, the institution has a skilled nursing facility (SNF) for those patients who require closer health care monitoring. In addition, the institution runs medical clinics at four yards, which provide routine health care services. The institution also has a treatment and triage area (TTA), an onsite specialty clinic, a receiving and release (R&R) clinic for screening arriving and departing patients, and a clinic for patients in administrative segregation.

In early November 2015, CCWF was one of three California prisons that converted to the newly developed Cerner Millennium Electronic Health Record System (EHRS). While the EHRS system essentially replaced the previously utilized electronic unit health record (eUHR) system, the eUHR is still the depository and reference point for patient medical records prior to November 2015. From a clinical monitoring standpoint, the EHRS allows clinicians from a broad range of disciplines to more timely and thoroughly monitor patient care than was previously possible under its eUHR predecessor.

In August 2015, the institution received national re-accreditation from the Commission on Accreditation for Corrections. 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, as of early June 2016, CCWF's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 9 percent. The highest vacancy percentages was among nursing supervisors at 24 percent, which equated to 2.5 vacant positions out of the total 10.5 authorized positions. Nursing staff had the total most unfilled positions with 10.8 vacancies out of 123.8 authorized positions, a 9 percent vacancy rate. In addition to the vacancies, CCWF also had five staff nurses who were on long-term medical leave. Finally, at the start of the OIG's inspection, the CEO reported that there was one additional nursing staff member who still worked at the institution, but who was not providing health care services. To help offset some of the nursing vacancies, CCWF employed 2.5 registry nurses. The chart below summarizes the institution's staffing resources.

CCWF Health Care Staffing Resources as of June 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	10.5	7%	10.5	7%	123.8	83%	149.8	100%
Filled Positions	5	100%	10.5	100%	8	76%	113	91%	136.5	91%
Vacancies	0	0%	0	0%	2.5	24%	10.8	9%	13.3	9%
Recent Hires (within 12 months)	3	60%	4	38%	2	25%	15	13%	24	18%
Staff Utilized from Registry	0	0%	0.3	3%	0	0%	2.5	2%	2.8	2%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	1	1%	1	1%
Staff on Long-term Medical Leave	0	0%	0	0%	2	25%	5	4%	7	5%

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

As of June 6, 2016, the Master Registry for CCWF showed that the institution had a total population of 2,867. Within that total population, 4.4 percent were designated as high medical risk, Priority 1 (High 1), and 6.0 percent 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 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 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.

CCWF Master Registry Data as of June 6, 2016

Medical Risk Level	# of Patients	Percentage
High 1	127	4.4%
High 2	173	6.0%
Medium	1,339	46.7%
Low	1,228	42.8%
Total	**2,867**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general and 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 results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At CCWF, all 16 of the quality indicators were applicable, consisting of 14 primary clinical indicators and 2 secondary administrative indicators. Of the 14 primary indicators, 9 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of

operations. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 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: CCWF Sample Sets*, the OIG clinicians evaluated medical charts for 73 unique patients. *Appendix B, Table B–4: CCWF Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 25 of those patients, for 98 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 28 charts, totaling 58 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 38 patients. These generated 1,459 clinical events for review (*Appendix B, Table B–3: CCWF 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 four chronic care patient records, i.e., one diabetes patient and three anticoagulation patients (*Appendix B, Table B–1: CCWF Sample Sets*), the 73 unique patients sampled included patients with 241 chronic care diagnoses, including 14 additional patients with diabetes (for a total of 15) (*Appendix B, Table B–2: CCWF Chronic Care Diagnoses*). 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 were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. 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 either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *CCWF 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 June to August 2016, deputy inspectors general and registered nurses attained answers to 108 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 health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 453 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 June 20, 2016, field inspectors conducted a detailed onsite inspection of CCWF's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,385 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 CCWF's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

The OIG rated the institution in the following 11 primary (clinical) and 2 secondary (administrative) quality indicators for compliance testing:

- Primary indicators*: Access to Care, Diagnostic Services, Health Information Management (Medical Records), Health Care Environment, Inter- and Intra- System Transfers, Pharmacy and Medication Management, Prenatal and Post-Delivery Services, Preventive Services, Reception Center Arrivals, Specialized Medical Housing (OHU, CTC, SNF, Hospice), and Specialty Services*.

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

After compiling the answers to the 108 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

In the first ten medical inspection reports of Cycle 4, the OIG identified where similar metrics for some of the individual compliance questions were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. However, there was not complete parity between the metrics due to differing time frames for data collecting and differences in sampling methods, rendering the metrics unable to be compared. The OIG has removed the Dashboard comparisons to eliminate confusion. Dashboard data is available on CCHCS's website, www.cphcs.ca.gov.

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

To derive an overall assessment rating 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 CCWF, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CCWF 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

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page *ii* of this report, all 14 of the OIG's primary indicators were applicable to CCWF. Of those 14 indicators, 9 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 2 were rated by the compliance component alone.

The *CCWF Executive Summary Table* on page *viii* shows the case review and compliance ratings for each indicator.

Summary of Case Review Results: The clinical case review component assessed 12 of the 14 primary (clinical) indicators. Of these 12 indicators, OIG clinicians rated 7 *adequate* and 5 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, none was *proficient*, 22 were *adequate*, and 8 were *inadequate*. In the 1,459 events reviewed, there were 421 deficiencies, of which 107 were significant and considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There were 11 unsafe conditions or sentinel events identified in the case reviews at CCWF.

- In case 2, a cancer patient with a new serious obstruction of the bile system had a delay in care with a dropped order for computerized tomography (CT) scan to detect the cause of the obstruction.

- Also in case 2, the patient's condition worsened with intractable vomiting and jaundice, but the provider failed to transfer her to a higher level of care.

- In case 5, during a recent hospitalization, an abnormal 7 millimeter spot was identified on a CT scan, but, upon the patient's return, the provider failed to address the abnormality.

- Also in case 5, a nurse failed to urgently obtain nitroglycerin for a patient having chest pain. Instead, the pharmacy was requested to deliver the patient's medication the next day.

- Also in case 5, the patient had a dangerously high blood glucose level that was above the glucometer's upper measurement limits. Despite insulin being given, the glucose level remained high and unmeasurable. The provider gave no follow-up order.

- Again in case 5, a psychiatric technician reported the patient's glucose reading of "high" (seriously high, and too high to measure). The report was given only to a certified nursing assistant, but not to an RN or provider.

- Finally in case 5, the patient returned from the hospital for care of severely low potassium and severely high blood glucose, and the provider failed to order a follow-up visit.

- In case 6, the patient arrived at CCWF from a county jail and her seizure medications were not continued. The patient had a seizure two days later.

- In case 20, appropriate follow-up care was not provided to the patient after a gastroenterology visit. The patient had inflammation of the colon with bleeding and abdominal pain. Laboratory tests, abdominal ultrasound imaging, and follow-up with the specialist as ordered did not occur.

- Also in case 20, a provider inappropriately failed to send a patient with a dangerously low blood count (hemoglobin 6.2) to a higher level of care.

- In case 27, the patient received an unordered second dose of warfarin (blood thinner).

Summary of Compliance Results: The compliance component assessed 11 of the 14 primary (clinical) indicators. Of these 11 indicators, OIG inspectors rated one *proficient*, one *adequate*, and nine *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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:
Inadequate
Compliance Score:
Inadequate
(66.3%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 865 provider and nurse encounters and identified 78 deficiencies relating to *Access to Care*. Of those 78 deficiencies, 31 were significant. The case review rating for *Access to Care* was *inadequate*.

Nurse-to-Provider Referrals

Nurses assessed patients and were required to refer the patient to a provider if a situation needed a higher level of care. The OIG identified 26 deficiencies where provider appointments did not occur timely or did not occur at all. Of those 26 deficiencies, five were significant:

- In case 8, a nurse evaluated the patient for vomiting and increased thirst and requested a provider appointment within 24 hours, but the appointment did not occur.
- In case 16, a nurse evaluated the patient for umbilical pain and documented an urgent referral to the provider, but the appointment did not occur.
- In case 20, a nurse evaluated the patient for diarrhea and abdominal pain and requested a routine provider appointment in 14 days; the appointment did not occur.
- In case 55, a nurse evaluated the patient for vaginal discharge and requested a provider appointment in 14 days; the appointment did not occur.
- In case 56, a nurse evaluated the patient for abdominal pain and requested for a provider appointment in 14 days; the appointment occurred more than one month later.

Nursing Sick Call and Follow-up Appointments

Nurses are required to review sick call requests on the same day each request is received and to identify if patients required either an expedited (same day) or a next-business-day assessment. There were seven deficiencies related to nursing sick call and follow-up appointments. Of those seven deficiencies, four were significant:

- In case 7, the patient submitted two sick call requests for abdominal pain, but nursing staff did not schedule the patient for nursing assessment.
- In case 13, a nurse evaluated the patient for leg swelling and documented a 14-day referral to the nursing case manager, but no appointment occurred.
- In case 20, a nurse evaluated the patient for diarrhea and requested the patient follow-up in the nurse line in 14 days, but no follow-up occurred.
- In case 51, the patient submitted a sick call request for vaginal discharge. The patient did not receive a nursing assessment until five days later.

Provider-to-Provider Follow-up Appointments

CCWF performed poorly with provider-ordered follow-up appointments. These appointments are important elements of the *Access to Care* indicator. The OIG clinicians identified ten deficiencies related to provider appointments that either did not occur timely or did not occur at all. Of those ten deficiencies, four were significant:

- In case 7, a provider discharged the patient from the specialized medical housing unit and requested patient follow-up with the yard provider in five days. The appointment occurred more than one month later.
- In case 56, a provider requested to have the patient follow up in seven days for reassessment of a headache; the appointment occurred 50 days later.
- In case 62, a provider evaluated the patient for urinary frequency and requested patient follow-up in two weeks, but the appointment occurred five weeks later.
- In case 78, a provider evaluated a patient for possible new onset diabetes and requested a follow-up in two weeks; the appointment occurred more than two months later.

Provider Follow-up after Specialty Service Visits

After specialty service visits, most patients are required to be evaluated by a provider within 14 days, or earlier if indicated. These appointments are crucial in the delivery of care to patients because it is during these visits that providers review and address specialists' recommendations.

CCWF performed poorly in timely providing these follow-up appointments. The OIG clinicians identified 15 deficiencies in this area, of which 4 were significant:

- In case 15, the gastroenterologist evaluated the patient for inflammatory bowel disease and made specific recommendations. The 14-day provider follow-up appointment did not occur until more than one month later.

- In case 20, the gastroenterologist evaluated the patient for abdominal pain and recommended an urgent abdominal ultrasound; the provider follow-up appointment to address the recommendation did not occur, and the ultrasound was not ordered.

- Also in case 20, the orthopedic surgeon evaluated the patient for an ankle fracture. The 14-day provider follow-up appointment did not occur until more than four months later.

- In case 21, the cardiologist recommended increasing the beta-blocker dose (blood pressure). The provider follow-up appointment occurred more than one month later.

Provider Follow-up after Hospitalization

Provider follow-up appointments after hospitalization should occur in a time frame that ensures patient safety and optimal clinical outcomes. CCHCS policy requires that these visits occur no later than five days from hospital discharge. The OIG clinicians identified four deficiencies in which the appointments did not occur timely or at all. The following two instances were significant deficiencies:

- In case 5, the patient returned from a hospital visit with the diagnosis of severely low potassium and high blood glucose, requiring treatments. The recommendation was to have the patient follow-up with a provider in one to two days. The provider follow-up did not occur, placing the patient at risk of harm.

- In case 8, as the patient returned from the hospital for chest pain. An on-call provider was consulted and requested to have the patient follow up with a provider the next day. The appointment occurred 12 days later.

The following two minor deficiencies were identified:

- In case 5, the patient returned from a hospital visit for chest pain, but the provider follow-up did not occur until nine days later.

- In case 6, the patient returned from hospitalization for seizure and low blood pressure requiring intravenous seizure medication and fluid treatments. The receiving nurse requested patient follow-up with a provider in two days, but the appointment occurred four days later.

New Arrival History and Physical Exams

CCWF had a reception center to process newly arriving patients from county jails. Due to the institution's high number of backlogged provider appointments, as discussed below, newly arriving patients also suffered from a lack of timely provider visits. Deficiencies related to new arrivals are discussed in the *Reception Center Arrivals* indicator.

Specialized Medical Housing

The provider timely saw patients in the institution's Skilled Nursing Facility (SNF) and performed history and physical exams on all newly admitted patients. This is further discussed in the *Specialized Medical Housing* indicator.

Clinician Onsite Inspection

During the onsite visit, OIG clinicians learned that CCWF clinic nurses saw eight to ten patients each day on the nurse lines. CCWF's health care representatives also told OIG clinicians that there were no nursing care backlogs. However, the institution's patients did have hindered access to timely provider care. CCWF records showed backlogs of 888 provider appointments for the reception center and the four primary yard clinics. To help minimize the impact of the backlog, the clinic's office technicians attended daily clinic huddles and coordinated with the providers to ensure that important follow-up appointments were scheduled.

Clinician Summary

CCWF performed poorly with regard to *Access to Care.* Based on the OIG's case review, numerous important provider appointments occurred either late or not at all. This lack of continuity hindered patient care. Because of the above findings, the OIG clinicians rated this indicator *inadequate.*

Compliance Testing Results

The institution performed in the *inadequate* range in the *Access to Care* indicator, with a compliance score of 66.3 percent. CCWF scored in the *inadequate* range on the six tests below:

- Among 12 Health Care Services Request forms (CDCR Form 7362) sampled on which nursing staff referred the patient for a provider appointment, only four patients (33 percent) received a timely appointment. Two patients received their appointments 9 and 11 days late. Three patients received their appointments from 47 to 101 days late, and three other patients did not receive a provider visit at all (MIT 1.005).

- Inspectors sampled 30 patients who suffered from one or more chronic care conditions; only 14 patients timely received their provider-ordered follow-up appointments (47 percent). Sixteen other patients received their appointments late or not at all, including two patients whose follow-up appointments occurred between 10 and 11 days late; 13 patients whose

appointments were between 24 and 99 days; one patient whose appointment was 172 days late (MIT 1.001).

- Among ten sampled patients who transferred into CCWF from other institutions and were referred to a provider during the initial health care screening process, only four were seen timely (40 percent). Two patients' referral appointments occurred 9 and 13 days late, three appointments were from 64 to 100 days late, and another patient never received her referral appointment at all (MIT 1.002).

- Only 14 of 27 sampled patients who received a high-priority or routine specialty service (52 percent) also received a timely follow-up appointment with a provider. Of those 13 patients who did not receive a timely follow-up appointment, four patients' high-priority specialty service follow-up appointments were 5 to 28 days late. Seven patients' routine specialty service follow-up appointments were one to 30 days late and two did not receive an appointment at all (MIT 1.008).

- OIG inspectors initially sampled 30 patients who submitted a sick call request. Of the 30 sampled patients, three patients ultimately required a second provider follow-up visit. However, of these three patients, only two actually received their follow-up appointments timely (67 percent). For one patient, the follow-up visit never occurred and the patient's medical file contained no refusal form (MIT 1.006).

- Inspectors tested 25 patients discharged from a community hospital to determine if they received a provider follow-up appointment at CCWF within five calendar days of their return to the institution, or earlier if a TTA provider ordered the appointment to occur sooner. Only 18 of the patients (72 percent) received a timely provider follow-up appointment. Seven patients received their appointments from 2 to 11 days late (MIT 1.007).

The institution scored in the *proficient* range in the following test areas:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected (MIT 1.101).

- Nursing staff reviewed 28 out of 30 sampled services request forms on the same day they were received (93 percent). On two forms sampled, nurses did not document required date evidence to demonstrate that the forms were timely received and promptly reviewed (MIT 1.003).

- Inspectors sampled 29 services request forms submitted by patients across all facility clinics. In 27 instances (93 percent), nursing staff completed a face-to-face encounter with the patient within one business day of reviewing the service request form. However, for another patient, the nurse had a face-to-face encounter but did not document the event with a

supporting progress note and referral. For another patient, the nurse completed the encounter one day late (MIT 1.004).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(64.0%)

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 test(s) ordered and the clinical response to the results.

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*. The key factors were compliance's significant findings that CCWF's providers timely reviewed a low percentage of radiology and pathology test results and some results were not reviewed at all. Further, the compliance review also found that providers communicated a low percentage of radiology, laboratory, and pathology test results to their patients. Overall, the inspection team concluded that the deficiencies identified in the compliance reviews were significant enough to outweigh the case review's higher rating and that the overall rating of *inadequate* was most appropriate.

Case Review Results

The OIG clinicians reviewed 174 events in diagnostic services and found 12 deficiencies. Eleven related to the health information management process. Most diagnostic tests reviewed were performed as ordered, reviewed timely by providers, and relayed quickly to patients. The case review rating for the *Diagnostic Services* indicator was *adequate*. Of the 12 deficiencies, one was significant:

- In case 6, there was a three week delay in retrieving and scanning a urine culture that reported resistance to the antibiotic prescribed.

Eleven minor deficiencies were identified, including two electrocardiogram (EKG) reports filed as echocardiograms and eight diagnostic result notifications either sent to patients late or not sent at all.

Conclusion

The OIG clinicians rated the *Diagnostic Services* indicator at CCWF *adequate* because the improperly processed diagnostic orders were infrequent.

Compliance Testing Results

The institution received an *inadequate* compliance score of 64.0 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service type is discussed separately below:

Radiology Services

- Radiology services were timely performed for nine of ten patients sampled (90 percent); one sampled patient received her test one day late (MIT 2.001). CCWF providers then timely reviewed the corresponding diagnostic services reports for only six of the ten patients (60 percent); providers reviewed four patients' reports from one to 59 days late (MIT 2.002). Providers also timely communicated the test results to only six of the ten patients (60 percent), while they communicated four patients' results from 6 to 59 days late (MIT 2.003).

Laboratory Services

- Eight of ten sampled patients (80 percent) received their provider-ordered laboratory services timely, while two of the ten services were provided three and five days late (MIT 2.004). The institution's providers also reviewed nine of the ten resulting laboratory services reports within the required time frame (90 percent); one report was reviewed ten days late (MIT 2.005). Finally, providers timely communicated the results to only five of the ten patients (50 percent); the other five patients never received any results information at all (MIT 2.006).

Pathology Services

- The institution timely received the final pathology report for nine of ten patients sampled (90 percent). For one patient, the institution did not receive the pathology report at all (MIT 2.007). Providers also only timely reviewed the pathology reports for four of the nine patients (44 percent). Four other patients' final pathology reports had no evidence of a provider review, and one additional report was reviewed 12 days late (MIT 2.008). Lastly, providers timely communicated the final pathology results to only one of the nine patients (11 percent). For four patients, the provider communicated the pathology result from 3 to 22 days late, while four other patients never received a provider communication at all (MIT 2.009).

Recommendation

No specific recommendations.

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 (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice.

The OIG evaluates this quality indicator entirely through clinicians' reviews of case files and conducts no separate compliance testing element.

Case Review Results

The OIG clinicians reviewed 75 urgent or emergent events and found 35 deficiencies, 9 of which were significant. The OIG rated the *Emergency Services* indicator at CCWF *adequate.*

Provider Performance

The CCWF provider performance was marginally adequate in emergency care. There were ten deficiencies. Of those ten deficiencies, four were significant. These cases are also described in the *Quality of Provider Performance* indicator:

- In case 2, a TTA provider evaluated a jaundiced patient but did not recognize the significantly elevated total plasma bilirubin and alkaline phosphatase results suggestive of an obstructive jaundice, which required urgent intervention.

- In case 5, a TTA nurse consulted a provider because the patient's plasma glucose reading was so high that the glucometer was unable to give a result. It remained high even after the patient received additional insulin. The urine test was positive for ketones (chemical the body makes due to insufficient blood insulin), suggesting ketoacidosis, a serious complication of poorly controlled diabetes. Even though the patient refused to remain in the TTA, the provider should have scheduled the patient for next-day follow-up.

- In case 10, a TTA nurse evaluated the patient, who presented with vaginal discharge and was at risk for a sexually transmitted disease. Even though the nurse notified a provider, the provider failed to evaluate the patient.

- In case 20, a TTA nurse evaluated the patient for a severely low blood count (hemoglobin 6.2 g/dL). While a provider spoke with the patient prior to returning her to housing, the provider did not complete a corresponding progress note or otherwise document evidence that the patient's vital signs were assessed or a physical exam was completed. Because the patient's anemia level was severe, the patient was at risk for a heart attack or stroke.

The OIG also identified the following minor provider deficiencies:

- In case 5, a TTA nurse consulted a provider for a patient with dizziness and critically high blood glucose (404 mg/dL). The provider should have followed up with the patient the next day. Furthermore, there was no provider progress note documenting this emergent event.

- In case 6, the patient had a urinary tract infection and was placed on antibiotics. However, the TTA provider did not review the urine culture or sensitivity, which indicated resistance to the antibiotic.

- In case 12, a TTA nurse documented that the patient was seen by a provider for a red swollen foot, but there was no provider progress note documenting this event.

- In case 17, on two different encounters, there were no provider progress notes documenting TTA events.

- In case 20, a TTA provider evaluated the patient with diarrhea and severely low blood count. The provider should have transferred the patient to a community hospital for a higher level of care.

Nursing Performance

There were 18 nursing deficiencies identified, four of which were significant. While most deficiencies were minor, some TTA encounters displayed inadequate nursing assessments and interventions. The OIG found emergency nursing care to be adequate in general. The following examples demonstrated deficiencies in emergency nursing care:

- In case 2, the nurse waited almost 45 minutes before contacting a provider for a patient who lost consciousness from a fall and was actively bleeding.

- In case 6, the nurse failed to perform a subjective assessment for a patient who had a seizure. The nurse should have done a complete physical and neurological exam and consulted with a provider. This case is also discussed in the *Reception Center Arrivals* indicator.

- In case 8, there was no first responder form completed to determine how the patient arrived in the TTA. The nurse also failed to complete a full assessment, including checking the patient's blood glucose.

- In case 78, the first responder did not document the initial findings and treatment plans, and the TTA nurse failed to complete a full assessment.

The following cases showed minor deficiencies:

- In case 2, the nurse did not perform a complete assessment for a patient who had been vomiting.

- In case 5, there were two deficiencies. First, the nurse documented giving the patient regular insulin, but did not recheck the patient's blood glucose before releasing her back to the housing unit. Secondly, the patient was treated in the TTA two months later for chest pain, and the nurse failed to obtain the patient's oxygen saturation or provide oxygen as indicated.

- In case 33, the medical records did not reflect the disposition of the patient after assessment was completed in the TTA.

In cases 5, 6, and 10, documentation was incomplete or illegible.

Clinician Onsite Inspection

CCWF had a well-equipped, readily accessible TTA, staffed with two nurses each shift. There was one provider Monday through Friday during the day shift. The emergency bags had an attached pouch containing naloxone (narcotic antidote), glucagon (medication for low blood sugar), and other emergency supplies.

Conclusion

The OIG rated the *Emergency Services* indicator *adequate*.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(67.1%)

Overall Rating:
Inadequate

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

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 testing resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both results. For this indicator, the team considered the compliance testing to be more robust than the case review program. In addition, the compliance testing identified significant deficiencies related to providers' timely reviews of patients' hospital discharge reports and with timely scanning of the those reports into patient's health care records. As a result, the inspection team considered the compliance reviews' *inadequate* score as the appropriate overall rating as well.

Case Review Results

The OIG clinicians identified 32 health information management deficiencies, 5 of which were significant. The OIG clinicians rated the *Health Information Management* indicator *adequate*.

Hospital Records

The institution's health care staff timely retrieved, reviewed, and scanned most hospital discharge summaries into patients' medical records. However, there were three deficiencies, one of which was significant:

- In case 2, the third page of the hospital discharge summary was not retrieved or scanned into the patient's medical record.

The following constituted minor deficiencies:

- In case 4, the hospital discharge summary was not scanned into the medical record until two weeks after the patient's return from the hospital.

- In case 6, the patient's medical record contained a hospital record that related to a different patient.

Missing Progress Notes and Forms

Most provider and nursing progress notes were scanned into the medical record; however, there were five deficiencies related to missing progress notes, one of which was significant:

- In case 4, TTA staff evaluated the patient for dizziness and nausea, but there was no documentation of the event.

Diagnostic Reports

There were 11 deficiencies related to diagnostic services reports. Of these, one deficiency was significant, also discussed in the *Diagnostic Services* indicator:

- In case 6, there was a three-week delay in retrieving and scanning a urine culture report.

Specialty Services Reports

There were 11 deficiencies related to specialty services reports, 2 of which were significant:

- In case 20, the gastroenterologist's evaluation report was not retrieved or scanned until more than five months later.

- In case 28, the general surgeon's evaluation report was not retrieved or scanned into the medical record at all.

Legibility

Most provider and nursing progress notes were dictated or legibly written. There were two illegible progress notes.

Clinician Onsite Inspection

CCWF medical records staff were prompt in retrieving and scanning specialty reports and hospital discharge summaries.

Conclusion

CCWF performed well with retrieval of specialty reports and hospital discharge summaries. Missing documents were infrequent. The OIG clinicians rated this indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.1 percent in the *Health Information Management (Medical Records)* indicator and scored in the *inadequate* range in the following three tests:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic unit health records. Most of the errors were mislabeled documents, such as medical records incorrectly dated, a consulting report labeled as a physician's request for services, and a medication administration record (MAR) labeled as physician orders. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. During the CCWF medical inspection, inspectors identified 14 total documents with scanning errors, two more than the maximum allowable number (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to the institution, CCWF's providers timely reviewed only 15 patients' corresponding hospital discharge reports within three calendar days of the patient's discharge (60 percent). For ten of the sampled patients, providers did not timely review the discharge reports; four reports were each reviewed one day late, five reports were reviewed from four to nine days late, and another report was not reviewed at all (MIT 4.008).

- CCWF's records management staff timely scanned community hospital discharge reports or treatment records into only 13 of the 20 sampled patients' health records (65 percent); seven reports were scanned late; four reports were each scanned one day late, and three reports were scanned from three to nine days late (MIT 4.004).

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

- CCWF staff timely scanned all 12 sampled non-dictated documents into patients' electronic health care records within three calendar days of the patient encounter. These documents included providers' progress notes, patients' initial health screening forms, and health care services request forms (MIT 4.001).

- Institution staff timely scanned 18 of 20 specialty service consultant reports sampled into the patients' electronic health care records (90 percent). The other two specialty reports were scanned 3 and 63 days late (MIT 4.003).

- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication records, and specialty service reports to ensure that clinical staff legibly documented their names on the forms, 35 of 40 samples (88 percent) showed compliance. Five of the samples inspected did not have a legible signature or stamp to clearly identify the clinician (MIT 4.007).

Recommendations

No specific recommendations.

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:
Adequate
(84.1%)

Overall Rating:
Adequate

Clinician Comments

Although OIG clinicians did not rate the health care environment at CCWF, they did obtain the following information during their onsite visit:

- The four medical yard clinics had adequate space needed to provide patient care with auditory and visual privacy. The clinics had ample lighting and were stocked well with medications and medical equipment.

- The TTA had four beds and adequate space for patient evaluation, with working areas for both nurses and providers. The TTA also had ample lighting and was stocked well with medications and medical equipment, such as an automated external defibrillator (AED) and an emergency crash cart.

- Providers, clinic and medication nurses, care coordinators, office technicians, and custody personnel all attended morning huddles. These meetings were productive, and staff discussed pertinent nurse- and provider-line-related matters, as well as any custody issues related to access to care.

Compliance Testing Results

In the *Health Care Environment* indicator, CCWF received an *adequate* score of 84.1 percent. The institution performed at a *proficient* level in the following areas:

- Health care staff at all nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).

- CCWF's non-clinic medical storage areas generally met the supply management process and support needs of the medical health care program (MIT 5.106).

- All nine clinics followed adequate protocols for managing and storing bulk medical supplies (MIT 5.107).

- All nine clinics had an environment adequately conducive to providing medical services (MIT 5.109).

- Eight of the nine clinic locations inspected (89 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. However, one clinic's exam area where medical procedures were periodically performed did not have an operable sink, soap, or disposable hand towels. CCWF health care staff told OIG clinicians that due to a historical lack of proper hand hygiene supplies and a sink, proper hand sanitation protocols had been difficult to employ (MIT 5.103).

- OIG inspectors observed health care clinicians in each clinic to ensure they employed proper hand hygiene protocols. In eight of nine clinics tested, clinicians adhered to universal hand hygiene precautions, scoring (89 percent). In one other clinic, OIG inspectors observed a clinician who failed to wash or sanitize their hands both before and after patient contact. This procedural failure was in the same clinical area where health care staff reported a historical problem of insufficient access to a sink and hand hygiene supplies (MIT 5.104).

- Eight of nine clinics observed (89 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. However, one clinic exam room measured less than 90 square feet, which was not sufficient space for patients to move or walk during physical exams (MIT 5.110).

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly, and whether the bags contained all essential items. Emergency response bags were compliant at six of the seven clinical locations (86 percent). In one clinic, an emergency response bag contained an emergency oxygen tank that was not fully charged (MIT 5.111).

The institution scored within the *adequate* range in the following test area:

- CCWF appropriately disinfected, cleaned, and sanitized seven of nine clinic locations inspected (78 percent). Two clinics were not appropriately cleaned. At one clinic, the exam room's sink was visibly stained and unsanitary (*Figure 1*). Another clinic had an unsealed porous concrete floor that was dirty and not effectively cleaned or sanitized with hospital-grade disinfectant cleaner (MIT 5.101).

Figure 1: Visibly stained and unsanitary exam room sink

The institution scored in the *inadequate* range and showed room for improvement in the following areas:

- Only four of nine clinic locations (44 percent) met compliance requirements for essential core medical equipment and supplies. The remaining five clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a demarcation line for the Snellen eye exam chart, a medication refrigerator, an exam table, a nebulization unit, an ophthalmoscope and tips, and tongue depressors. In addition, a pulse-oximeter and ultrasound machine did not have calibration stickers, and one nebulization unit had an expired calibration sticker (MIT 5.108).

- In only four of eight clinics inspected, clinical health care staff ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (50 percent). While all eight clinics generally employed adequate non-invasive medical equipment disinfection protocols, four of these clinics did not have adequate sterilization safeguards for invasive medical equipment. Specifically, four of the clinics periodically used sterilization equipment but did not have a written policy or procedure for sterilizing reusable invasive medical instruments. Further, one of the four clinics did not properly process, package, or store previously sterilized instruments (MIT 5.102).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if 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 OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, CCWF had several significant infrastructure projects underway, which included increasing clinic space at four yards, building a new pharmacy, expanding medication distribution areas, remodeling the TTA, and creating a new space for an OB/GYN clinic. These projects started in the fall of 2016, and the institution estimates that these projects will be completed by the end of summer 2017 (MIT 5.999).

Recommendations

No specific recommendations.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(69.0%)

Overall Rating:
Inadequate

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 *Inter- and Intra-System Transfers* include patients received from other CDCR facilities and patients transferring out of CCWF to another CDCR facility. 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 testing 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* due to two significant factors: first, nurses often did not properly complete initial health screening forms for patients who recently arrived from other CDCR prisons; second, patients who transferred into CCWF often did not receive their previously approved medications without interruption. Consideration of these factors rendered the compliance score of *inadequate* the more appropriate overall rating.

Case Review Results

The OIG clinicians' case review included the examination of 52 encounters relating to inter- and intra-system transfers, including information from both the sending and receiving institutions. Further, 40 hospitalization events were reviewed, each of which resulted in a transfer back to the institution. In total, the clinicians identified seven deficiencies, of which only one was significant. Based on the CCWF transfer processes in place, the clinicians rated the case review portion of the *Inter- and Intra-System Transfers* indicator *adequate*.

Transfers In

There were a few minor nursing deficiencies with transfer-in documentation and with patients not timely receiving medication. These findings are also discussed in the *Pharmacy and Medication Management* indicator.

- In case 37, a patient with an anxiety disorder did not receive her antidepressant medications until almost 48 hours after her arrival.

- In case 38, the nurse documented the patient was not under a provider's care for medical reasons, but the patient had sickle cell anemia and asthma. The nurse failed to refer the patient to a provider for these chronic conditions.

- In case 39, there was a lapse in medication administration for a patient taking an antipsychotic three times a day. This patient missed three consecutive doses of the antipsychotic medication, as well as two consecutive doses of both an antidepressant and a blood pressure medication.

Transfers Out

There were no significant deficiencies for transfers out of the institution, but occasionally the health care transfer information form lacked important medical information.

- In case 6, the licensed vocational nurse (LVN) who completed the transfer form did not include the patient's history of seizures, high blood pressure, asthma, mental health issues, and the recent hospitalization the previous month.

- In case 46, the LVN who completed the transfer form did not indicate that the patient recently submitted a sick call request for joint pain. The transfer summary was not evaluated by a registered nurse per CCHCS policy.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. These patients are generally hospitalized for a severe illness or injury, and are at risk due to potential lapses in care that can occur during any institutional transfer. Patients who returned to CCWF after being discharged from a community hospital generally received adequate nursing assessments and reviews of hospital discharge summary information. However, two case review findings demonstrated that some nurses did not always follow these good nursing practices.

- In case 28, the patient underwent surgery and returned from the hospital with recommendations for continuation of blood thinners and pain medications. The nurse did not document receiving these discharge recommendations or inform the provider about the recommendations.

- In case 77, the nurse did not assess the wound site for a patient who had returned from the hospital after undergoing surgery for a bone infection.

As previously discussed in the *Health Information Management* indicator, health information staff did not always ensure accurate placement of patient information in the medical record:

- In case 2, the third page of the hospital discharge summary was not retrieved or scanned into the patient's medical record.

- In case 6, the patient's medical record contained a hospital record that related to another patient.

Compliance Testing Results

The institution obtained an *inadequate* compliance score of 69.0 percent in the *Inter- and Intra-System Transfers* indicator. The institution scored within the *inadequate* range in the following two test areas:

- Of 30 sampled patients who transferred into CCWF, only 20 had an existing medication order upon arrival; only 6 of the 20 patients (30 percent) received their medications without interruption. Fourteen patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

- Among the 30 sampled patients who transferred into CCWF from other CDCR facilities, nursing staff properly completed and documented the initial health screening on the same day the patient arrived for only 12 (40 percent). For 17 patients, the screening nurse did not document any explanatory language related to health conditions, and one other patient was not asked a required health screening question (MIT 6.001).

The institution scored within the *adequate* range in the following test area:

- Inspectors sampled 20 patients who transferred out of CCWF to another CDCR institution to determine whether CCWF identified scheduled specialty service appointments on the patients' health care transfer forms. Nursing staff correctly listed the pending specialty service appointments for 15 of 20 patients (75 percent). Staff failed to list five of the patients' pending specialty services (MIT 6.004).

CCWF performed in the *proficient* range in the following test areas:

- Transfer packages for all seven sampled patients who transferred out of the institution included all required medications and related documentation (MIT 6.101).

- For all 30 sampled patients, nursing staff timely completed the assessment and disposition section of the health screening forms on the same day they performed the patients' screenings (MIT 6.002).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(61.3%)

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.

As discussed in the *About the Institution* section of this report, CCWF began using the new Cerner Millennium Electronic Health Record System (EHRS) in early November 2015. Because of the timing and implementation of this new system, approximately 70 to 80 percent of the OIG's selected medication samples came from the new EHRS, while approximately 20 to 30 percent of the medication samples were from its predecessor, the eUHR system. Based on the OIG's analysis of its own test results, many of the *Pharmacy and Medication Management* indicator's medication-related deficiencies were a direct result of CCWF health care staff still learning how to use EHRS properly and effectively to order, issue, and document medication administration. When OIG compliance inspectors identified a medication administration record deficiency, it was often difficult to conclude whether it was an administrative data entry error in the new electronic system or the patient never actually received the right medication at the right time. Either way, these errors were a system failure the institution must overcome to be rated *adequate* or *proficient* in this indicator.

Case Review Results

The OIG clinicians evaluated pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing was a more targeted approach and was heavily relied on for the overall rating for this indicator. The OIG clinicians identified 25 deficiencies, of which 10 were significant. The OIG clinicians rated the case review portion of the *Pharmacy and Medication Management* indicator *adequate.*

Nursing Medication Administration

There were five significant deficiencies with medication administration:

- In case 5, the provider ordered an increase in the patient's insulin dose. The patient received the increased dose for the first two days, but then received the previous lower dose for the next two days.

- In case 19, the patient was discharged from the SNF but did not receive her cardiac medication for three days.

- Also in case 19, the provider ordered a vaccine but it was not given.

- In case 27, the patient received two doses of warfarin (blood thinner), but there was no order for the extra dose. This placed the patient at risk of over anticoagulation and bleeding.

- In case 76, there were two weeks of missing medication administration records over a one-month period. As a result, it was unclear if the patient received any medications during this period.

Antibiotics Administration

In the majority of cases, patients received their antibiotics timely and as prescribed. However, there were three significant deficiencies specifically related to antibiotics administration:

- In case 14, the patient had an infected wound requiring antibiotics, but she refused half of her medication. However, the nurse did not inform the provider of the refusals. The nurse also failed to ask the patient about the reasons for the refusals, or to provide patient education.

- In case 18, after the patient was discharged from a hospitalization for pneumonia, the provider prescribed an antibiotic to be administered four times a day. The patient received the antibiotic only three times on one day and only two times the next day.

- In case 28, after the patient was hospitalized for an appendectomy and discharged, the provider prescribed an antibiotic to be taken three times a day for 11 doses; however, the patient only received 8 of the 11 doses.

Medication Continuity

Newly arrived patients often did not receive their medications for up to a week. In cases 6, 32, 34, 35, 36, 41, and 43, there were missed or delayed medication administrations for the new arrivals. The following two significant deficiencies were identified:

- In case 6, a provider ordered seizure medication on the day the patient arrived at the facility, but the medication was not administered until the third day after her arrival. The patient had a seizure on her second day at the institution.

- In case 35, there was a nine-day delay for a patient's prenatal vitamin prescription.

Clinician Onsite Inspection

During the onsite visit, the pharmacist in charge (PIC) indicated that the nurses were incorrectly documenting patient's keep-on-person (KOP) medications. The PIC was able to verify patients' receipt of their KOP medications, but the verifications were not shown in EHRS. In addition, the onsite visit revealed that some missed medication doses might have been from custody staff not being able to escort the patient to the medication line.

Conclusion

The OIG clinicians rated the *Pharmacy and Medication Management* indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 61.3 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 average score of 35.1 percent, which fell into the *inadequate* range. The institution scored poorly in the following areas:

- For 4 of 26 patients sampled, the institution timely and correctly administered all required chronic care medications or else followed proper protocols when patients refused or did not show up to receive their medications (15 percent). However, 22 sampled patients had one or more interruptions in the receipt of their medications, or required protocols were not followed for medication refusals and "no-shows." The following are examples in which medication continuity was not maintained (MIT 7.001):
    - Eleven patients never received their monthly supply of KOP chronic care medications, and health care staff documented no evidence of patient refusal or provider medication counseling.
    - Six patients did not receive their directly observed therapy (DOT) medications for three or more days in a row, or missed more than 50 percent in one week, and no provider medication counseling occurred.
    - Five patients had DOT medication administration summaries that included one or more unexplained missed doses.
    - Two patients had insufficient or absent health care record information to explain why they received early refills of their chronic care KOP medications. More specifically, one

patient received a double issuance of KOP medications in two different months. Another patient was issued two 30-day supplies of her KOP medications just four days apart.

  - One patient's chronic care KOP medication was issued 30 days late.

  - In at least eight notable instances, medication nurses who utilized the institution's recently implemented EHRS entered erroneous, unclear, or unsupported comments related to a patient's DOT medication administration. For example, nurses periodically entered the comment "not done: not appropriate at this time" without any further explanation, or "not done: I/P failed to report" without any further explanation or timely follow-up. In most applicable instances, nursing staff also failed to identify the barriers that impeded patients from receiving their daily DOT chronic care medications.

- Among the 30 sampled CCWF patients who had transferred from one housing unit to another, only eight received their medications without interruption (27 percent). Twenty-two sampled patients experienced an interruption in receiving their nurse-administered (NA) or DOT medications that occurred just before transfer, just after transfer, or both. Further, while some patients' health care records contained clear evidence that required medications were not given, other health records were unclear as to whether patients received all of their medications during the transfer process, or the records lacked details related to barriers that prevented patients from receiving all of their medications. Sampled patients had one or both of the following types of identified deficiencies (MIT 7.005):

  - For 16 sampled patients, the medication nurse documented that they failed to report to the medication line, but did not document the barriers that prevented them from receiving their medications.

  - For nine sampled patients, the medications were not available, the patient had an unexplained missed dose, or the patient's medication administration record was otherwise unclear about whether the nurse administered the medication.

- Out of 20 sampled patients who arrived directly from a non-CDCR facility, 14 were on prescribed medications at the sending location. CCWF ensured the timely ordering and issuance of continuation medications for only four of these new arrivals who were previously on medications (29 percent). Ten other patients who arrived on medications did not have all of their medications made available timely, administered timely, or both. Some patients experienced more than one of the following deficiencies (MIT 7.004):

  - Five patients had one or more medications made available one day late.

  - Nine patients' medications were administered late, which included five patients who experienced delays of one to three days and four who experienced delays of 6 to 17 days.

- One patient never received two of her medications.

- CCWF timely provided hospital discharge medications to only 10 of 25 patients sampled who had returned from a community hospital (40 percent). The institution's health care staff did not either timely order, timely make available, or timely administer 15 other patients' medications within the required time frames. The patients experienced one or more of the following types of deficiencies (MIT 7.003):

  - Two patients were not seen by a provider, or did not have their medications ordered within eight hours of hospital return.

  - Thirteen patients had one or more medications that were made available from one dosing period to five days late. Two other patients' medications were made available 32 and 104 days late.

  - Nine patients had one or more medications that were administered from one dosing period to eight days late. Three other patients' medications were made available from 28 and 98 days late.

  - Three patients had medication administration records that did not clearly indicate whether the patients ever received their discharge medications.

With regard to the test above, inspectors found many contributing factors that led to the poor score. Often the nurse documented that the medication was not given because the patient was "out of the institution" when, in fact, the patient was at the institution according to other health care or custody records, or the nurse made unclear MAR entries, such as "not done: given KOP." In several instances, the nurse documented that the patient "failed to report" without evidence of custody being notified to locate the patient, or the nurse documented "med not available" with no evidence of contacting pharmacy staff or any other attempts to obtain the medications.

- Only four of the ten sampled patients who were in transit to another institution and temporarily laid over at CCWF received their medications without interruption (40 percent). Six patients did not receive all of their required medications while temporarily housed at CCWF. More specifically, upon arrival, each of these six patients did not receive one or more of their medications for one or more dosing periods, and the patient's medical records did not include any evidence of patient refusal (MIT 7.006).

- The institution timely administered or delivered new medication orders to only 18 of the 30 patients sampled (60 percent). Twelve other patients' medications were either not timely made available or not timely administered or delivered. More specifically, seven patients received their medications from one to four days late, and two patients had missing or incomplete eUHR or EHRS records to demonstrate that they ever received their new medications. Further, one other patient had a conflicting medication record; in one location,

the record indicated that the patient received "1 tab," while in another location of the same record, it indicated the patient received "2 cards" of the medication. Finally, two patients had KOP medication orders with expedited start times and, while the patients ultimately picked up the medications within the required period, the institution did not initially make the KOP medications available to the patients within the required time frame (MIT 7.002).

Observed Medication Practices and Storage Controls

For this sub indicator, the institution received an *adequate* average score of 79.1 percent, scoring in the *proficient* range in the following four test areas:

- Nursing staff at all five sampled medication preparation and administration locations followed proper hand hygiene protocols during the medication preparation and administration processes (MIT 7.104).

- Nursing staff at all five of the inspected medication and preparation administration locations followed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

- The OIG inspected 12 applicable clinics' and medication lines' non-refrigeration storage locations and found non-narcotic medications properly stored at 11 of those locations (92 percent). At one medication line, two emergency kits contained expired glucagon prefilled syringes (diabetes medication) (MIT 7.102).

- Among seven inspected clinics and medication line storage locations, non-narcotic medications that require refrigeration were properly stored in six locations (86 percent). One inspected clinic location had no designated refrigeration area for medications intended for return to pharmacy (MIT 7.103).

The institution performed in the *inadequate* range in the following two test areas:

- Only two of five inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (40 percent). At two different locations, OIG inspectors observed where CCWF nurses did not follow manufacturer's guidelines related to the proper administration of insulin to diabetic patients who require both fast acting and long lasting types of the medication. Those guidelines require nurses to administer the medications in different body locations, a practice that observed nurses did not employ. At a third medication line location, patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather (MIT 7.106).

- The OIG interviewed nursing staff and inspected narcotics storage areas at seven applicable locations to assess narcotics security controls. Overall, only four clinic locations (57 percent) had good controls. In the three other sampled locations, nursing staff did not

always complete required narcotic control log entries. More specifically, for the OIG's limited 30-day review period, log books in each of the three clinics were missing numerous required signatures entries used to account for narcotic medications (MIT 7.101).

Pharmacy Protocols

For this sub-indicator, the institution received an average score of 71.3 percent, scoring in the *inadequate* range on the following test areas:

- OIG inspectors conducted an onsite physical inventory of the CCWF pharmacy's Class II scheduled control substances (narcotics), and the physical count did not agree with the pharmacy's perpetual inventory records for morphine sulfate. At the time of the physical count, pharmacy staff told the OIG that they had previously identified the deviation two days earlier, but had not yet determined the cause of the error. Because the narcotics inventory records were inaccurate at the time of the OIG's inspection, CCWF scored a zero on this test (MIT 7.110).

- OIG inspectors examined 25 medication error follow-up reports and five monthly medication error statistics reports generated by the institution's pharmacist in charge (PIC). Only 17 of the PIC's 30 reports were timely or correctly processed (57 percent). Thirteen sampled reports contained deficiencies (MIT 7.111):

    - The CCWF's PIC was unavailable during the OIG's site visit, and for five sampled medication errors, pharmacy staff were unable to provide corresponding support such as the PIC's medication error follow-up report for inspectors' examination.

    - Among the 20 medication error follow-up reports provided for inspectors' review, the institution's PIC completed six between 4 and 13 days late.

    - Two of the five sampled monthly medication error statistics reports contained an error in the total number of Level 4 medication errors that actually occurred during the reporting period.

CCWF scored in the *proficient* range on the following tests:

- CCWF's main pharmacy followed general security, organization, and cleanliness management protocols. In addition, the institution, properly stored non-refrigerated and refrigerated medications (MIT 7.107, 7.108, 7.109).

Non-Scored Tests

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

The OIG tested patients in isolation units to determine if they had immediate access to their prescribed KOP rescue asthma inhalers and nitroglycerin medications. In mid-June 2016, of 20 patients sampled who were prescribed such medication, 15 (75 percent) indicated they had possession of them; five patients did not have possession of their prescribed rescue medications. The OIG promptly notified the institution's CEO, who indicated the medications would be immediately reissued. However, prior to completing this medical inspection in early October 2016, the OIG learned that timely replacement had not occurred. In fact, of the five identified patients, one received her rescue medication seven days later, three received their rescue medications 60 to 88 days later, and one never received it at all (MIT 7.999).

Recommendations

The OIG recommends that CCWF research the medication errors identified by OIG inspectors during testing to determine if the errors occurred because of the implementation of EHRS, and provide training as necessary for consistency among nursing staff and improve the medication administration process. In addition, supervisors must monitor the process for system-wide improvement.

PRENATAL AND POST-DELIVERY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.4%)

Overall Rating:
Adequate

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

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 *adequate*. As discussed below, the poor compliance score directly resulted from low scores related to five pregnant patients who did not receive required allotments of extra food and milk, and one patient who did not receive a timely post-partum provider visit. The OIG's inspection team considered the nature and extent of the compliance deficiencies along with case review's findings that relatively few deficiencies existed. Since neither identified compliance issue resulted in any significant increased risk of harm to the mother, fetus, or newborn, the team concluded that the case review's *adequate* rating was also the appropriate overall rating.

Case Review Results

The OIG clinicians reviewed five cases related to prenatal care and rated this indicator *adequate*. The two minor deficiencies found did not result in risk of harm to the mother or fetus:

- In case 36, the patient incurred a two-day delay in receiving her obstetrics appointment.
- Also in case 36, the obstetrics provider did not adequately review the patient's medical record or appreciate that the patient had been seen in the TTA three days prior for abdominal pain. However, the provider did document that the patient did not have any abdominal pain during this encounter. The provider also failed to assess the persistent abnormal urine test results.

Clinician Onsite Inspection

At the time of the OIG's inspection, there was one full-time obstetrics provider. Because patients arriving at CCWF in the first trimester of pregnancy were transferred to another institution for obstetrics care, deliveries and postnatal care rarely occurred.

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.4 percent in the *Prenatal and Post-Delivery Services* indicator, with scores of *inadequate* in the following two areas:

- Five sampled patients who were pregnant did not receive their required extra food and milk. More specifically, the only two sampled patients who delivered their babies at CCWF had transferred in just 20 and 23 days prior to delivery. Neither patient received a physician's order for extra food and milk. In addition, three other patients who arrived pregnant at CCWF also did not receive a physician's order for extra food and milk prior to transferring to the California Institution for Women one to two weeks later. As a result, CCWF scored a zero on this test (MIT 8.003).

- CCWF did not timely provide the required six-week postpartum visit to one applicable patient. This patient received her six-week postpartum visit 22 days late. As a result, the institution scored a zero on this test (MIT 8.007).

CCWF scored 100 percent in the following five test areas:

- All seven pregnant patients saw an obstetrician or nurse practitioner within seven calendar days of arriving at the institution (MIT 8.001).

- CCWF ensured that all seven sampled pregnant patients were assigned to a lower bunk and placed in lower-tier housing (MIT 8.002).

- All seven pregnant patients received all of their prenatal visits with a supervising obstetrician or obstetrics nurse practitioner at the required intervals (MIT 8.004).

- Providers timely completed and reviewed all seven patients' initial prenatal screening tests (MIT 8.005).

- Clinical staff documented the patient's weight and blood pressure at every prenatal visit for all seven samples tested (MIT 8.006).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

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

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 74.2 percent. The following areas showed room for improvement:

- CCWF scored poorly for the timely administration of tuberculosis (TB) medications. The OIG examined the health care records of all seven patients who were on TB medications during the inspection period, and only one patient received all of her required medications (14 percent). More specifically, six of the seven examined patients did not receive their medications at the provider-scheduled interval dates. Each of the six patients missed one or more scheduled dates, and none of them received provider counseling regarding their missed doses. One of the six patients missed six scheduled days of her medication and received doses on two other unscheduled days. Finally, according to the medication administration records, one of the six patients also received two doses of the TB medications on the same day, and seven days later, the medication error happened again (MIT 9.001).

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Fifteen of the sampled patients were classified as a Code 22 (requiring a skin test in addition to a signs and symptoms check), and 15 sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check). CCWF only scored 57 percent for its ability to conduct these annual screenings timely and properly. The low score was because only 4 of the 15 Code 22 patients were properly tested. For each of the other 11 Code 22 patient screenings, the 48-to-72-hour compliance window to read the test results was not determinable because nursing staff did not document either the administered (start) or read (end) date and time on the Tuberculin Testing/Evaluation form (CDCR Form 7331). In addition, 2 of the 15 patients identified as Code 34 did not receive a proper evaluation because nursing staff did not properly complete the history section of the TB form (MIT 9.003).

- The OIG tested whether CCWF offered required influenza, pneumonia, and hepatitis vaccinations to patients who suffered from a chronic condition; 12 of the 17 patients sampled (71 percent) received them. Of the five patients who did not have current vaccinations, three patients had no record of recently being offered the vaccinations, and two other patients had their vaccinations timely ordered, but no evidence was found that the medication was ever received or refused (MIT 9.008).

The institution scored in the *adequate* range in the following area:

- The OIG found that 24 of 30 patients sampled (80 percent) either had a normal colonoscopy within the last ten years or were offered a colorectal cancer screening in the last year. However, six patients' medical records did not contain evidence of a normal colonoscopy within the last ten years or that they were offered a colorectal cancer screening within the previous 12 months (MIT 9.005).

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

- All 30 patients sampled timely received or refused influenza vaccinations during the most recent influenza season (MIT 9.004).

- All 30 sampled patients received or refused a mammogram within CCHCS policy guidelines (MIT 9.006).

- CCWF offered Pap smear screenings to 26 of 30 sampled patients aged 21 through 65 (87 percent). Four patients did not have evidence of a timely offer, including two patients who neither received nor were offered a pap smear within the last 36 months, and one patient who refused to come to a provider visit and for whom staff did not discuss the risks of forgoing the test or obtain a refusal form. Another patient received a provider order for the test, but no evidence that the patient received or refused the test was in the medical record (MIT 9.007).

- OIG found that six of seven patients sampled (86 percent) received monthly or weekly monitoring while taking TB medications. One patient did not receive the required monthly monitoring (MIT 9.002).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

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

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 661 nursing encounters, 317 were for outpatient nursing. There were 117 nursing deficiencies, 26 of which were significant. The OIG nursing clinicians rated the *Quality of Nursing Performance* at CCWF *inadequate*.

Nursing Triage

Nurses often failed to perform face-to-face assessments or identify urgent medical conditions.

- In case 13, the nurse did not assess a patient with vaginal pain, but instead forwarded the request to the specialist. The patient was not seen until three weeks later. More than one week later, the patient submitted another sick call request stating she had stopped taking her asthma medication because of the side effects and was having trouble breathing. The nurse did not assess the patient on the same day.

- In case 14, the patient submitted a request for excruciating nerve pain. The nurse did not see the patient face to face but referred her to the provider. The appointment did not occur until nine days later. The patient submitted several requests related to pain over a four-month period, and each time the nurse failed to see the patient face to face. The patient also

submitted sick call requests for the pain medication discussed by the provider. She was not informed that the medication was not approved by the non-formulary approver for over six weeks.

- In case 16, the patient submitted two sick call requests related to severe abdominal pain. The nurse did not assess the patient until two days later.

- In case 18, the patient recently had pneumonia and submitted a sick call request related to chest pain, cough, and worsening shortness of breath. The nurse did not assess the patient on the same day.

- In case 62, a patient with diabetes reported frequent urination, which is usually a sign of high blood sugar. The nurse did not perform a face-to-face assessment with the patient, but rather referred her to see a provider. Three days later, the patient submitted another sick call request. Again, the nurse did not see the patient and merely noted that the patient had a scheduled provider appointment in three days.

Nurses also failed to see the patient in cases 2, 4, 7, 8, and 72.

Nursing Assessment

Nurses failed to collect appropriate data, perform adequate nursing assessments, and document the presence or absence of physical signs and symptoms in some cases.

- In case 2, the patient had been vomiting since her colonoscopy three weeks earlier. The nurse did not assess the amount and frequency of the vomiting. The patient saw the nurse two weeks later for the same symptoms. Nursing assessment of the patient was inadequate, with documentation showing the patient had no vomiting and diarrhea. The nurse also failed to recognize that the patient had steadily lost weight over the previous few months.

- In case 4, the nurse did not check the blood pressure of a hypertensive patient who was frequently sent out to the community hospital with pressures as high as 300/160.

- In case 11, the patient received daily wound care on her foot. The nurses performing the wound care did not assess the foot for signs and symptoms of infection. The patient also saw the nurse several times for various medical symptoms, and the nurses failed to perform an adequate assessment each time.

- In case 48, the patient saw the nurse for eye pain. The nurse did not assess the patient's eye or check her vision.

- In cases 51 and 55, the patient submitted a sick call request for vaginal discharge. The nurse did not assess for the presence or absence of other physical symptoms and obtain more information about onset and duration.

- In case 64, the patient saw the nurse for groin and feet pain. The nurse did not assess the patient's feet and did not provide pain medication per the nursing protocol.

- In case 70, the patient reported severe shoulder pain. The nurse did not perform an adequate assessment.

Nurses also did not perform adequate nursing assessments in cases 5, 7, 8, 13, 14, 15, 16, 17, 49, 50, 52, 53, 54, 57, 59, 60, and 61.

Nursing Intervention

In some cases nurses failed to initiate timely interventions or to establish an appropriate plan of care, such as referral to a provider and higher level of care.

- In case 5, the patient had acute chest pain and had run out of sublingual nitroglycerin used to treat the pain. The nurse should have transferred the patient to the TTA for further evaluation and treatment.

- In case 17, the patient submitted multiple sick call requests for foot pain and provider follow-up. Multiple provider appointments were rescheduled. The nurse failed to ensure that the provider appointment occurred timely. The patient eventually saw the provider six weeks after the initial scheduled appointment.

- In case 52, the patient saw the nurse for abdominal pain. The nurse performed a urinalysis with abnormal findings, and did not contact the provider regarding the test results and follow-up care.

Nursing Documentation

Nursing documentation deficiencies included omitting weights, missing documentation, contradicting notes, and the use of cloned notes. These nursing documentation deficiencies were identified in cases 2, 4, 8, 11, 12, 15, 17, and 19.

Clinician Onsite Inspection

The clinical areas held huddles, which were managed well and attended by providers, case managers, medication nurses, office technicians, mental health staff, and custody staff. One topic discussed was employees' scheduled time off and who would be replacing them. The employees felt this made for a smoother transition of care. The nurses were prepared to talk about their assigned patients, and nurses had an active role in participating in and leading the discussion.

The nurses working in the clinics were knowledgeable about their roles as case managers. The patients were identified through the patient registries, and population management meetings were held twice each month. The nurses stated they were seeing mostly diabetic patients, with other chronic care cases being scheduled as needed. There was no nursing backlog at CCWF, but the

providers' backlog caused considerable delays in access to care when scheduling nurse-to-provider visits.

The nurses felt the transition from a paper scanning system to a functional electronic health record system (EHRS) was still not fully implemented at the time of the visit, and continued to require a considerable amount of effort to solve problems. During the onsite visit, one clinic nurse demonstrated the new process used by nurses when assessing a patient, and noted that a major problem was the numerous additional steps required when seeing a patient for a minor problem, such as a rash. EHRS required the nurse to create an order for an appointment, and then the schedulers pulled the order from the queue and made the appointment. In cases 8, 16, and 20, the nurse did not order the appointment as documented. Because of the provider backlog, nurses were ordering appointments for patients beyond the standard required time frames to avoid having to reschedule them, which only an RN or SRN could do.

Recommendations

No specific recommendations.

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:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

OIG clinicians reviewed 292 medical provider encounters and identified 79 deficiencies related to provider performance. Of those 79 deficiencies, 21 were significant. As a whole, CCWF provider performance was rated *inadequate*.

Assessment and Decision-Making

The following three significant deficiencies in provider encounters demonstrated inadequate assessment and unsound medical decision-making:

- In case 2, a jaundiced patient had diarrhea and vomiting for one month and a significantly elevated laboratory liver test (total bilirubin level 19.1 mg/dL). However, the provider failed to address this finding suggestive of obstructive jaundice. The patient was later transferred to a community hospital, where a biliary stent was placed to alleviate the bile duct obstruction. This case is also discussed in the *Emergency Services* indicator.

- In case 5, a provider was consulted for critically high blood glucose (474 mg/dL) and ordered regular insulin. Subsequent recheck of the blood glucose showed slight improvement (356 mg/dL). However, the provider gave no further instruction. The same provider evaluated the patient later on the same day, but did not address the continued high blood glucose level.

- Also in case 5, the patient had a growing pulmonary nodule suspicious for lung cancer, and the provider ordered routine 90-day positron emission tomography (PET) and computed tomography (CT) scans. Based on the condition, the provider should have ordered urgent PET and CT scans, which normally would be provided in 14 days. The patient's delay in receiving the service and the provider's delay in diagnosing a possible cancer placed the patient at risk of harm. Fortunately, the nodule was benign.

Hospital Return

As patients returned from hospitalization, CCWF providers generally reviewed hospital discharge summaries; however, the providers did not always address all recommendations and findings. There were five significant deficiencies:

- In case 5, the patient returned from a recent hospital visit for severe low blood potassium and high blood glucose. The hospital consultant recommended having the follow-up with a provider in one to two days. The receiving nurse consulted the on-call provider, who requested no follow-up. This placed the patient at risk for recurrent problems and complications, such as cardiac arrhythmia and diabetic ketoacidosis.

- Also in case 5, a provider evaluated the patient after a recent hospital return but did not address a lung nodule found during the hospital visit, placing the patient at risk of delay treatment for possible lung cancer.

- In case 6, a provider evaluated the patient after recent hospitalization for seizure requiring treatment with intravenous antiepileptic medication, and did not address the hospital consultant's suggestion of an outpatient neurology evaluation. The provider also did not address the patient's anemia also identified during hospitalization.

- In case 19, during a hospitalization, the patient had high blood glucose suggesting new diabetes. In the hospital, the patient required insulin before meals and at bedtime. On return to the institution, the provider did not address this, and failed to continue the insulin.

- In case 28, the patient had an inherited condition for blood clots and had had two prior strokes requiring anticoagulation with warfarin (blood thinner). After the patient underwent surgery and returned to CCWF, the hospital advised continuing enoxaparin, an injectable anticoagulant medication until the oral warfarin was acting. The provider did not address the recommendation, and placed the patient at risk for another stroke or blood clot.

Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA, and were typically available for consultation with the TTA nursing staff. However, there were four significant deficiencies relating to the quality of provider care in emergency services. These cases are also discussed in the *Emergency Services* indicator:

- In case 2, also discussed above, a TTA provider evaluated a jaundiced patient and did not recognize the even more serious liver test results (total bilirubin 26.1 mg/dL) suggestive of an obstructive jaundice. This condition required urgent surgical intervention.

- In case 5, a TTA staff member consulted a provider regarding a glucometer's reading of "high" blood glucose, which remained high even after giving ten units of regular insulin.

The laboratory urine test was also positive for ketones suggesting diabetic ketoacidosis, a life-threatening complication of poorly controlled diabetes. Even though the patient refused to remain in the TTA, the provider should have scheduled the patient to follow up the next day.

- In case 10, a TTA nurse evaluated the patient, who was at risk for sexual transmitted diseases, for vaginal discharge. The provider failed to evaluate this condition.

- In case 20, a TTA nurse evaluated the patient for a severely low blood count (hemoglobin 6.2 g/dL). The nurse contacted the provider, regarding this. However, the provider failed to transfer the patient to a higher level of care, and placed the patient at risk for heart attacks and strokes.

Chronic Care

CCWF providers performed poorly in managing chronic medical conditions. In diabetic care there were four significant deficiencies:

- In case 5, a provider documented the patient's diabetes as "at goal." However, the provider had cited a laboratory test from four months earlier (HbA1c of 6.4). The provider failed to review current laboratory that showed the patient had poorly controlled diabetes with high average fasting glucose. The provider should have adjusted the basal insulin and had the patient follow up much sooner than 30 days later for reassessment of glycemic control.

- In case 16, the providers failed to recognize the poorly controlled diabetes over three months with elevated fasting blood glucoses that had risen. On two occasions, the provider stated that the diabetes was "at goal," and cited the laboratory test completed three months prior. The providers should have adjusted basal insulin and scheduled timely follow-ups for reassessment and medication adjustment until the patient's blood glucose was at goal.

- In case 21, the patient had poorly controlled diabetes (HbA1c at 11.4 percent, and high average fasting glucose 300 mg/dL). The provider did not review the blood glucose log or adjust insulin. In addition, the provider did not recognize that patient's failure to receive her noontime insulin was due to a conflict with scheduled educational classes, which led to further worsening diabetes control.

- In case 78, a provider did not diagnose diabetes in a patient with two consecutive elevated average blood glucose levels (HbA1c of 6.6 percent and 6.7 percent).

CCWF providers generally managed patients on anticoagulants effectively, but there was one significant deficiency:

- In case 28, the patient had an inherited hypercoagulable state (insufficiently thinned blood) requiring anticoagulation with warfarin and was scheduled for a routine surgery. The

provider failed to stop the warfarin for four to five doses prior to the surgery and to add a different, shorter-acting blood thinner before surgery.

The OIG clinicians also identified the following two significant deficiencies in chronic care:

- In case 5, during the OIG's six-month case review period, CCWF providers evaluated the patient 12 times for chest pain and transferred her to a community hospital five times for a possible heart condition. On every hospital visit, a heart attack was ruled out. A stress echocardiogram was performed to exclude heart disease. However, the specificity of this test for this patient was poor in ruling out coronary artery disease (CAD). It was only 77 percent sensitive, not 100 percent, and patients with high risk factors of diabetes, hypertension, and high cholesterol may still have CAD. The provider should have consulted cardiology for a more definitive work-up, such as an angiogram.

- In case 19, the patient had a calculated ten-year risk of heart disease or stroke of 25 percent, but the provider did not prescribe the recommended moderate- to high-intensity statin to lower cholesterol and risk. This placed the patient at risk for a cardiovascular event.

Specialty Services

CCWF providers generally referred appropriately and reviewed specialty reports timely; however, the providers did not address all recommendations. Two significant deficiencies were identified:

- In case 21, the patient had poorly controlled diabetes. The provider did not address the endocrinologist's recommendation to provide regular insulin before meals and inappropriately decreased the patient's daily standing insulin dose. The patient remained on this lower insulin regimen for two months, which led to worsening of an already poor glycemic control.

- In case 22, the rheumatologist documented that the patient experienced a heart rhythm disturbance with a new biologic medication (adalimumab) and recommended discontinuing the medication. The provider did not address the recommendation, placing the patient at risk of harm. The medication was discontinued five weeks later.

The OIG clinicians also identified four minor deficiencies when providers did not address specialists' recommendations:

- In case 7, the provider did not address the dermatologist's recommendation to prescribe daily vitamin D.

- In case 14, a provider evaluated the patient after a rheumatology visit but did not address a recommendation to decrease a daily steroid.

- In case 15, a provider did not address the gastroenterologist's recommendation to prescribe sublingual daily vitamin B12.

- In case 22, the rheumatologist recommended prescribing calcium with vitamin D. The provider did not address the rheumatologist's recommendation.

Health Information Management

The providers, in general, timely documented outpatient, TTA, and specialty housing encounters. Most progress notes were dictated and generally legible.

Clinician Onsite Inspection

The clinical areas held morning huddles led by providers, attended by nurses, the care coordinator, custody staff, and an office technician. The meetings were productive; they discussed significant TTA encounters and hospital returns that occurred on the previous day. In addition, daily morning provider meetings were held and attended by all providers and case managers, and the providers discussed hospitalized patients and hospital returns.

During the OIG clinician's site visit, CCWF's monthly provider meeting also occurred after the morning providers' meeting. The participants reviewed CCHCS's guidelines for opioid prescribing, diabetic care, and osteoporosis screening. The providers also discussed pain management for two patients. In addition, the providers completed a workplace questionnaire, which revealed low morale among the providers. The providers expressed concern that EHRS slowed the providers down and contributed to the already significant backlog of appointments, which was previously discussed in the *Access to Care* indicator. The providers believed that additional EHRS training would be beneficial.

At CCWF, providers were generally assigned to one clinic to enhance continuity of care, and they evaluated 8 to 12 patients per usual day. At the time of the OIG inspection, both the chief medical executive (CME) and chief physician and surgeon had just joined the institution six weeks prior. The CME expressed concern related to two provider vacancies, which contributed to the backlog of over 850 provider appointments for the reception center and the institution's four main yard clinics combined.

The significant provider backlog was a key factor in the institution's poor case review rating for the *Access to Care* indicator. However, to avoid negatively rating two indicators (*Access to Care* and *Quality of Provider Performance*) for the same basic condition, the OIG clinicians only gave minimal consideration to the backlogged provider appointments for this indicator. However, the presence of backlogged provider appointments could be a contributing cause of the providers' low morale, and the increased systemic risk of medical complications incurred by delayed provider care.

Conclusion

CCWF providers performed poorly in multiple aspects of patient care, including emergency care, chronic care, hospital return, and specialty services. The high number and severity of the deficiencies led to an *inadequate* rating in the *Quality of Provider Performance* indicator.

Recommendations

No specific recommendations.

RECEPTION CENTER ARRIVALS

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(40.7%)

Overall Rating:
Inadequate

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.

Case Review Results

The OIG clinicians examined 12 cases in which patients arrived at the institution's reception center and identified 21 related deficiencies. Ten of the deficiencies were significant (cases 6, 32, 33, 34, 35, 40, 41, 42, 43, and 44). In general, CCWF nurses performed thorough health screenings and made appropriate referrals. However, as discussed in the *Access to Care* indicator, CCWF had a significant provider backlog in timely completing new patients' history and physical exams. More specifically, in two cases, the patient did not receive a history and physical, and in three cases, the history and physical was 21 to 29 days late. In four cases, patients did not receive timely medication administration after arrival at CCWF. Based on the case review results, the OIG clinicians rated the *Reception Center* indicator *inadequate*.

The following example is one of the few identified deficiencies related to nursing performance for reception center arrivals:

- In case 6, the nurse performed an initial health screening of a patient with a seizure disorder but failed to ask the patient when the last seizure occurred and the frequency of the seizures. The patient's blood pressure was elevated at 140/106, but the nurse failed to recheck the blood pressure. The nurse documented that a referral was made for the patient, but did not document to whom and when.

Initial History and Physical Evaluation

Patients arriving at a State reception center such as CCWF from a county jail are required to have an initial health assessment performed by a primary care provider within seven calendar days of arrival. The OIG clinicians identified eight history and physical exams that did not occur timely or at all. Of those eight deficiencies, five were significant:

- In case 32, a newly arrived pregnant patient with asthma did not receive her history and physical exam.

- In case 34, a newly arrived pregnant patient did not receive her history and physical exam.
- In case 42, a newly arrived patient with asthma, hypertension, and arthritis did not receive her history and physical exam until 36 days after her arrival (29 days late).
- In case 43, the new-arrival history and physical exam occurred 28 days after the patient's arrival (21 days late).
- In case 44, the new-arrival history and physical exam occurred 34 days after the patient's arrival (27 days late).

Medication administration

Several reception center patients did not receive their medications on time or as prescribed:

- In case 6, the patient was a new arrival with a seizure disorder, but did not receive her seizure medication for three days. The patient had an unwitnessed seizure on her second day after arrival.
- In case 34, the order for acetaminophen was never completed, although the reception center nurse documented the medication to be continued.
- The patient in case 35 did not receive prenatal vitamins in a timely manner.
- In case 36, the order for prenatal vitamins was not filled, and the provider reordered the medication two weeks later.

Clinical Onsite Inspection

The reception center space at CCWF was small but well stocked with equipment and supplies, but deficient in lacking an exam table and Snellen chart. Although the nurse working the day of the OIG's onsite visit stated she had received no special training, she did appropriately answer questions related to the reception center's transfer process.

Compliance Testing Results

The institution received an *inadequate* compliance score of 40.7 percent in the *Reception Center Arrivals* indicator. The poor score was directly attributable to low scores received in six of the indicator's seven applicable test areas, as follows:

- The OIG sampled 20 reception center arrivals to ensure that each patient had a timely completed and properly document tuberculosis (TB) skin test. While all 20 patients appeared to have their skin tests timely initiated within 72 hours of arrival, CCWF's health care staff did not timely complete or correctly document any of the 20 sampled patients' test information. More specifically, nursing staff failed to document the TB serum's batch lot

number or expiration date into EHRS for all 15 applicable patients whose information was electronically documented using the new system. In addition, five patients' health care records did not contain the date and time the TB test was administered or the results were read. As a result, the institution scored a zero on this test (MIT 12.007).

- Providers timely completed reception center history and physical examinations within seven calendar days of arrival for only one of 20 sampled patients (5 percent). For 18 patients, the history and physical was completed one to 36 days late; another patient's exam was 138 days late (MIT 12.004).

- Among 20 sampled patients who arrived at CCWF from county jails, nurses referred four patients to see a provider. Out of the four referred patients, only one (25 percent) was seen timely by a provider. The three other patients were seen 12, 22, and 70 days late (MIT 12.003).

- Inspectors sampled 20 reception center patients to ensure that they received timely health screenings upon arrival at the institution. Nursing staff conducted timely and complete screenings for only 8 of those 20 patients (40 percent). The low score was attributable to nurses' failure to document additional explanatory information for questions that were answered "Yes" on 12 patients' health screening forms (MIT 12.001).

- After ordering intake tests for reception center arrivals, providers timely reviewed and communicated the test results to only 9 of 20 patients sampled (45 percent). For 11 patients, providers either reviewed the test results late, communicated the patient's results late, or both. The lateness of the deficiencies ranged from one to 56 days (MIT 12.006).

- Fourteen of 20 sampled reception center patients received all required intake tests (70 percent). Of the six patients who did not timely receive all of their required intake tests, three did not receive timely pelvic exams and pap smears due to menses. Two of these patients did not have the exams performed until three months later, while the third patient transferred to another prison without ever having the test performed. Three other patients also did not timely receive all of their required intake tests, including one patient whose laboratory tests were ordered 40 days late, one patient whose specimens were collected six days late, and one new arrival who had no evidence of a pelvic exam and pap smear being either offered or refused during the intake process (MIT 12.005).

CCWF scored a *proficient* 100 percent on the following test:

- Reception center nursing staff timely completed, signed, and dated the assessment and disposition section of the initial health screening form for all 18 patients sampled (MIT 12.002).

Recommendations

No specific recommendations.

SPECIALIZED MEDICAL HOUSING (OHU, CTC, SNF, HOSPICE)

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. CCWF's only specialized medical housing unit is a skilled nursing facility (SNF).

Case Review Rating:
Adequate
Compliance Score:
Proficient
(98.0%)

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 a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate.* The key decision factors were that the case review process includes a more robust SNF assessment on the quality of health care provided while the compliance review primarily assesses whether the medical housing unit met required time lines in providing health care. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

CCWF had 39 onsite specialized medical housing beds in the SNF. The OIG clinicians reviewed 313 encounters and noted 61 deficiencies, 7of which were significant. The OIG case review clinicians rated the *Specialized Medical Housing* indicator *adequate.*

Provider Performance

Provider performance was adequate. The OIG clinicians reviewed 67 provider encounters in the SNF and noted four deficiencies, two of which were significant in cases 16 and 19. However, there were four deficiencies related to patients with elevated blood glucose. These deficiencies are also described in the *Quality of Provider Performance* indicator:

- In case 1, a provider reviewed recent laboratory tests but did not address an elevated blood glucose that suggested new-onset diabetes.

- In case 16, the patient had poorly controlled diabetes with high average fasting blood glucoses (202 mg/dL), but the provider failed to adjust the patient's basal insulin.

- In case 19, there were two deficiencies. During a hospitalization, the patient had high blood glucose, which required regular insulin treatment. When the patient returned to CCWF and was admitted to the SNF, the provider failed to address this condition suggestive of new-onset diabetes. On the following day, a nurse noticed that the patient was receiving regular insulin during her hospitalization and requested management from the provider, but the provider failed to respond.

Nursing Performance

Nursing performance was adequate. There were 175 nursing events reviewed and 48 deficiencies identified, the following two of which were significant:

- In case 76, the nurse did not initiate a care plan for a patient with a risk of falling and breakdown of the skin.

- In case 77, the nurse did not assess the breathing of a patient returning from hospitalization for pneumonia.

Nurse-to-Provider Notification

In cases 73, 74, 76, and the following, nurses failed to notify a provider of abnormal assessment findings:

- In case 1, the nurse did not notify a provider when the patient had pain despite receiving her pain medication.

- In case 3, the nurse did not notify a provider of skin breakdown after discovering a new area of redness.

Nursing Documentation

Nursing documentation deficiencies were identified in cases 1, 16, 17, 18, 19, 73, 75, and the following:

- In case 77, the patient told the nurse that she was in pain. The nurse documented that the pain medication was effective; however, there was insufficient information documented on the medication administration record that clearly identified the type of pain medication or the delivery times.

Care Plans

A completed SNF care plan was only found for one of five sampled patients whose medical records were stored in the new EHRS.

Clinician Onsite Inspection

The SNF had 39 medical beds, 25 of which were occupied during the OIG visit. There were two negative pressure rooms (designed to minimize spread of airborne infections). A physician was assigned as the primary provider for specialized medical housing, and other providers were involved in patient care.

Conclusion

Provider care was adequate and the nursing staff provided good and coordinated patient care to the patients during their SNF stays. The care helped prevent common occurrences such as skin breakdown and hospital-acquired infections. The OIG case review clinicians found the *Specialized Medical Housing* indicator *adequate.*

Compliance Testing Results

The institution received a *proficient* score of 98.0 percent for the *Specialized Medical Housing* indicator, which focused on the institution's SNF. The institution scored in the *proficient* range in all of the indicator's test areas, as follows:

- For all ten patients sampled, nursing staff timely completed an initial assessment on the day of the patient's SNF admission (MIT 13.001).

- The SNF's assigned providers completed history and physical examinations within 72 hours of arrival for all ten patients sampled; however, only nine of these patients also timely received an initial provider assessment within 24 hours of arrival (90 percent). One patient's initial assessment occurred six hours late (MIT 13.003, 13.002).

- CCWF's providers timely completed subjective, objective, assessment, plan, and education (SOAPE) notes at required intervals for all seven applicable SNF patients sampled (MIT 13.004).

- When the OIG sample tested the working order of call buttons in the SNF patient rooms, all inspected call buttons were working properly. In addition, knowledgeable housing unit staff told OIG inspectors that their average urgent or emergent response time to access a patient's room was less than one minute, and management did not identify any concerns related to this reported response time (MIT 13.101).

Recommendations

No specific recommendations.

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:
Inadequate
Compliance Score:
Inadequate
(69.5%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 144 events related to S*pecialty Services,* and there were 36 deficiencies, 11 of which were significant. The case review rating for the *Specialty Services* indicator was *inadequate.*

Provider Performance

The case review showed that providers usually referred patients appropriately to specialists; however, the providers did not always address all specialist recommendations. There were six identified deficiencies, two of which were significant. These episodes are also discussed in the *Quality of Provider Performance* indicator.

Provider Follow-up after Specialty Service Visits

After a patient's specialty service visit, a provider should evaluate her within 14 days. These appointments are crucial in the delivery of care to patients as the providers review and address specialists' recommendations. Based on the OIG's case review, CCWF performed poorly in timely delivering these appointments. The OIG clinicians identified 15 deficiencies, four of which were significant. These four cases are also discussed in in the *Access to Care* indicator. The OIG clinicians consider the sufficiency of the specialty service follow-up process to be more directly related to the *Access to Care* indicator than to this *Specialty Services* indicator. As a result, the sufficiency of the follow-up process is only given minimal consideration in rating this indicator.

Specialty Access

Specialty appointments are integral aspects of specialty services. The OIG identified eight deficiencies in which specialty appointments did not occur within the requested time frame or did not occur at all. Seven deficiencies were significant:

- In case 2, there were two significant deficiencies. The patient was jaundiced, and the oncologist requested to have the patient follow up in one week with a CT scan of the abdomen. The follow-up appointment with the oncologist was 17 days later, but the CT scan was not done prior to the appointment.

- In case 13, the patient had poorly controlled glaucoma; the ophthalmologist added an additional eye medication to lower ocular pressure, and requested follow-up in three months to reassess glaucoma control. The appointment occurred more than five months later.

- In case 16, after a cardiac catheterization, the cardiologist requested a patient follow-up to occur in one week, but it did not actually occur until one month later.

- Also in case 16, the provider ordered an audiogram, but it was not done.

- In case 20, the gastroenterologist evaluated the patient for abdominal pain and recommended an abdominal ultrasound as soon as possible, with follow-up in four weeks. The follow-up appointment did not occur, and the ultrasound was not done.

- Again in case 20, the orthopedic surgeon evaluated the patient for a non-healing ankle fracture and requested a follow-up appointment in one month; the appointment did not occur. Four months later, a provider reviewed the consultation and requested a routine (within 90 days) orthopedic appointment; the appointment occurred four months later.

Health Information Management

The OIG identified three specialty reports that were not retrieved or scanned into the medical record:

- In case 1, a radiation oncologist's evaluation report was not retrieved or scanned into the medical record.

- In case 17, an orthopedic progress note was not found in the medical record.

- In case 28, a general surgeon's evaluation report was not retrieved or scanned into the medical record.

There were delays in retrieving two specialty service reports:

- In case 20, a gastroenterologist's evaluation report was not retrieved until more than five months later.

- In case 35, a pregnant patient had an urgent ultrasound to detect possible fetal developmental problems, but the report was not retrieved or scanned into the medical record until 12 days later.

There were two specialty reports not properly signed by the provider to evidence timely review:

- In case 2, a colonoscopy report was scanned into the medical record without a provider signature.
- In case 11, the consulting ophthalmologist evaluated the patient, but the primary care provider did not review the report until two weeks after the visit.

There were also four misfiled specialty service reports:

- In case 8, the carotid ultrasound request form was not found in the patient's medical record.
- In case 11, a podiatry consultation note was incorrectly labelled as an orthopedic consultation note.
- In case 21, a hematology consultation request form was incorrectly filed as public health document.
- In case 28, the patient's medical record contained a surgical consultation record that related to a different patient.

Clinician Onsite Inspection

At the time of the OIG inspection, there were four specialty services staff assigned to offsite and onsite specialty services. They scheduled specialty appointments, retrieved specialty reports, and made necessary orders and referrals. A tracking process was established to ensure that patients received their appointments. However, the staff believed that during the initial transition to EHRS, some specialty appointments were missed.

Conclusion

The OIG clinicians rated the *Specialty Services* indicator *inadequate* because numerous missed and delayed provider follow-up appointments led to untimely review of specialists' recommendations and hindered patient care.

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.5 percent in the *Specialty Services* indicator. The following three areas displayed opportunities for improvement:

- When patients are approved or scheduled for specialty services at one institution and then transfer to another, policy requires that the receiving institution reschedule and provide the patient's appointment within the required time frame. Only one of the six applicable patients sampled who transferred to CCWF with an approved specialty service (17 percent) received it within the required time frame. The remaining five sampled patients did not timely receive

their previously approved services. One patient had two approved services, of which CCWF provided one service 79 days late and the other service was not provided at all; two other patients never received their services; finally, two more patients received their specialty services 10 and 87 days late (MIT 14.005).

- Among 20 patients sampled for whom CCWF's health care management denied a specialty service, only four patients (20 percent) received a timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For eight patients, the provider's follow-up visit occurred from 9 to 59 days late, and three other provider visits or notifications occurred 90 to 184 days late. For five patients, there was no provider follow-up to discuss the denial at all (MIT 14.007).

- Providers timely received and reviewed 11 of the 15 routine specialists' reports that inspectors sampled (73 percent). For three patients, providers reviewed the reports from one to three days late, and a fourth report was reviewed 41 days late (MIT 14.004).

CCWF scored in the *proficient* range on the following tests:

- Providers timely received and reviewed the high-priority specialists' reports for all 15 patients sampled (MIT 14.002).

- For 14 of 15 patients sampled (93 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order; however, one patient received her specialty service six days late (MIT 14.001).

- CCWF provided routine specialty service appointments to 14 of 15 patients tested within the required time frame (93 percent). One patient received her specialty service 42 days late (MIT 14.003).

- CCWF's health care management timely denied providers' specialty services requests for 18 of 20 sampled patients (90 percent). Management denied two specialty services requests two and five days late (MIT 14.006).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

The last two quality indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*) involve health care administrative systems and processes. Testing in these areas applies only to the compliance component of the process. Therefore, there is no case review assessment associated with either of the two indicators. As part of the compliance component of the first of these two indicators, the OIG does not score several questions. Instead, the OIG presents the findings for informational purposes only. For example, the OIG describes certain local processes in place at CCWF.

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to CCWF in June 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. Of these two secondary indicators, OIG compliance inspectors rated both *inadequate*. The test questions used to assess compliance for each indicator are detailed in *Appendix A.*

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(73.0%)

Overall Rating:
Inadequate

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, and whether the institution is making progress toward its Performance Improvement Work Plan initiatives. In addition, the OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held.

Compliance Testing Results

The institution scored within the *inadequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, with a compliance score of 73.0 percent. The following test areas received low scores, which contributed to the overall poor indicator rating:

- Inspectors reviewed the summary reports and related documentation for CCWF's medical emergency response drills conducted for all three watches during the prior quarter. Based on inspectors' examination of the drill packages support, two drills lacked the inclusion of custody staff's participation, which is a required key component of medical response drills. For one other drill, custody staff did not complete the CDCR Form 837-C. As a result, CCWF received a score of zero on this test (MIT 15.101).

- CCWF's local governing body met quarterly during the four-quarter period ending March 2016, but only one of the quarter's corresponding meeting minutes were sufficiently detailed and timely approved (25 percent). Three quarters' meeting minutes were insufficient because they did not include discussions on the adoption of local operating procedures as CCHCS policy requires. In addition, the institution's CEO also approved one of three quarters' meeting minutes 50 days late (MIT 15.006).

- CCWF improved or reached targeted performance objectives for just two of the five quality improvement initiatives identified in its 2015 Performance Improvement Work Plan, resulting in a score of 40 percent (MIT 15.005).

The institution scored in the *proficient* range in the following test areas:

- CCWF timely processed patient medical appeals for all 12 of the most recent months. In addition, inspectors sampled ten second-level patient medical appeals and found that all of the appeal responses addressed patients' initial complaints (MIT 15.001, 15.102).

- The OIG reviewed the only CCWF adverse/sentinel event (ASE) that both occurred during the prior six-month period and required a root cause analysis. Inspectors' examination concluded that the institution followed ASE reporting requirements (MIT 15.002).

- CCWF's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).

- Medical staff promptly submitted the initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for all three applicable deaths that occurred at CCWF in the prior 12-month period (MIT 15.103).

- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by CCWF's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period; 11 of 12 sampled packages (92 percent) complied with policy. One did not include the required EMRRC checklist (MIT 15.007).

Other Information Obtained from Non-Scored Areas

- 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 any of the three CCWF 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 expeditiously notify the institution's chief executive officer (CEO) of the review results, so that any needed corrective action may be promptly pursued. For one patient death, the committee completed its summary 6 days late (36 days after death) and the institution's CEO was notified of the results 22 days late (65 days after death). For another patient, the DRC completed the death review summary timely, but the CEO received notification 14 days late. Lastly, for one other patient death that occurred on April 4, 2016, the death review had not been completed as of late November 2016 (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about CCWF's protocols for tracking medical appeals. Inspectors learned that management received weekly and monthly reports, including appeals, overdue appeals, disposition levels, and statewide comparisons. The institution received monthly appeal updates broken down by each category (CCWF used 25 different categories, such as ADA, administrative, bodily injury, chronic care, etc.). Finally,

management reviewed the reports to identify and track problem areas, and used the data to address specific issues, trends, significant appeals, and solutions (MIT 15.997).

- The OIG gathered non-scored data regarding CCWF's practices for implementing local operating procedures (LOPs). The data indicated that the institution had an effective process in place for developing LOPs. According to the institution's health program manager, the various department heads and health program specialist were responsible for reviewing changes to statewide policies and procedures and determining what, if any, impact they had on CCWF's established LOPs. Once a consensus was reached, the LOP was sent to the QMC. LOP updates were communicated to staff through annual meetings and forwarded via email to staff. At the time of the OIG's inspection, CCWF had implemented 28 of 31 applicable stakeholder-recommended LOPs (MIT 15.998).

- CCWF's health care staffing resources are discussed in the *About the Institution* section on page *2* of this report (MIT 15.999).

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(65.0%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.0 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. The institution has an opportunity to improve in the following three indicators:

- CCWF's health care management did not properly complete clinical performance evaluations for any of the institution's nine applicable providers. All nine providers' most recently completed performance appraisal packages lacked required 360 Degree Evaluations. As a result, the institution scored zero on this test (MIT 16.103).

- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency (DEA) registrations. However, the pharmacy did not have a process in place to independently track each provider's DEA registration status. As a result, CCWF scored zero on this test (MIT 16.106).

- Inspectors sampled nursing supervisors' April 2016 monthly records to ensure that they properly completed the required performance reviews for their subordinate nurses. Among five subordinate nurses the OIG sampled, only two nurses' supervisors properly completed their required reviews (40 percent). For two other nurses, no supervisory reviews were completed at all; and for a fifth sampled nurse, a performance review was completed, but the reviewing supervisor's name was not documented on the evaluation form (MIT 16.101).

The institution scored within the *adequate* range on the following test:

- Eight of the ten nurses sampled (80 percent) were current with their clinical competency validations. For two other nurses, there was no evidence found that the nurses recently received clinical competency validations (MIT 16.102).

The institution received *proficient* scores on the following tests:

- All providers were current with their professional licenses. In addition, all nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- All providers, nurses, and custody staff were current with their emergency response certifications (MIT 16.104).
- All nursing staff hired within the last year timely received new employee orientation training (MIT 16.107).

Recommendations

No specific recommendations.

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 Central California Women's Facility, 13 HEDIS measures were selected and are listed below in the following *CCWF Results Compared to State and National HEDIS Scores* table; however, only 12 measures were applicable to the institution. 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

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. For chronic care management, the OIG chose five measures related to the management of diabetes. Those measures included the institution's effectiveness in providing routine monitoring, minimizing patients who have poor HbA1c control, maximizing patients with good HbA1c control, managing diabetic patient blood pressure levels, and conducting routine dilated eye exams. Overall, compared to Statewide and national data, CCWF did very well in four of the five measures. However, as detailed below, the institution only scored moderately well in its ability to provide routine diabetic patient eye exams.

Statewide, CCWF outperformed Medi-Cal in all five diabetic measures and the institution outperformed both Kaiser North and Kaiser South in four of the five diabetic measures. However, for the dilated eye exam measure, the institution scored 3 and 15 percentage points lower than Kaiser North and Kaiser South, respectively.

Compared nationally, CCWF scored much higher in all five diabetic measures than the averages for Medicaid and commercial health plans. The institution also outperformed Medicare in four of the five diabetic measures and when compared to the U.S. Department of Veterans Affairs (VA), CCWF scored higher in three of the four applicable measures. Similar to the statewide results discussed above, CCWF respectively scored 3 and 24 percentage points lower than Medicare and the VA for the dilated eye exam measure.

Immunizations

For the three selected immunization measures, comparative data was only fully available for the VA and partially available for Kaiser, Medicare, and commercial health plans. With respect to administering influenza vaccinations to younger adults, CCWF matched Kaiser North results, but scored slightly lower than both Kaiser South and the VA. With regard to administering influenza vaccinations to older adults, CCWF outperformed the only two comparable entities, which were Medicare and the VA. Finally, with regard to pneumococcal vaccinations there were also only two other comparable entities in which case, CCWF outperformed Medicare, but underperformed the VA by 9 percentage points. Overall, the institution's comparable immunization measure scores were negatively impacted by patient refusals. For each of the above immunization measures, had patient refusals not occurred, CCWF would have had a perfect or near perfect scores which would have also resulted in higher scores than all other State and national figures.

Cancer Screening

For cancer screening, three comparative measures were selected which related to breast cancer screening, cervical cancer screening, and colorectal cancer screening. With regard to breast cancer screening, CCWF outperformed all statewide and national plans. However, CCWF scored only

moderately well for the cervical and colorectal cancer screening comparative measures. For cervical cancer screenings, CCWF scored better than Medi-Cal, Medicaid, and commercial health plans; however, the institution scored lower than Kaiser North, Kaiser South, and the VA. For colorectal cancer screenings, CCWF scored better than commercial plans and Medicare, but scored lower than Kaiser and the VA. Similar to the immunization results, CCWF's colorectal cancer screening comparable score was adversely affected by a 23 percent patient refusal rate. Had the refusals not occurred, CCWF would have scored better than all comparable entities in this measure.

Prenatal and Postpartum Care

Comparative data for the two prenatal and postpartum care measures selected was only available for Medi-Cal, Kaiser, Medicaid, and commercial health plans. With regard to providing pregnant patients with timely initial prenatal care visits, CCWF scored 96 percent, outperforming Medi-Cal, Medicaid, and commercial health plans, while matching Kaiser North's score and falling just 1 percent below Kaiser South's score. For this measure, CCWF would have received a perfect score and outperformed all entities had one patient not refused their prenatal service. With regard to the postpartum measure, while comparative data was available, CCWF did not have a sufficient number of childbirths from which to make an appropriate comparison. As a result, this measure was not applicable to the institution.

Summary

Based on the institution's comparative HEDIS results, CCWF's performance reflected only a moderately adequate chronic care program. The institution scored comparatively well in the areas of providing comprehensive diabetes care (except dilated eye exams), influenza shots to older adults, and breast cancer screenings. However, the institution has room to improve in the areas of providing diabetic eye exams, influenza shots to younger adults, pneumococcal immunizations to older adults, cervical cancer screenings, colorectal cancer screenings, and prenatal care. In all of the underperforming measures, except eye exams, CCWF's scores were significantly impacted by patient refusals. The institution can improve its scores by increasing patient education to reduce patient refusals.

CCWF Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	CCWF Cycle 4 Results[1]	HEDIS Medi-Cal 2015[2]	Kaiser (No.CA) HEDIS Scores 2015[3]	Kaiser (So.CA) HEDIS Scores 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2014[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**10%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**78%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**87%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**66%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)	**54%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	**80%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**84%**	-	-	-	-	-	70%	93%
Cancer Screening								
Breast Cancer Screening (50–74) [8]	**90%**		87%	88%	59%	74%	72%	87%
Cervical Cancer Screening (21-65) [9]	**84%**	59%	92%	87%	60%	76%	-	93%
Colorectal Cancer Screening	**70%**	-	80%	82%	-	64%	67%	82%
Prenatal and Postpartum Care								
Prenatal Care	**96%**	82%	96%	97%	82%	88%	-	-
Postpartum Care [10]	**N/A**	59%	93%	93%	62%	77%	-	-

1. Unless otherwise stated, data was collected in May 2016 by reviewing medical records from a sample of CCWF'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 the Medi-Cal Managed Care Program*.
3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the 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*.
6. For this indicator, the entire applicable CCWF population was tested.
7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.
8. The Kaiser HEDIS data age range is 52-74 and the VA is 50-69.
9. The HEDIS data age range is 21-64, while the CCHCS policy age range is 21-65. No patients aged 65 were randomly sampled.
10. With regard to postpartum care, CCWF only had one patient for whom postpartum care was applicable during the sample test period. Because of the limited universe sample size, a HEDIS comparison was deemed inappropriate. However, had the one applicable patient been included in the HEDIS comparison, CCWF's comparable score would have been a zero.

APPENDIX A — COMPLIANCE TEST RESULTS

Central California Women's Facility Range of Summary Scores: 40.71% - 98.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	66.33%
Diagnostic Services	63.95%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	67.08%
Health Care Environment	84.05%
Inter- and Intra-System Transfers	69.00%
Pharmacy and Medication Management	61.28%
Prenatal and Post-Delivery Services	71.43%
Preventive Services	74.24%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	40.71%
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	98.00%
Specialty Services	69.52%
Internal Monitoring, Quality Improvement, and Administrative Operations	72.96%
Job Performance, Training, Licensing, and Certifications	65.00%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	14	16	30	46.67%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	4	6	10	40.00%	20
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	28	2	30	93.33%	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	2	29	93.10%	1
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	4	8	12	33.33%	18
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?	2	1	3	66.67%	27
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment with a primary care provider within the required time frame?	18	7	25	72.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	14	13	27	51.85%	3
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**66.33%**	

Reference Number	*Diagnostic Services*	Scored Answers				
		Yes	No	Yes + No	Yes %	N/A
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	6	4	10	60.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	5	5	10	50.00%	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?	4	5	9	44.44%	1
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	1	8	9	11.11%	1
Overall percentage:					**63.95%**	

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

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	12	0	12	100.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	Not Applicable				
4.003	Are specialty documents scanned into the eUHR within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	13	7	20	65.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	Not Applicable				
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	35	5	40	87.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	15	10	25	60.00%	0
Overall Percentage:					**67.08%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	7	2	9	77.78%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	4	4	8	50.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	1	9	88.89%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	8	1	9	88.89%	0
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	9	0	9	100.00%	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	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	9	0	9	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	5	9	44.44%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	9	0	9	100.00%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	8	1	9	88.89%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	6	1	7	85.71%	2
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall Percentage:					**84.05%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	12	18	30	40.00%	0
6.002	**For endorsed inmate-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 inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	6	14	20	30.00%	10
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	15	5	20	75.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medication Administration Record (MAR) and Medication Reconciliation?	7	0	7	100.00%	3
Overall Percentage:					**69.00%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	4	22	26	15.38%	4
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	18	12	30	60.00%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	10	15	25	40.00%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	4	10	14	28.57%	6
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	8	22	30	26.67%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	4	6	10	40.00%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	4	3	7	57.14%	7
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?	11	1	12	91.67%	2
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	6	1	7	85.71%	7
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?	5	0	5	100.00%	9
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	5	0	5	100.00%	9
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	2	3	5	40.00%	9
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	*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?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	0	1	1	0.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	17	13	30	56.67%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**61.28%**	

Reference Number	*Prenatal and Post-Delivery Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
8.001	For patients identified as pregnant, did the institution timely offer initial provider visits?	7	0	7	100.00%	0
8.002	Was the pregnant patient timely issued a comprehensive accommodation chrono for a lower bunk and lower-tier housing and did the patient receive the correct housing placement?	7	0	7	100.00%	0
8.003	Did medical staff promptly order recommended vitamins, extra daily nutritional supplements and food for the patient?	0	5	5	0.00%	2
8.004	Did timely patient encounters occur with an OB physician or OB nurse practitioner in accordance with the pregnancy encounter guidelines?	7	0	7	100.00%	0
8.005	Were the results of the patient's initial prenatal screening tests timely completed and reviewed?	7	0	7	100.00%	0
8.006	Was the patient's weight and blood pressure documented at each clinic OB visit?	7	0	7	100.00%	0
8.007	Did the inmate-patient receive her six-week post-partum visit?	0	1	1	0.00%	6
Overall Percentage:					**71.43%**	

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed TB medications:** Did the institution administer the medication to the inmate-patient as prescribed?	1	6	7	14.29%	0
9.002	**Inmate-patients prescribed TB medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	6	1	7	85.71%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	17	13	30	56.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	24	6	30	80.00%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	30	0	30	100.00%	0
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	26	4	30	86.67%	0
9.008	Are required immunizations being offered for chronic care inmate-patients?	12	5	17	70.59%	13
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**74.24%**	

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

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

Reference Number	*Reception Center Arrivals*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	**For inmate-patients received from a county jail:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	8	12	20	40.00%	0
12.002	**For inmate-patients received from a county jail:** When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	18	0	18	100.00%	2
12.003	**For inmate-patients received from a county jail:** If, during the assessment, the nurse referred the inmate-patient to a provider, was the inmate-patient seen within the required time frame?	1	3	4	25.00%	16
12.004	**For inmate-patients received from a county jail:** Did the inmate-patient receive a history and physical by a primary care provider within seven calendar days?	1	19	20	5.00%	0
12.005	**For inmate-patients received from a county jail:** Were all required intake tests completed within specified timelines?	14	6	20	70.00%	0
12.006	**For inmate-patients received from a county jail:** Did the primary care provider review and communicate the intake test results to the inmate-patient within specified timelines?	9	11	20	45.00%	0
12.007	**For inmate-patients received from a county jail:** Was a tuberculin test both administered and read timely?	0	20	20	0.00%	0
12.008	**For inmate-patients received from a county jail:** Was a Coccidioidomycosis (Valley Fever) skin test offered, administered and read timely?	Not Applicable				
Overall Percentage:					**40.71%**	

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	9	1	10	90.00%	0
13.003	**For OHU, CTC, and SNF only:** Was a written history and physical examination completed within the required time frame?	10	0	10	100.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	7	0	7	100.00%	3
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall Percentage:					**98.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	14	1	15	93.33%	0
14.002	Did the PCP review the high-priority specialty service consultant report within the required time frame?	15	0	15	100.00%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	14	1	15	93.33%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	11	4	15	73.33%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	1	5	6	16.67%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	18	2	20	90.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	4	16	20	20.00%	0
Overall Percentage:					**69.52%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	1	0	1	100.00%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	Not Applicable				
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	2	3	5	40.00%	0
15.006	**For institutions with licensed care facilities:** Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	1	3	4	25.00%	0
15.007	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
15.101	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?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	0	3	100.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**72.96%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	13	0	13	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	2	3	5	40.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	8	2	10	80.00%	0
16.103	Are structured clinical performance appraisals completed timely?	0	9	9	0.00%	3
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the Pharmacist in Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	0	1	1	0.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall Percentage:					**65.00%**	

APPENDIX B — CLINICAL DATA

Table B-1: CCWF Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	5
Death Review/Sentinel Events	3
Diabetes	1
Emergency Services - CPR	2
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
Perinatal Services	5
RN Sick Call	25
Reception Center Transfers	5
Specialty Services	3
	73

Table B-2: CCWF Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	7
Anticoagulation	3
Arthritis/Degenerative Joint Disease	8
Asthma	26
COPD	11
Cancer	5
Cardiovascular Disease	10
Chronic Kidney Disease	3
Chronic Pain	13
Cirrhosis/End-Stage Liver Disease	1
DVT/PE	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	15
Gastroesophageal Reflux Disease	12
Gastrointestinal Bleed	2
HIV	4
Hepatitis C	12
Hyperlipidemia	17
Hypertension	38
Mental Health	26
Migraine Headaches	2
Rheumatological Disease	3
Seizure Disorder	11
Sickle Cell Anemia	1
Thyroid Disease	9
	241

Table B-3: CCWF Event - Program	
Program	**Total**
Diagnostic Services	175
Emergency Care	90
Hospitalization	59
Intra-System Transfers In	4
Intra-System Transfers Out	8
Outpatient Care	598
Prenatal & Postpartum Care	22
Reception Center Care	20
Specialized Medical Housing	313
Specialty Services	170
	1,459

Table B-4: CCWF Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	2
RN Reviews Detailed	28
RN Reviews Focused	38
Total Reviews	98
Total Unique Cases	73
Overlapping Reviews (MD & RN)	25

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Central California Women's Facility			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) 30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.008	• 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 (6)	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 (12)	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	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	*N/A at this institution*	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible Signatures & Review (40)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (9)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (30)	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 (10)	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 (30)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (30)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders (20)	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	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 (14)	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 (30)	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 (20)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries (2)	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals (5)	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 (7)	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 (30)	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 (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram (30)	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear (30)	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (30)	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 (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (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 CTC (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 (6)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (19)	InterQual	• Review date (3–9 months) • **Randomize**
	 (1)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (1)	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	Performance Improvement Work Plans (PIWP) (5)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 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 (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (3)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local Operating Procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (13)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	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 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (12)	OIG Q:16.001	• All required performance evaluation documents
MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff ○ Providers (ACLS) ○ Nursing (BLS/CPR) ○ Custody (CPR/BLS)
MIT 16.105	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

March 8, 2017

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Central California Women's Facility (CCWF) conducted from June 2016 to August 2016. California Correctional Health Care Services (CCHCS) acknowledges all 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

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
Roy Wesley, Chief Deputy Inspector General, OIG
Ryan Baer, Senior Deputy Inspector General, OIG
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